Mental Health & Disabilities Workforce Workgroup

December 12

2012

Eighty nine of Iowa's ninety-nine counties fall into Mental Health Provider Shortage Areas as designated by the Iowa Department of Public Health Primary Care Office. A Mental Health & Disabilities Workforce Workgroup has begun meeting to deliberate the health service providers needed to meet the needs of Iowans.

Interim Report to the Iowa General Assembly

Overview

The Iowa 2012 General Assembly charged the Iowa Department of Public Health with creating a mental health and disabilities group to make workforce recommendations in support of services to Iowans (Senate File 2315, Division II, Section 24). The Department of Human Services Mental Health Redesign Initiative was already underway since 2010. Workforce supply is a critical element of service capacity. IDPH leadership reviewed the legislative language, conferred with DHS leadership, appointed the workforce, and began deliberations in fall 2012.

Under the Iowa Code THE IOWA DEPARTMENT OF PUBLIC HEALTH (IDPH) is charged with professional practice oversight to protect citizens. The Department does this through a number of licensing boards and certifying bodies. Many of these address health services such as the Boards of Medicine, Nursing, Dentistry and Psychology. Other professional licensing boards that impact workers in the mental health and disability fields include social work, occupational therapy, speech therapy, physical therapy, and certified vocational rehabilitation, among others. The scope of IDPH engagement with employment is through this licensing-for-practice function. The Center for Health Care Workforce located in the IDPH Bureau of Oral and Health Delivery Systems has a number of programs addressing Iowa's health workforce issues.

THE DEPARTMENT OF HUMAN SERVICES (DHS) organizes workforce services into categories for reimbursement; these categories may or may not relate to the professional licenses of IDPH. For example the DHS job classification of "Social Worker" does not require a college degree in social work nor a license as a social worker. The job duties reflect a set of activities grouped into the job class for the purposes of contracting and payment for services.

Despite these distinct differences in approach, both departments are intimately engaged in service supply to vulnerable Iowans and to encouraging and enhancing a strong and skilled workforce. To that end both departments have multiple programs that monitor, recruit and enhance opportunities for both licensed and unlicensed health and service providers, while also providing public protections. These support programs range from health services planning, (DHS & IDPH) to loan repayment for specific providers (IDPH) willing to serve in shortage areas.

WORKFORCE SHORTAGE of mental health professionals, especially those able to prescribe medications is a national crisis with over half of the US counties having some unmet need (Konrad et el, Psych Services, 60:1307-14, 2009). Iowa is an extreme example of this national problem. Iowa ranks forty-seventh (47th) out of fifty states in the number of psychiatrists per capita – half the national average. Complicating the problem of workforce number is the maldistribution of the existing providers. For example, over half the existing psychiatrists practice in just two (2) Iowa counties. The aging of the current workforce adds another recruitment strategy need. These workforce trends driven by increased service demand are exemplified by each of the other mental health professional groups including psychologists, social workers, etc.

Mental Health & Disabilities Workforce Workgroup

The Mental Health and Disabilities Workforce Workgroup (MHDWW) was impaneled in August and September, met in October 2012 to review its charge and hear concerns and issues, and again in November 2012 to hear from professional groups and begin discussions.

The 2013 meeting plans will continue the demand and supply deliberations of the workgroup to identify specific recommendations to address the challenges and population service needs. The group will deliberate the impact of reorganizations of DHS administration under redesign as well as any impacts of the new federal Affordable Care Act. The Mental Health and Disabilities Workforce Workgroup is listed in the appendix along with the extensive interested parties list. Multiple groups, organizations, professional associations, and individuals are intimately involved and interested in these deliberations and accordingly they have been included in the discussions. The final report of the workgroup will detail the recommendations focusing on the strategies necessary to meet the identified Iowa service needs.

Health Manpower Shortage Area Designations

The Iowa Department of Public Health, Primary Care Office designates Health Manpower Shortage Areas following guidelines established by the federal Health Research and Services Administration (HRSA). These designations certify that there are too few providers to meet the predicted needs of the resident populations. Shortage areas are geographically defined groupings of counties that have provider-to-population ratios below an established national standard. Designated shortage is a requirement for National Health Service Corps loan repayment and placement of scholars, State Loan Repayment Program participation, J-1 Visa Physician Placement Waivers and the participation in over 40 federal health programs, including Rural Health Clinic designation and Federally Qualified Health Center status.

Mental Health Provider Shortage Areas are called Catchment Areas; sixteen (16) area designations cover 89 of Iowa's 99 counties. Ten (10) of the catchment areas are "geographic" meaning that the population to provider ratio is greater than 30,000 people to 1 licensed Psychiatrist. Five (5) of the catchment areas are designated due to high needs of the population in the areas – greater levels of youth, elders or impoverished individuals. One (1) catchment area is designated due to the large percentage (>30%) of the population living at or below the federal poverty level. Provider shortage affects timely intervention, chronic disease management, crisis and acute treatments both as inpatient and in outpatient services. Shortages put stress on other social systems especially police and court systems, and place local hospitals and primary care providers in behavior management situations on a regular basis. (Note the Iowa Shortage Designation Maps in the Appendix pages 6 & 7.) Since 1995 a number of other mental health professions besides psychiatrists qualify for federal programs, including psychologists, social workers, mental health nurse practitioners, licensed counselors and marriage and family therapists. The HRSA website (last checked December 2012) notes it would take 5,972 mental health providers to meet the needs of 89.3 million people living in 3,760 mental health HPSAs using a population to provider ratio of 10,000 to one(1).

Shortages compound each other and the Mental Health Provider Shortages push the acute mental health services to the primary health care, adding to the burden for Primary Care Physicians and Advanced Registered Nurse Practitioners. Geographically where there are both Mental Health and Primary Care Provider Shortage Designations there are few resources for resident populations. Many of Iowa's most rural counties face multiple provider shortages and a weakened local health system as a result.

