The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy

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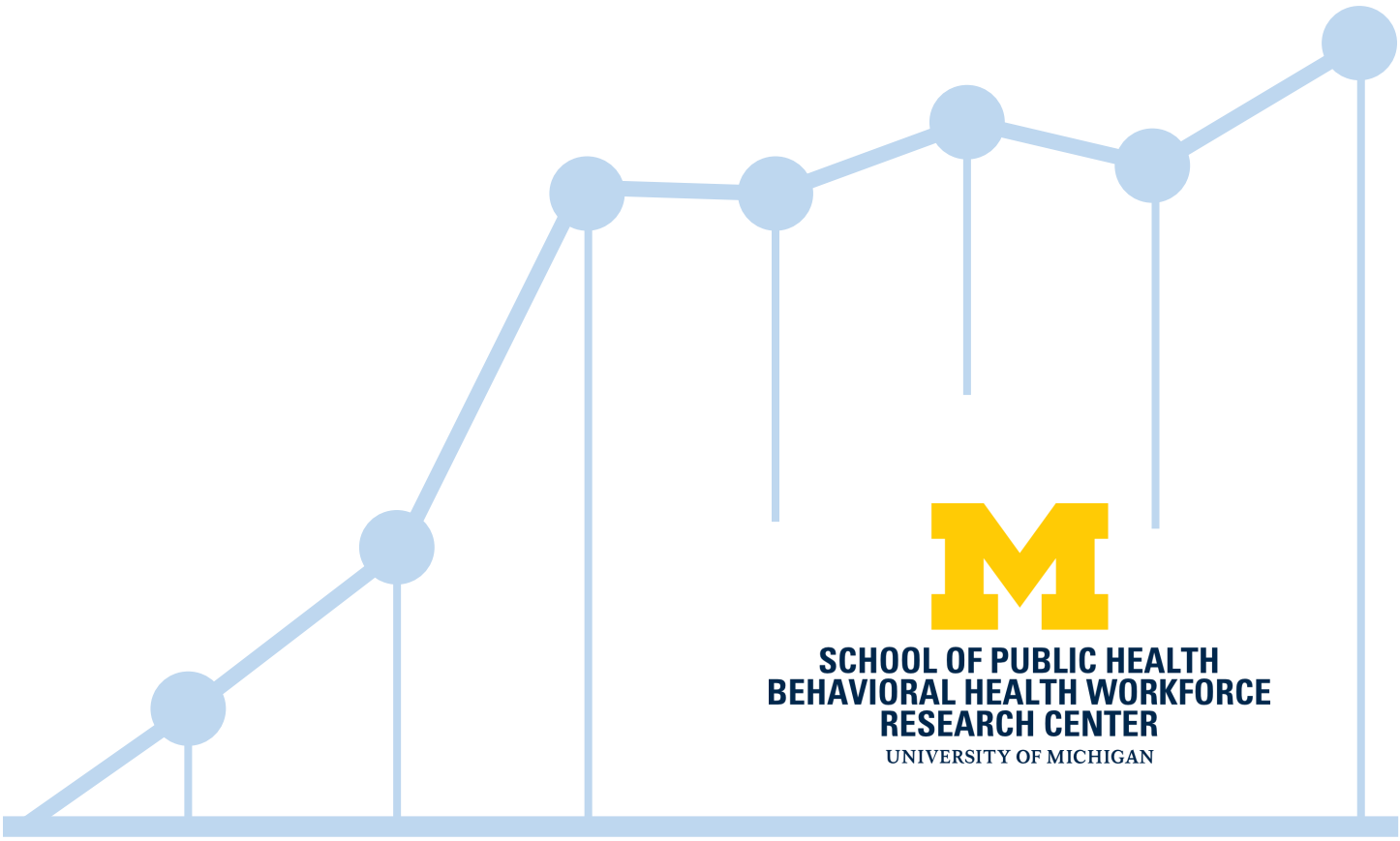

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Overview

States employ a variety of approaches in their efforts to recruit and retain behavioral health workers in rural areas, including loan repayment, scholarships, pipeline/pathway programs, visa waiver programs, and shared job postings. They make investments in telehealth, to extend access to services and provide professional guidance for providers, support integrated care environments, and provide learning collaboratives to support rural providers.

