Mental Health and Disabilities Workforce Workgroup Recommendations

The Mental Health and Disabilities Workforce Workgroup met over eight months to hear from providers involved in the mental health and disability communities in order to address potential deficits and needs of the available and anticipated workforce, and to make recommendations to the legislature. It was determined that the Workgroup would concentrate on licensed professionals, as it is a lengthy education and training pipeline for these individuals to actively provide services. Though the focus was on licensed professionals, there is also a very important group of peer advocates and direct care workers who are part of the mental health and disability team. As mental health redesign regions are formed, the numbers needed of this category of providers will be less obscure.

The Workgroup was very appreciative of all of the professionals and individuals who took time to come to meetings and to provide their input into the following recommendations.

1. Improve the mental health and disabilities training of primary care doctors and other primary care providers

Although we typically think of physicians in mental health as being psychiatrists, there are also primary care providers such as family practitioners, internists and pediatricians who also can be part of the mental health and disability team, and who have prescribing authority.

Primary care providers may be reluctant to be that first line of defense for individuals with mental illness or disabilities, however with an almost statewide mental health provider shortage designation, we will need to create a network of services to meet the needs of citizens. A key element of that network is the primary care provider who would serve as an early diagnosis screening referral for specialty services, and ongoing therapeutic management with assistance as desired. Enhancing the role of physicians, in addition to psychiatrists, will require improved training curricula and continuous medical education related to the identification and early diagnosis of mental illness and substance abuse, as well as monitoring and case management for patients with mental illness and disability.

With a team-based approach and the assistance of other mental health professionals, either directly in the same facility or through telemedicine, we think that we can alleviate some of the reticence to provide mental health services in the primary care setting.

2. Develop a systems approach and incent the use of a team to improve treatment services, monitoring and case management of those with mental illness, co-occurring chronic illness, and those with co-morbidities of mental health and substance use disorder diagnoses

Work needs to be done to identify the makeup of the optimal team to provide services to a catchment population with support of preventive, early diagnosis, treatment and monitoring for that small percentage with mental health and disabilities health issues. A wide range of providers with variable licenses or other credentials and even wider specializations are practicing within Iowa's Legislative Authority. Many of these licenses overlap in their scope of practice and some license limitations may inhibit access to the types of services necessary for optimal treatment, particularly in shortage or rural areas of Iowa.

Assessing the statewide mental health and disabilities needs is a first step to development of a statewide service system that meets the needs of all citizens for prevention and treatment services and targets special populations for critical core services that manage their ongoing acute and chronic diseases. Integration of systems of service and care with education, justice and health organizations is important for the variations in acute, crisis and chronic disease management services necessary in a systems approach.

An incentive program to train, recruit and retain those core team providers should be implemented. This expands successful recruitment programs such as the PRIMECARRE, State Loan Repayment Programs, and Coordination of National Health Service Corps Placements or Scholarship programs. Colleges and universities should be made aware of the team approach and provider skill sets most necessary to meet population needs and encouraged to partner in development of team treatment models and production of curriculum components for primary care providers.

Community models for direct support (family support, peer support, etc.) are being implemented and studied for efficacy and efficiency and identification of the appropriate educational preparation for this level of workforce. Family and friends who offer support in early stages of illness may burn out or move away over the long term and chronic nature of these illnesses. Education and training for

committed individual support systems has been shown to decrease the isolation of individuals with high care needs. Once regions are established, a community support model that provides social integration, employment, and supervision for a subset of the population with mental illness or limiting disabilities will be implemented and may require further education for the direct care workforce.

3. Review licensing and credentialing eligibility criteria for adequate and efficient production of a workforce that meets Iowa's provider needs

Professional license to practice is granted by the state following a credible educational preparation, a comprehensive examination, and compliance with eligibility criteria. The development of these criteria in licensing code has expanded over the decades, mostly driven by the professions' efforts to control their practices. The high cost of education, coupled with the low reimbursements has created severe and profound shortages across the state and most impactful in rural areas. Inequities across and between professional licensing categories are wide and limiting. Credentialing and eligibility criteria may be unfounded. Intern and residency requirements, while valuable and mandated, may serve to drive educated providers out of state (limiting Iowa recruitments) or cause the student to forgo the residency not allowing their practice at a higher professional level. A statewide licensing policy review is warranted to assess the provider production designed to meet population needs.