Provider Production

As in many professional fields, provider supply is inversely proportional to the length of time required to prepare that professional for their clinical practice. In exploring the issues associated with Iowa's

Mental Health Provider Shortage Designations, The Mental Health and Disabilities Workforce Workgroup (MHDWW) identified the education and residency or internships necessary to produce practitioners in the local mental health teams. The psychiatrist as physician requires twelve (11-12) years of study and residency to prepare for independent practice. That is, four years of undergraduate education, four years of medical school, a year of internship, and a three or four year residency tops off the cumulative list. Psychologists enter practice at the Doctoral level. They have a four year undergraduate degree, followed by an average of six years of graduate training, including an internship and do 1 year residencies for a total of eleven (11) years. Advanced Nurse Practitioners have a similar four years of undergraduate, nursing, and then advanced psychiatric nursing training for two years to obtain a Master's degree or four years to obtain a doctoral degree. Social Workers who are licensed to provide mental health services have an undergraduate degree and two years graduate training for the Master's degree or four years of graduate school for the doctoral degree in social work and can provide counseling after six (6) or more year's preparation. However, all mental health professions are pushing for the Doctoral level as the terminal degree. With such long preparation times, it is reasonable to believe that solutions are decades away, if producing providers is our strategy for solving the shortage. A snapshot of other Midwestern states demonstrates the same provider supply circumstances, and importing providers seems to be an unlikely total solution.

In the decade between 1996 and 2005 eighty-six (86) residents were educated at the University of Iowa Psychiatry Residency Program and half (43) left the state immediately after training. Of the 43 who stayed, 32 remain in Iowa practice; 17 at the University, 10 in private practice, and 5 are working in community mental health settings. In total about two-hundred twenty one (221) Iowa psychiatrists provide psychiatric treatment for Iowa's mental health systems of care. (Strategies to Enhance Iowa's Psychiatric Workforce, division of Public and Community Psychiatry, University of Iowa Carver College of Medicine, February 2009, by Michael Flaum, MD, Nancy Williams, MD, and Douglas Steenblock, MD.) The shortages of other mental health professionals are as severe as the shortage of psychiatrists.

The 2013 work of the MHDWW will be to deliberate these issues and challenges for provision of services to Iowa's population. They will assess the impact of health system changes on workforce demand and supply. Then they will develop recommendations for contemplation by Iowa's 2014 General Assembly.

Wicked Problems

Wicked problems are defined as those that have no perfect solution; in fact, any attempt to address the problem will have only a partial impact and may cause harm as well as create a positive response. This is a wicked problem. Several concurrent solutions are likely to be necessary. Each will only marginally address the total scope of the issue, and reforms in federal and state programs will be required to build a better service climate for improved rural health services. A global and long term approach will be necessary and investment in a long ignored infrastructure will have to be a part of any global change plan.

There is no one strategy that is likely to significant change Iowa's mental health and disability workforce shortage trend, however, there are a number of strategies that together could have significant impact. It is certain the solutions will require thinking "outside the box" about mental health and disabilities services, workforce and workforce deployment. Different treatment models and networks such as integrated care models of mental health and primary care might be considered. Expanding the health

workforce to include consumers and family support systems might offer some solutions. Ensuring reimbursement practices in line with other states will help recruitment and retention of all workers. Expanding use of technology and using mid-level providers supports the broader system of care. In the midst of DHS broadly based system reform there is opportunity to assess and reassess not only the provider supply but also the system capacity and improve both to meet Iowa's demand for mental health and disability services.

Provider Training and Expanded Practice

A partial service solution might be the expansion of the primary care provider engagement in identifying, screening and managing chronic mental health illnesses. Primary care providers include doctors of medicine and osteopathey, physician assistants and advanced nurse practitioners who are licensed at the Masters level in order to prescribe medications. Most primary providers in shortage areas already are fully engaged and busier than or as busy as they want to be. Expanding mental health services into their current practices might require system redesigns. While expanded training and cross training are also needed because the primary care physicians currently are broadly trained in general medicine and may lack sufficient preparation to manage the complex behavioral health issues. Access to specialists helps partially resolve this problem. Yet, as an overall strategy it will be insufficient to address the need even with supportive tele-health connections to distant specialists. (Note the Primary Health Provider Shortage Designation Map in the Appendix 6 -11.)

Provider Recruitment

Most (but not all) shortage areas are non-metropolitan areas geographically. This means that many of them will not have the educational facilities to produce their own mental health workforce and will need to recruit providers to meet their population service needs. Recruitment is a complex and complicated process with a wide variation in the strategies that will be successful with any specific provider. Nationally, educators have noted that urban universities and teaching sites don't prepare practitioners for unique rural practice and their tenure there is shortened as a result (American Academy of Family Physicians. Rural health care: medical education. In: AAFP reference manual. Leawood KS: 2001). Recruiters note that jobs for spouses, schools for kids, available housing stock, and recreational activities are community based issues that go beyond the capacity of clinics and hospitals and require a broad community-based recruiting strategy for local success. Retention is often based on support for practices, time off, available educational opportunities and the ability to attend educational conferences, as well as professional practice management. Each of these elements can be satisfiers or job dissatisfiers and affect retention. Finally, long educational preparation leaves large educational loans and along with home mortgages and raising a family requires a salary that can service these obligations. Rural pay scales are significantly different than urban and federal payment to rural or non-metropolitan areas is lower as a result of payment patterns developed in the mid-sixties.

Successful rural models have been implemented in Minnesota and New Mexico. In both states, rural residents who have an interest in serving their rural neighbors are given economic and education assistance to enter their chosen fields in medicine, mental health and related fields. They are mentored throughout their training, although there are provisions to allow persons who do not meet minimum standards to leave their programs. These programs demonstrate retention rates higher than 80 percent. These models include special coursework to prepare participants to meet the unique

challenges of rural residents and practices and to be culturally prepared to best serve the underserved Iowa population.

Iowa and ten other states participated in a broad study of retention of all kinds of providers in all HPSAs and demonstrated that retention was the result of multiple factors but even when a site was able to retain a provider beyond their obligation period, over a third left by two years and over half were gone by the fifth year. While mental health providers were a smaller subset of this retention study, the clinics that participated reported longer recruitment times for mental health service providers but also slightly longer retention times. (See Appendix page 13: Findings of the First Year Retention Survey of the Multi-State/NHSC Retention Collaborative, November 5, 2012, Cecil G. Sheps Center for Health Services Research, The university of North Carolina at Chapel Hill, Donald E. Pathman, MD, MPH project investigator and Thomas Rauner project leader) An ongoing community-based recruitment strategy is necessary to maintain services to rural and underserved populations.

Non-Licensed Providers

While this initial IDPH deliberation has been the licensed providers who are the foundation of the health systems; this focus does not diminish the non-licensed providers in multiple specialty and service categories that are critical to the system of care as well. From direct care givers and peer support specialist to transportation supporters; these roles are necessary to Iowans who depend on this level of support for their stability and ability to cope. Indeed the Workgroup recognizes the corollary roles of the licensed and unlicensed and family providers for Iowans who need their support.