Background

The supply of behavioral health workers is not sufficient to meet the demand for mental health and substance use services in the U.S., and this imbalance is worse in rural areas.[1,2] Concerns about the inadequacy of the behavioral health workforce require that state policymakers engage in various recruitment and retention efforts to meet the behavioral health needs of the U.S. population.

Offering educational experiences and clinical training in underserved communities can influence providers to practice in those communities. Educating and engaging students who are from rural areas can also increase the chances that they will practice in those settings.[3,4] Important financial incentives such as loan repayment programs and signing bonuses are also effective approaches to recruitment and retention.[5] Policymakers and program directors diligently and creatively employ these and a broad swath of other approaches to encourage behavioral health workers to practice in underserved rural areas. The purpose of this study was to interview state-level experts in rural health and behavioral health to characterize the approaches they use to recruit and retain behavioral health workers to rural areas of their states.

Methods

This case comparison study was designed to use phone interviews to discern successful recruitment and retention strategies in the US. Interview subjects were identified from a purposeful sample of experts from state offices of rural health, offices of health workforce/health professions, and state mental health agencies. A semi-structured interview protocol was developed to elicit information about current strategies and encourage interviewees to share innovative approaches to provider recruitment and retention.

The two researchers conducted the first 14 interviews jointly to ensure consistency in approach to data gathering. Feedback from early joint interviews informed changes to the interview protocol. The researchers then conducted the last 61 interviews independently. All interviews were digitally recorded and professionally transcribed verbatim for content.

Preliminary data were analyzed concurrently with the interviews so that insights from early interviews could inform subsequent data collection and analysis. Analysts read early transcripts independently, and in an iterative process, developed and refined a coding scheme and code definitions. The authors reviewed the transcripts of eight interviews together and developed a codebook of themes and sub-themes, beginning with preliminary codes based on the domains in the interview protocol. They jointly coded four transcripts and further added and refined codes for themes that arose through discussion, building a final codebook and improving inter-rater reliability. The remaining transcripts were independently reviewed and coded, with researchers meeting regularly to compare coding results, resolve coding discrepancies, and maximize inter-rater reliability. All transcripts were coded and data were organized using QSR NVivo12 Pro software. The University of Michigan Institutional Review Board for Health Sciences Behavioral Sciences deemed this study exempt from ongoing review.

Results

In this study, the authors completed 75 1-hour interviews with experts from 47 states who readily shared their experiences in recruitment and retention efforts for behavioral health workers in rural areas of their states. State experts included 45 from rural health offices and 30 from behavioral health offices, and nearly all had

been in their positions for >2 years. Interviewees had nuanced and varied understandings of the factors that exacerbate shortages and shared information about current state efforts to recruit and retain the behavioral health workforce in rural areas. They shared ideas about what they thought was working and any approaches or programming they felt were innovative.

Most interviews began by asking whether experts knew which behavioral health workers were in highest need in their state, and whether they collected or had access to data about the numbers of providers. Their answers were based largely on impressions, with few having any data or methods for describing level of need by professional category.

Main Themes

- Experts described numerous efforts in place in their states to recruit and retain behavioral health workers to rural areas. Loan repayment and scholarship programs, pipeline/pathway programs, visa waiver programs, and online job databases were the most common tactics. Many also said they worked to retain providers by investing in telehealth, expert consultation (e.g., Project ECHO—Extension for Community Healthcare and Outcomes Model), integrated care environments, and learning collaboratives to create supportive work culture and reduce burnout.
- Experts were enthusiastic about the perceived effectiveness of pipeline programs, but few track data about actual recruitment to behavioral health professions in the state as a result of such programs. One program that did track results[6] found it was more effective to target college undergraduates than middle or high school students. Most pipeline programs seek to broadly engage young people in all health professions, but a few do have programs specifically designed to expose students to career opportunities in behavioral health.
- Although many expressed a desire to increase residency slots for psychiatry training, only a handful of states have been able to do so in recent years.
- State experts have little data indicating which behavioral health professions are in greatest need in their states. Many shared their perspectives that the need for psychiatrists was highest, although shortages of nearly every level of behavioral health provider in rural areas were reported.
- Most experts believe that raising behavioral health workers' salaries and improving Medicaid reimbursement for behavioral health services will positively impact workforce adequacy. These issues were threads in nearly all interviews, either as remedies for recruitment or to support retention efforts.
- Innovative approaches being implemented or considered to improve recruitment and retention included:
    - public private partnerships to fund additional loan repayment programs and scholarships, inform educational institutions of workforce training needs, cosponsor conferences, and fund pipeline programs;
    - tiered certification to move providers into the field earlier in their training, with supervision, or requirements for service following clinical supervision;
    - inventive pipeline programs that included specialty training such as mental health first aid or peer support trainings, and reach from middle school through college;
    - funding for additional loan repayment beyond traditional National Health Service Corps (NHSC) programs including state-only funding, or partnered funding between states and foundations or states and health systems/facilities; and
    - efforts to improve work/life balance such as job sharing and flexible work schedules.
- Many respondents suggest that greater investment in pipeline programs and loan repayment programs may go the farthest to address the gaps in rural recruitment and retention of behavioral health workers.