There is some evidence that individuals prepared at higher professional levels are accepting jobs at entry level, because that is the job/role for which a position is available. Most frequently we see master's level social workers filling a bachelor's level position or an advanced nurse practitioner filling a psychiatric nursing position. This level of mismatch should be explored to identify the opportunities for better preparation to position matches in our provider systems.

Provider credentialing/licensing/certification is a barrier to employment in the field, but one that is perceived as necessary to maintain public safety and the quality of patient services and care. However, professionals at the higher levels of preparation may find themselves with administrative duties that take them from their treatment focus. An evaluation of the efficiency opportunities that could be gained from a systems review and integrated practices could enjoy some system efficiencies that would be cost effective.

The Workgroup determined that there are additional needs for another psychiatric residency training program and another psychiatric advanced registered nurse practitioner programs, and that self-imposed

licensing requirements for an additional year for psychologists creates a barrier to entry for new professionals. There are also supervisory requirements of the licensed independent social workers that can be addressed to facilitate the creation of more licensed independent social workers in the active workforce.

4. Plan immediately for provider service needs over the next 20 years

It takes more than a decade to prepare a psychiatrist for licensing and practice and currently 89 of Iowa's 99 counties are a health manpower shortage area for psychiatrists. Additionally, over 50 percent of the current Iowa mental health and disabilities workforce is over 55 years of age and will be expected to retire in the next decade. Iowa would need to double its current workforce to meet current needs, but production or recruitment of this high level professional is a handful of providers each year. It will not be possible to meet future demand at a crucial time when demand is expected to increase as the population ages and more neurological or dementing conditions occur.

Advanced Practice Nurses and Licensed Independent Social Workers are required to complete 7-10 years of preparation in their fields. In these fields 53% and 50% of the providers, respectively, are over 50 years of age. Production of these specialists is also limited and will not meet the demand created from retirements. The added challenge is that the oldest component of the workforce is the professors and educators who are critical to the production of new professionals. In fact, some schools currently limit applications based on their funds or educators available.

Across all provider categories, wide disparities occur across urban and rural geographic settings. Most years, more providers seek loan repayment (PRIMECARRE) for locating in high need areas than there is money. Expanding state allocations for this successful recruitment and retention tool would benefit local service provision.

We strongly encourage additional loan repayment programs for psychiatrists, psychiatric ARNPs, and psychologists to be considered and implemented. Another strategy would be for the mental health redesign regions to create shared funding of a position with the community helping with salary of a licensed professional. The dental foundation has a model for this program.

Telemedicine or telepsychiatry also offers the opportunity to place more providers in rural locations. However this needs to be more than simply a videoconferencing approach, and should be a systems approach that can involve multiple family members and multiple team members within the community to facilitate care coordination and communication across all team members.

5. Identify and implement strategies to fix system problems that inhibit production of needed providers

Create a state systems approach that builds an integrated professional and lay team approach to services of population needs. This larger systems approach will be expected to address care gaps and the inadequate production of professionals to meet system needs. The team needed to meet the population needs should be created in a way that minimizes the stress of overlapping scopes of practice competition of professional groupings and focuses on providing the needed services for the whole geographic population being served. Regional or local provider team development should be guided by statewide needs assessments and practice reviews that identify the makeup that best serve the population needs. Support the implementation of medical homes, care coordination, and electronic medical records to facilitate team handoffs, transitions and care planning. Evaluate the impact of the systems, the team effectiveness as well as the patient care in an ongoing process.

Allow and fund supervision expenses for professional internships and residencies to be part of administrative expenses to allow health entities to support these experiences in their environments.
Encourage professional commitment to preparing the next generation of providers.
Expand Iowa residency programs and opportunities to draw more providers to local environments and enhancing the possibility of their recruitment.

Psychiatric rehabilitation services should incorporate materials and approaches for that proportion of the population with co-morbidities – that is, both mental health and substance use disorders. These curriculum adjustments should be targeted for that special audience.