The workgroup recognized the community health systems that are necessary for complete services that address both mental and disability needs. This system encompasses the educational institutions, the health facilities and clinics, the providers, the support systems and the families and friends that serve those in need. The Workgroup focus acknowledges the importance of these roles – but seeks to support them in creation of a stronger licensed-professional infrastructure and health system foundation built on an integrated and efficient provider base.

2013

The New Year will bring continuation of the Workgroup deliberations. The final report will be submitted in December 2013 with a set of recommendations for addressing the service issues for mental health and disability services in Iowa.

Marianette Miller Meeks
Director, Iowa Department of Public Health
515-281-8474
Mariannette.miller-meeks@idph.iowa.gov

Jane Schadle
Workgroup Coordinator
515-281-0917
Jane.schadle@idph.iowa.gov

APPENDIX

Support Documents & Resources

Mental Health and Disabilities Provider Workforce Workgroup

11-5-12

Workgroup Member Name	Representation	Phone Numbers	Email Address	Providence
Senator Amanda Ragan	State Capitol, Des Moines, IA 50319	515-281-3371 641-424-0874	amanda.ragan@legis.iowa.gov	Legislative Appointments D-7
Representative Mark Smith	State Capitol, Des Moines, IA 50319	515-281-3221 641-750-9278	mark.smith@legis.iowa.gov	Legislative Appointments D-43
Senator David Johnson	State Capitol, Des Moines, IA 50319	515-281-3371 712-758-3280	david.johnson@legis.iowa.gov	Legislative Appointments R-3
Representative Linda Miller	State Capitol, Des Moines, Iowa 50319	563-449-9956 563-650-9539	Linda.miller@legis.state.ia.us	Legislative Appointment R-82
Dr. M. Miller-Meeks	Director Iowa Department of Public Health	515-281-8474	Mariannette.Miller-Meeks@idph.iowa.gov	Legislative Directive
Kathy Stone	IDPH, Division of Behavioral Health	515/281-8021 C- 515/720-2011	Kathy.Stone@idph.iowa.gov	MBA, LMSW Subject Expert
Dr. Michael Flaum	Clinical Professor, University of Iowa School of Medicine	319 353 4340	michael-flaum@uiowa.edu	Strategies to address psychiatric workforce shortage
Karalyn Kuhns	Executive Officer III DHS - - Division of Mental Health & Disability	515-281-6003	kkuhns@dhs.state.ia.us	DHS liaison
Michele Greiner	Training Development Director Iowa Psychological Association	(641)472-4888	mgreiner@lisco.com mgreinerphd@hotmail.com	Ph.D.
Mike Rosmann, PhD	Executive Director, AgriWellness, Inc.	712-155-1516	agriwellness@fmctc.com	Psychology Rural health nomination REC: IRHA
Dr. Joyce Vista-Wayne	Board of Medicine	641-683-4454	Joyce.vista-wayne@iowa.gov hsggg212@yahoo.com Kswjvw92@lisco.com	BOM
Katie Van Blair, PhD	Director, School of Social Work Associate Professor of Social Work	563-333-3912	VanBlairKatherine@sau.edu	MSW, Ph.D., LMFT

Workgroup Member Name	Representation	Phone Numbers	Email Address	Providence
Judy Collins	Nurse clinician Nurse educator	563-349-9622	collinsju43@gmail.com	Psych ARNP REC: INA
Linda Gerkie	Family Nurse Practitioner	641-864-3301	LKGFNP@aol.com	ARNP
Myke Selha	National Association of Social Workers, Iowa Chapter	641-236-6137	mselha@pcmentalhealth.org	CMHC Poweshiek

State Staff

Julie McMahon, Director	Division Health Promotion and Chronic Disease Prevention Iowa Department of Public Health 321 E. 12th Street Des Moines, Iowa 50319	515-281-3104	Julie.mcmahon@idph.iowa.gov
Jane Schadle	Iowa Department of Public Health 321 E. 12th Street Des Moines, Iowa 50319	515-281-0917	Jane.schadle@idph.iowa.gov
Deborah Thompson, Policy Advisor	Iowa Department of Public Health 321 E. 12th Street Des Moines, Iowa 50319	515-281-0917	Deborah.thompson@idph.iowa.gov
Megan Hartwig, Advisory Council	Iowa Department of Public Health 321 E. 12th Street Des Moines, Iowa 50319	515-281-8465	Megan.hartwig@idph.iowa.gov
Patty Funaro	Senior Legal Counsel Iowa Legislative Services Agency Legal Services Division State Capitol Des Moines, Iowa 50319	515-281-3040	Patty.funaro@legis.state.ia.us
Aaron Todd	Iowa Legislative Services Agency Legislative Services Division State Capitol Des Moines, Iowa 50319	515-281-6764	aaron.todd@legis.state.ia.us
Joanna Schroeder	DHS Redesign Coordinator DHS Hoover Building Des Moines, Iowa 50319	515-725-2238	jschroe3@dhs.state.ia.us

Interested Parties

Workgroup Member Name	Representation	Phone Numbers	Email Address	Providence
Jim Rixner	Siouxland Mental Health Center Executive Director	712-252-3871 x 256	jwrx@aol.com	
Ann Riley	Centers for Disabilities and Development University of Iowa	319-353-6523	Ann-l-riley@uiowa.edu	Deputy Director
Teresa Bomhoff	MH Planning Council – NAMI	515-574-9279 515-274-6876	tbomhoff@mchsi.com	Consumer activist, served on adult MH workgroup in 2011
Ron Askland	Horizons Unlimited	712-852-2211	ronaskland@horizons-unlimited.net	Nom. By Center for Disabilities and Development
Kelli. Soyer	Executive Director National Association of Social Workers, Iowa Chapter	515-277-1117	exec@iowanasw.org	NASW 60% of MH counseling
Deanna Clingan-Fischer, JD	Legal Services Developer Iowa Department of Aging	515- 725-3319	deanna.clingan@iowa.gov	
Terry Hornbuckle	Workforce and Employment Specialist Iowa Department of Aging	515-725-3323	terry.hornbuckle@iowa.gov	
Kelly Myers	Iowa Health Care Association	515- 978-2204	kelly@iowahealthcare.org	
Di Findley /John Hale	Iowa CareGivers Association	515- 249-0138 515-313-7766	di.findley@iowacaregivers.org Hale_johnd@msn.com	
Dan Royer	Iowa Hospital Association	515-288-1955	royerd@ihaonline.org	
Kate Walton	Iowa Medical Society	515-223-1401	kwalton@iowamedical.org	
Jay Iverson	Executive Director, Iowa Nurses Association	515-225-0495 515-422-2828	executivedirector@iowanurses.org	CAE, IOM
Deb Kazmerzak	Program Director Iowa Primary Care Association	515-333-5013	dkazmerzak@iowapca.org, www.iowapca.org	
Casey Westhoff	Executive Director ARC of Iowa	515-210-6686	Cwesthoff@arceci.org	