State Recruitment and Retention Approaches

Expert interviewees from all states shared a complex array of approaches to improving the supply of behavioral health workers in rural areas. These included financial incentives, pipeline/pathway programs, visa waiver programs as well as investments in telehealth, integrated care delivery, and a variety of provider professional development and supports.

Financial Incentives

Loan repayment programs. Programs through the NHSC, as well as those funded solely by state general funds or combinations of states and private entities, were among the programs that state experts widely cited as most effective. Nearly all indicated that loan repayment was an important tool to recruit providers to practice in rural areas. Some programs were harder to access because they required matching funds (e.g., NHSC state loan repayment program) and experts needed to weigh the general opportunity cost of applying those matching funds to loan repayment against other recruitment and retention tactics. When asked where they would invest additional resources for recruitment and retention if available, many named loan repayment programs as the place they felt could have the biggest impact.

Tax credit programs. Experts in a few states shared that they provide tax credits to qualifying providers working in rural areas. At the time of the interviews, at least one other state had pending legislation to reduce physician's tax liability up to $25,000 per year for practicing in rural areas.

"Recently we just passed some tax incentives where people can receive a $5,000 or $10,000 tax break if they're operating in certain jurisdictions or certain areas, like psychiatrists in a rural area …that's one of the ways we're trying to tackle that issue as well ."

Scholarships. Experts from 18 states reported the use of scholarship programs to recruit providers to rural areas. Most scholarships were available for health professional studies generally, not specifically for behavioral health, and some described the NHSC as difficult to attain. In one example in Michigan and Wisconsin, a partnership between a large provider and community partners provides scholarships and preferential hiring to students with ties to the two-state geographic area.[7] In other areas, scholarships are expanding beyond physicians and nurses to include community health workers (in Montana) and peers with lived experience (in Florida) to pay the costs associated with applying for and receiving trainings or certifications.

Education and Training Programs

Increasing residency slots. Many experts shared their understanding that residents tend to stay and practice in the state where they complete their residency, so it is important for states to have residency programs for psychiatry and training programs for other behavioral health workers.[8] Despite reporting that psychiatrists were likely the provider in greatest need, most interviewees did not report that their states were increasing residency slots for psychiatry. With limits on federal funding for residency training, funding for increasing residency slots would likely need to come from limited state general funds. Some experts did report state plans and pending legislation to use state funding for increasing psychiatry residencies, and some more generally for primary care, which can include psychiatry. Michigan has a state-funded program called MI Docs, based at Wayne State University.[9] It is a collaborative of four universities to increase residency slots for primary care, including psychiatry, for placements in underserved areas. It also includes a loan repayment benefit supported with public and private funds. Other states including Iowa, Utah, Wisconsin, Montana, Washington, and New Jersey also reported recent increase in residency slots for psychiatry or primary care more broadly.

Pipeline/pathway programs. These programs introduce middle school, high school, or community college students to opportunities in health professions. Many interviewees were enthusiastic about the potential for pipeline/pathway programs in their states to attract students to needed professions, yet few knew of any efforts to track actual recruitment. Tracking information about these individuals over many years is difficult, and many participants were minors, so tracking would require parental involvement as well. One program that does track results, the Behavioral Health Education Center of Nebraska Ambassador program, found that it was more effective to target college undergraduates than middle or high school students. Other

experts were most excited about engaging high school and middle school students.