Workgroup Member Name	Representation	Phone Numbers	Email Address	Providence
Patricia Clinton	Clinical professor, Assistant Dean for Graduate Programs	319-335-7055	patricia-clinton@uiowa.edu	PhD, RN, ARNP, FAANP Research: ARNP supply
Todd Noack	Regional Coordinator Iowa Office of Consumer Affairs	563-726-3244	toddnoack@yahoo.com	ocaiowa.org
Kristten Buttermore	Creative Counseling & Intervention Services	515-233-1699 515-450-7436	kbuttermore@ccsames.org	http://ccsames.org/
Linda Hinton	Gov. Relations Manager Iowa State Assoc. of Counties	515-244-7181	lhinton@iowacounties.org	

Iowa Mental Health Provider Shortage Designation Catchment Areas

Mental Health Professional Shortage Area Overview

The US Health Resources & Services Administration (HRSA), Bureau of Clinical Recruitment and Service, Division of Policy and Shortage Designation, Shortage Designation Branch provides guidelines for determining federally qualified health professional shortage areas. Health Professional Shortage Areas (HPSAs) indicate geographic areas with a shortage of primary care providers, mental health providers and dental providers.

In Iowa, many of our HPSAs are entire counties; some are census tracts or groupings of census tracts or townships. State Primary Care Offices (PCO) analyzes and submits requests for shortage designations to HRSA. The Iowa PCO is located within the Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health. A link to the PCO can be found by entering the URL: http://www.idph.state.ia.us and entering the term Primary Care Office into the search option.

Mental Health HPSA designations provide access to a number of programs including:

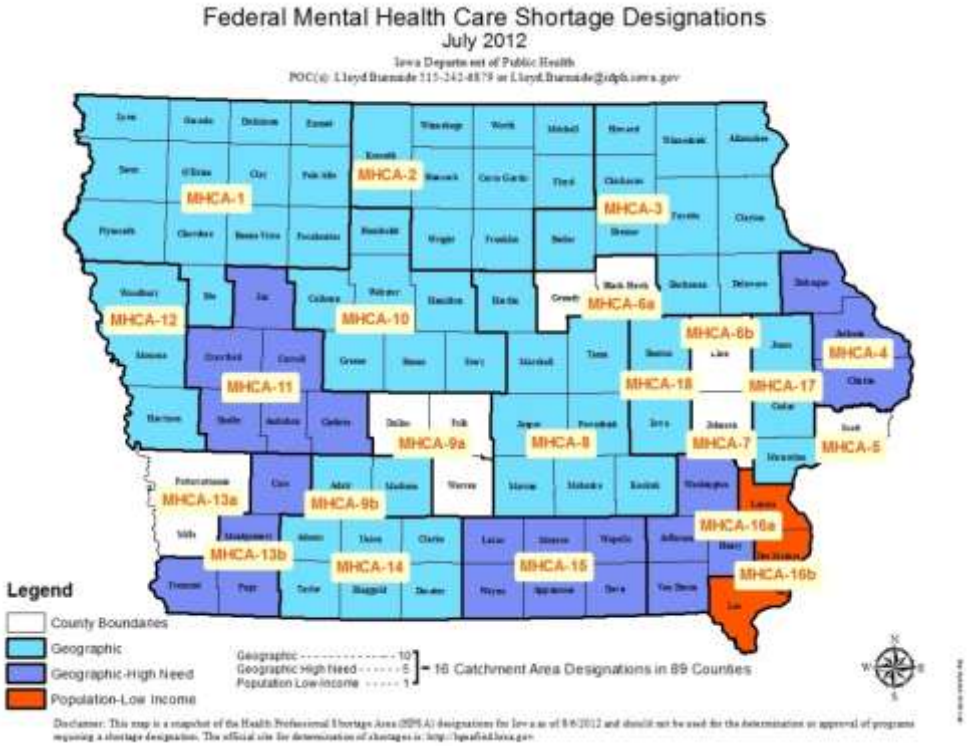
- National Health Service Corps loan repayment and placement of scholars,
- State Loan Repayment Program,
- J-1 visa waiver physician placement, and
- State Mental Health Shortage Area program.

Mental Health HPSA

Iowa's mental health HPSAs are comprised of groupings of counties called Mental Health Catchment Areas. Currently 89 of 99 counties are located in a designated Mental Health HPSA. Mental Health Care HPSAs are required to be re-analyzed every 4 years for re-designation or de-designation.

HPSA=population-to-psychiatrist ratio greater than **30,000 to 1.**

If the area has high needs, defined by having a high poverty rate **or** high youth ration **or** high elderly rate **or** high substance abuse prevalence, then the area may qualify at a **20,000 to 1 ratio.**

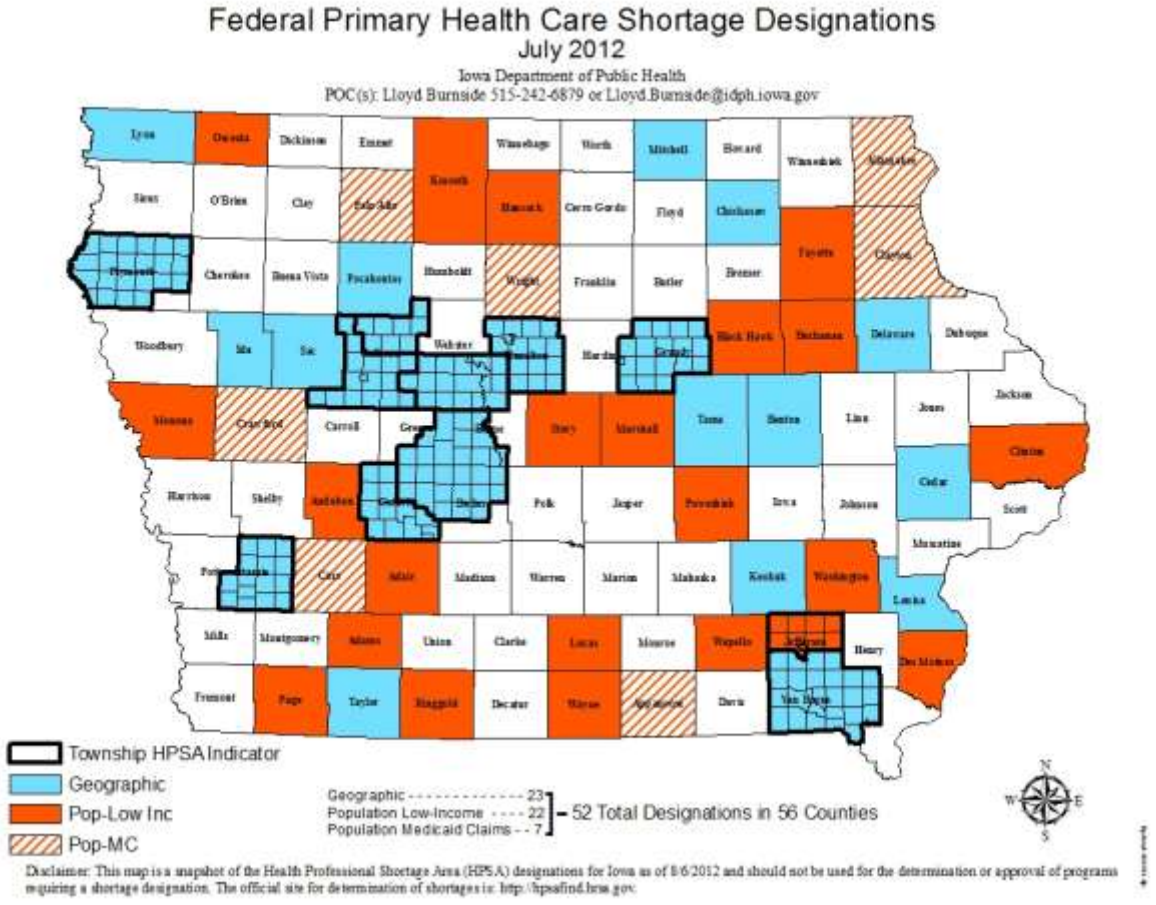


Iowa Primary Care Health Provider Shortage Designations

Primary Care HPSA Criteria *most common current methods

The Rationale Service Area Analysis (RSA) is the application of shortage criteria to an area to determine if shortage exists. All shortage designations use the same step-by-step process. First the ratio of primary care physician providers to resident population is calculated against the criteria of 3,500 residents to one (1) primary care physician. If the geographic area has high-needs populations, (percent of youth, elderly, or impoverished individuals); then a ratio of 3,000 to one (1) can be used.

Second, a population group HPSA can be designated based upon a series of calculations: first, at least 30 percent of the population in the service area is at or below 200 percent of the federal poverty level; second, the percent of Medicaid and sliding fee scale program participants served by the provider practice is calculated to determine the service full-time equivalent (FTE); third, the ratio of the FTE per percentage-of-population-at 200% of poverty is used to designate the provider-to-population ratio for calculation of the shortage designation and it must be at least 3,000 to one.



Psychiatrists in Iowa 2012

Psychiatrists are medical doctors who are uniquely qualified to assess both the mental and physical aspects of psychological disturbance. Their medical education has given them a full working knowledge of the many causes for a patient's feelings and symptoms. Psychiatrists can make a complete, accurate diagnosis and then recommend or provide treatment. Because they are physicians, psychiatrists can order or perform a full range of medical and psychological tests that provide a complete picture of a patient's physical and mental state.

Medical students follow a standard medical curriculum and take courses in psychiatry, behavioral science and neuroscience in the first two years of medical school. In the last two years, students are assigned to medical specialty "clerkships," where they study and work with physicians in at least five different medical specialties. Medical students taking a psychiatry clerkship take care of patients with mental health diagnoses in the hospital and in outpatient settings. Newly graduated physicians take written examinations for a state license to practice medicine. After graduation, doctors spend the first year of residency training in a hospital taking care of patients with a wide range of medical illnesses. The psychiatrist-in-training then spends at least three additional years in psychiatry residency learning the diagnosis and treatment of mental health, gaining valuable skills in various forms of psychotherapy, and in the use of psychiatric medications and other treatments.

To be licensed to practice psychiatry in Iowa, practitioners must have a medical degree and at least one year post-graduate training in psychiatry. Once the psychiatric residency is complete, physicians may apply for licensure to practice from the State of Iowa. Licensure requires a degree from a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). Applicants from schools not accredited by these organizations may still qualify, but may need to take additional coursework and examinations. In addition, physicians must pass one of several medical licensure examinations. Examinations could include; one, a state medical examination, LMCC, NBOME or FLEX, among many others.

Iowa has one training program in psychiatry.

University of Iowa- Carver College of Medicine
Department of Psychiatry, Iowa City, IA
Website: http://www.medicine.uiowa.edu/pa/

Data Considerations

- **Iowa has 237 active Psychiatrists shown by county and within Mental Health Catchment Areas (MHCA) outlined in bold. See HPSA MHCA map at http://www.idph.state.ia.us/OHDS/RuralHealthPrimaryCare.aspx?prog=RHPC&pg=Resources**
- **Data is shown by practice site as opposed to residence and is updated 2X/year by the Office of Statewide Clinical Education Programs at the University of Iowa.**
- **Data shown does not reflect visiting consultations to clinics or tele-health encounters**

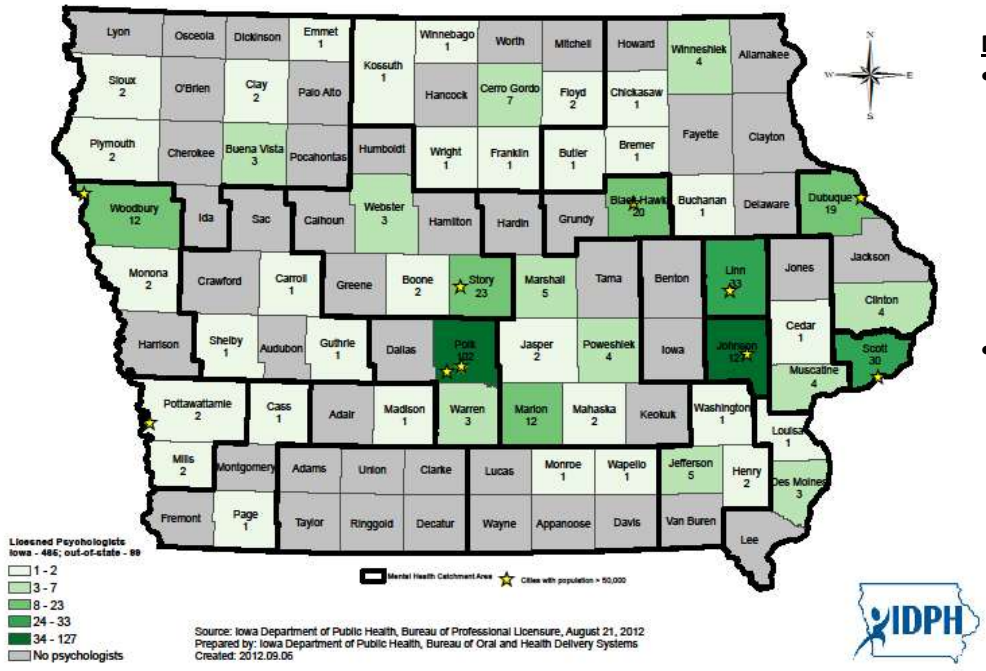
Psychologists in Iowa 2012

Psychologists diagnose and evaluate mental and emotional disorders. Iowa licensed Psychologists must hold a doctorate in psychology from an accredited institution, pass a national examination, and fulfill state requirements of one year or a minimum of 1500 hours of supervised professional experience. The most commonly recognized psychology professionals are clinical and counseling psychologists, those who provide psychotherapy and/or administer and interpret psychological tests. Psychologists may engage in specialized work with identified populations (e.g. medical, child, gerontological, rural, veterans, etc.). They have specialized skills for those who are qualified in such areas as neuropsychological assessments, biofeedback and prescriptive capacity. Psychologists in Iowa do not have prescriptive authority.

Ph.D. campus training programs in Iowa include:

Iowa State University – Department of Psychology W112 Lagomarcino Hall, Iowa State University Ames, IA 50011-3180 psychinf@iastate.edu	University of Iowa- Department of Psychology 11 Seashore Hall E Iowa City, IA 52242-1407 psychinf@iastate.edu

Iowa: Licensed Psychologists



Data Considerations

- **Iowa has 486 active Psychologists in state shown by county and within Mental Health Catchment Areas (MHCA) outlined in bold.**
  See HPSA MHCA map at http://www.idph.state.ia.us/OHDS/RuralHealthPrimaryCare.aspx?prog=RHPC&pg=Resources
- **Licensure data does not delineate between home or workplace address.**

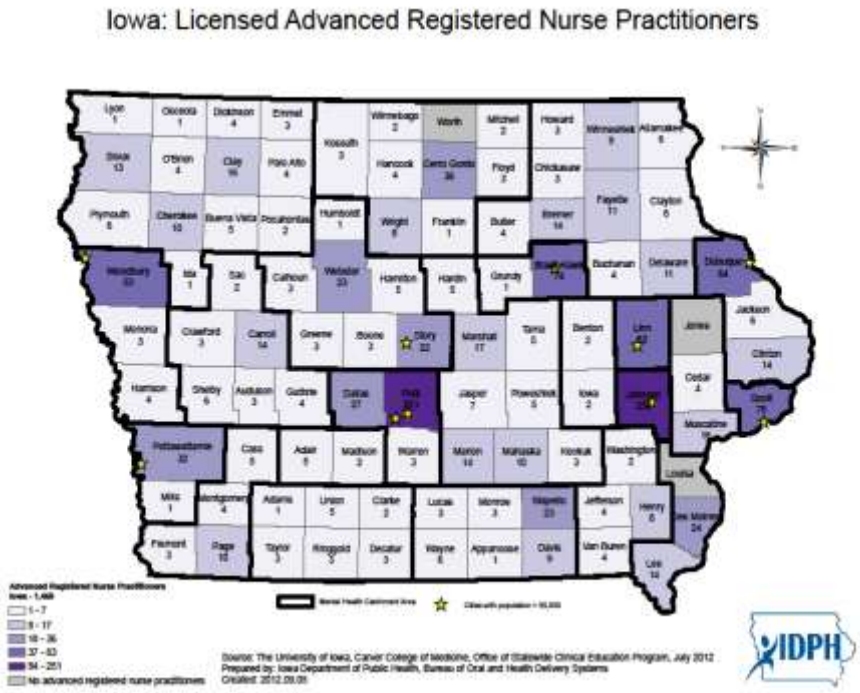
Advanced Registered Nurse Practitioners in Iowa 2012-Emphasis on Mental Health

Advanced Registered Nurse Practitioners (ARNPs) can work independently to provide primary, acute and specialty healthcare to patients of all ages. ARNPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans – including prescribing medications. The specialty areas of nursing practice for the ARNP in Iowa are a certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner and a certified registered nurse anesthetist. Graduation from a board approved advanced practice master's program or completion of a formal advanced practice education program is required for registration as an ARNP. Current licensure as a registered nurse is mandatory for advanced nursing practice in Iowa and as well as a current advanced level certification by a national professional nursing certifying body. ARNPs serve in certified community support programs and in outpatient mental health clinics, however, the data does not show nurses by area of specialty.

Nurse Practitioner Programs in Iowa with a Mental Health Program Specialty

Allen College Allen College, 1990 Heath Street, Waterloo, Iowa 50703 Programs Offered: Accelerated - BSN, RN to BSN, RN to MSN, Master of Science in Nursing (tracks: FNP, Acute Care NP, ANP/GNP, Adult Psychiatric Mental Health NP) Post-Master's Certificates	University of Iowa - College of Nursing College of Nursing - University of Iowa, 101 Nursing Building, 50 Newton Road, Iowa City, IA 52242-1121, PH: 319-335-7018 Programs Offered: MSN (Tracks: Clinical Nurse Leader, APN - Adult/Gerontological Nurse Practitioner or CNS, Nurse Anesthetist, Family Nurse Practitioner, Neonatal Nurse Practitioner, Pediatric Nurse Practitioner, Psychiatric/Mental Health Nursing, MSN - Nursing Systems Administration, Community Health Nursing, Genetics Nursing, Nursing Informatics, Nurse Educator, Nurse Educator, including Gerontological Nurse Educator, Occupational Health Nursing, School Health Nursing, MSN - Dual Degree - MSN/MPH, MSN/MBA)

Additional programs in Iowa are available but do not offer a mental health specialty.



Data Considerations

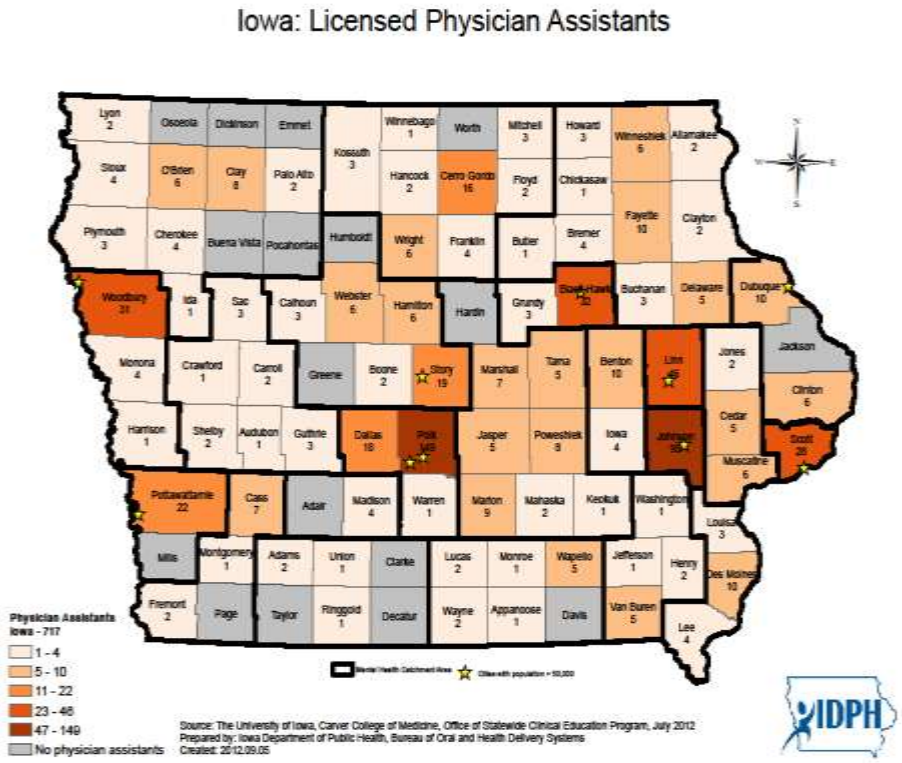
- **Iowa has 1,459 active ARNPs shown by county and within Mental Health Catchment Areas (MHCA) outlined in bold**
  See HPSA MHCA map at http://www.idph.state.ia.us/OHDS/RuralHealthPrimaryCare.aspx?prog=RHPC&pg=Resources
- **Data is shown by practice site as opposed to residence and is updated 2 X/year by the Office of Statewide Clinical Education Program at the University of Iowa.**
- **Data shown does not distinguish how many ARNPs provide psychiatric services. Data was not collected by specialty area of practice.**

Physician Assistants in Iowa 2012-Emphasis on Mental Health

A physician assistant (PA) works as part of a team with a doctor and is a graduate of an accredited PA post graduate educational program that is nationally certified. State-licensure to practice medicine is required with the supervision of a physician. The average length of a PA education program is 27 months. PAs also complete more than 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices and acute or long-term care facilities. Rotations include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry. Iowa has two Physician Assistant Training programs.

PAs in psychiatry expand access to mental health services. They often work in behavioral health facilities and psychiatric units of rural and public hospitals, where psychiatrists are in short supply. In private practices, PAs regularly conduct initial assessments and perform maintenance check-ups for patients on psychiatric medications. In jails and prisons, PAs help meet the need for psychiatric services and medical care. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, geriatric psychiatry, addiction medicine and care for post-traumatic stress patients. Iowa has two post-graduate Psychiatric training programs that provide a one year internship in psychiatry for PAs already in practice.

Des Moines University Physician Assistant Program , Des Moines, IA Website: http://www.dmu.edu/pa	**University of Iowa- Carver College of Medicine** Physician Assistant Program, Iowa City, IA Website: http://www.medicine.uiowa.edu/pa/



Data Considerations

- **Iowa has 717 active PAs shown by county and within Mental Health Catchment Areas (MHCA) outlined in bold**
  See HPSA MHCA map at http://www.idph.state.ia.us/OHDS/RuralHealthPrimaryCare.aspx?prog=RHPC&pg=Resources
- **Data is shown by practice site as opposed to residence and is updated 2X/year**
- **14 PAs practice in a mental health specialty area, of the 14:**
  - ✓ **3 are in a Mental Health Institute,**
  - ✓ **5 in Community Mental Health Centers,**
  - ✓ **3 in private practice,**
  - ✓ **1 is a federal employee in the VA,**
  - ✓ **1 in a state institution and**
  - ✓ **1 in public health.**

Iowa Provider Recruitment and Retention Study Report Summary – Project Year 2012

Through 2012 the Iowa Primary Care Office (PCO) participated in a multi-state/National Health Service Corps (NHSC) Retention collaborative study to identify the rates of retention of NHSC providers in Iowa communities and to identify those retention factors that could be addressed to increase satisfaction and retention.

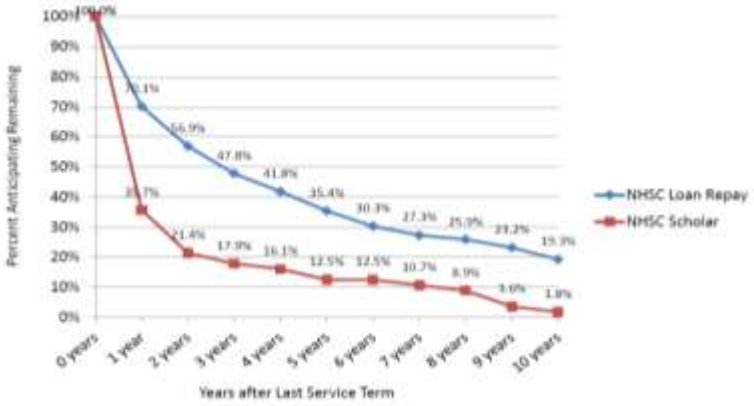
Participating States

This two-phase project drew state PCOs and other health workforce leaders from 11 participating states and the staff of the University of North Carolina's Cecil G. Sheps Center for Health Services Research to survey NHSC providers and analyze the satisfaction and retention information. The second year (2013) of the retention collaboration project will center on designing and building a longitudinal retention data gathering system that will routinely survey clinicians as they serve in their service programs.

The full report presents a large amount of information organized to provide an overall understanding of the experiences of 1,385 clinicians serving in eight federal and state programs in 11 states, and the anticipated retention of approximately 996 of these clinicians. Iowa's 65 clinicians (64 NHSC Loan Repayment Program and 1 NHSC Scholarship recipient) participated in these surveys and their responses were included in the analysis.

Retention after the obligation period varies but **clinicians anticipated remaining at the site** are shown in the table and graph below – of Iowa's 64 NHSC Loan Repayment Program participants 42 indicated they would remain after their obligation period, but less than 15 percent would stay 10 years.

Figure LC.3. Percentage of 11 State Clinician-Participants of the NHSC Loan Repayment (n=638) and NHSC Scholarship (n=56) Programs That Anticipate Remaining at Their Service Sites in Years Following Their Last Service Terms



Data for Figure I.C.5. Percentage of NHSC Loan Repayment Program Clinicians serving in Each of 11 States That Anticipate Remaining at Their Service Sites in Years Following Their Last Service Terms

Years After Last Service Term Ends	Alaska (n=20)	California (n=117)	Delaware (n=117)	Iowa (n=42)	Kentucky (n=63)	Montana (n=71)	Nebraska (n=45)	New Mexico (n=62)	North Carolina (n=82)	North Dakota (n=82)	Washington (n=79)
0 years	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1 year	55.0%	74.4%	71.4%	73.8%	77.8%	70.4%	75.6%	66.1%	61.0%	72.1%	67.1%
2 years	45.0%	62.4%	57.4%	61.9%	57.1%	59.2%	60.0%	51.6%	50.0%	58.1%	55.7%
3 years	30.0%	53.8%	57.1%	54.8%	47.6%	49.3%	51.1%	45.2%	35.4%	53.5%	46.8%
4 years	20.0%	47.0%	42.9%	52.4%	46.0%	46.5%	48.9%	37.1%	30.5%	41.9%	38.0%
5 years	15.0%	38.5%	35.7%	42.9%	39.7%	42.3%	42.2%	30.6%	26.8%	39.5%	29.1%
6 years	10.0%	29.9%	28.6%	40.5%	38.1%	38.0%	37.8%	25.8%	24.4%	30.2%	22.8%
7 years	5.0%	27.4%	21.4%	35.7%	34.9%	35.2%	35.6%	24.2%	24.4%	25.6%	17.7%
8 years	5.0%	25.6%	21.4%	35.7%	33.3%	31.0%	33.3%	22.6%	24.4%	25.6%	16.5%
9 years	5.0%	24.8%	21.4%	28.6%	30.2%	28.2%	28.9%	19.4%	24.4%	20.9%	12.7%
10 years	5.0%	23.1%	21.4%	14.3%	27.0%	23.9%	26.7%	12.9%	18.3%	16.3%	12.7%

The Iowa providers that participated in this study were located throughout the state at designated shortage sites and included a range of professional practices: physicians, advanced nurse practitioners, dentists, dental hygienists, psychologist and other mental health providers. Of the 64 Iowa participants, 68% were female, average age was 33 years, 98% were white, non-Hispanic, 85% married, 70% grew up in Iowa and 44% were trained in Iowa.

The odds ratios of retaining a provider based on their demographics is depicted in this table. For Iowa we have better chances of retaining providers who are raised and educated here and who have local family. Older providers and women as well as white-Non-Hispanic individuals also are more likely to stay.

Table II.B.3. Anticipated Retention within Service Sites at Two and Five Years by Clinician Demographics, Controlling for Other Demographics and Disciplines

	Odds Ratios** of Anticipated Retention	
	Model 1: Anticipated Retention at 2 Years	Model 2: Anticipated Retention at 5 Years
Demographics		
Male (vs. female)	0.95	1.05
Age 24-29 (vs. 30-34)	0.52*	0.56*
Age 35-39 (vs. 30-34)	1.36	1.09
Age 40-61 (vs. 30-34)	1.36	1.47
Non-Hispanic white (vs. minority)	1.69*	2.16*
Married/Partnered (vs. not)	1.06	1.73*
Raised in service state (vs. not)	1.61*	1.67*
Trained in service state (vs. not)	1.46*	1.32
Model R-Square	.121	.135

Models control for 7 major discipline groups in addition to the demographic characteristics listed

* $p \leq .05$

** Odds ratios at two or five years are the relative odds of anticipated retention of the named group (e.g., male) relative to the comparison group (e.g., female) controlling for the other listed factors. An odds ratio of "1.00" means that the odds of anticipated retention are identical for the two groups after controlling for the other factors. The greater the odds ratio is above"1.00" (e.g., 2.00 or 3.00), the greater are the odds of anticipated retention for the named group relative to the comparison group. The lower the odds ratio is below "1.00" (e.g., 0.50 or 0.20), the lower are the odds of anticipated retention for the named group relative to the comparison group.

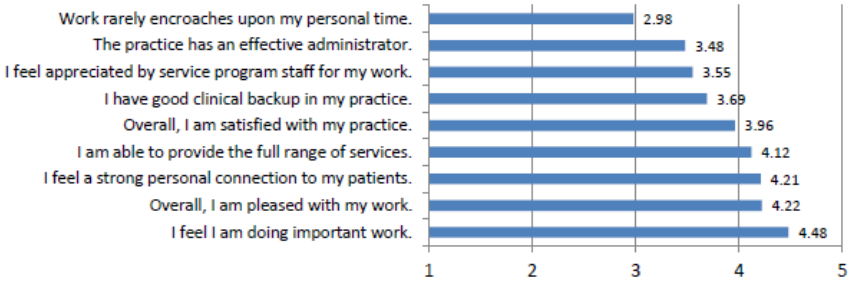
NHSC clinicians provide services in the following settings in Health Manpower Shortage Areas:

- Federally Qualified Health Centers,
- Rural Health Centers,
- Mental Health and Substance, Abuse Facilities,
- Prisons,
- Hospital Based clinics, and
- Other Primary Care Practices.

Most commonly their practice is in our mental health and substance abuse facilities (39%) or federally qualified health centers (26%) or Rural Health Centers (16%).

Retention of critical providers is intimately related to satisfaction with multiple factors in their work and community setting. While jobs for spouses, schools for children and available housing is important for communities to address, the job factors also become satisfiers/dissatisfiers with respect to retention as well. Clinician participants were asked about job satisfiers and the table below provides us guidance for strategies to improve our job dissatisfiers to improve our retention times and rates.

Figure II.D. Mean Agreement Ratings* with Statements about Service Practice; All Respondents Combined



* 1=Strongly disagree; 3=Neither agree nor disagree; 5=Strongly agree

Important to retention is time off, effective administration and good clinical backup as well as appreciation for the work done. These scores show these factors at midrange of this satisfaction scale offering us some opportunities for improvement.

Ongoing data collection will be important to assess future clinicians and to identify trends and to learn what works as we strive to improve recruitment and retention to serve Iowa's health care needs.