Most states have pipeline programs through Area Health Education Centers or other similar organizations, for middle and high school students as well as for community colleges. One example given was Montana's "Heads Up" camp, which exposes young adults to behavioral health careers.[10] Some expose younger students to various aspects of nursing, psychology, or social work practice, some are structured like camps, and others are focused on giving medical students short rotations in rural areas. Some experts reported that their pipeline programs were very low cost because they were run using in-kind contributions such as supervision by health system providers. When asked where they would put additional resources for recruitment or retention efforts if they had them, many experts said they would invest in expanding pipeline programs.

"It's a rural pipeline that is working with a few medical schools…it's open also to APRNs, PAs, dentists…it's a two-week program that exposes them to the local rural hospital, and a substance use treatment center, and an assisted living facility. I think there are five or six places that they rotate through, and what's so incredible about it is that it's been done at no cost. So all the accommodations, meals, entertainment, which is important, have been provided with in-kind contributions. This is something I'm super, super excited about…"

Practice-Oriented Tactics

Telehealth. Telehealth services were described by interviewees in two main ways. First, as an extender of access to behavioral health services, and second, as a way for rural providers to access support and consultation on best practices with specialists at Centers of Excellence. Many interview subjects said that although progress is being made in reimbursing for telehealth services, their state had not yet realized all the potential uses of telehealth services to improve substance use and mental health services owing to limited infrastructure and broadband access,[11] that in some cases licensure issues were not resolved yet, or that adequate reimbursement for telehealth services was not yet in place. One interviewee emphasized that even where telehealth infrastructure exists, behavioral health providers are so busy that they cannot find the time to do the telehealth consultations. Despite these limits, many experts shared their desire to have their state expand the use of telehealth services. One telehealth program running in many states and widely praised by interviewees is Project ECHO.[12] Project ECHO connects rural providers with behavioral health specialists for professional support and guidance as they deliver behavioral health services.

"Some hospitals are using that…the availability of tele services as a recruitment tool. They're able to bring in some providers that maybe were not comfortable potentially dealing with behavioral health issues and knowing that they have access to those tele services has made them feel better about it and they've then accepted positions at our critical access hospitals."

Licensure, certification, or scope of practice changes. Interviewed experts suggested that most behavioral health providers in their states were already practicing at the top of their licenses. The exception was three states where legislation had been introduced but not yet passed to allow clinical psychologists to prescribe psychotropic medications. Currently, five states[13] allow this prescribing. One interviewee reported state consideration of reducing licensure requirements to allow "tiered certification" for nurses and social workers. This approach would move providers into practice earlier in their training by reducing initial requirements for licensure, and providing a pathway, with supervision, to finish Masters-level training. Others suggested that increasing reciprocity in state licensure requirements could benefit efforts to increase supply of rural providers.

Integrated care. Although the evidence for integrating primary and behavioral health services is well established for improving patient outcomes,[14] state experts emphasized its dual role in creating a supportive professional environment for many rural providers and suggested it may contribute to provider retention.

Additional State Efforts

State commissions and planning. Experts from a number of states described state commissions focused on recruitment and retention of behavioral health workers. These commissions are made up of university, state employees, policymakers, provider associations, and others to strategize and collaborate on efforts to address workforce issues. Some include special representation from someone with a behavioral health perspective. Texas has written a statewide behavioral health workforce strategic plan for 2017–2021, [15] which, among other things, requests that relevant grant proposals show connections between requests and the strategic plan. The state of Washington recently established a Center of Excellence for training behavioral health professionals, and is increasing inpatient beds.

Allowance for retired workers. Some states, such as New Jersey, have lifted previous restrictions on allowing retired state behavioral health workers to work part-time in the system from which they retired, so they can help fill the gaps in need for workers in inpatient or other settings. Few other experts said they were aware of efforts to enlist retired behavioral health workers to help address workforce shortages.

Visa waiver programs. Interviewees reported their experience in obtaining visa waivers for international medical graduates. Though many states do fill their allotted 30 slots each year, a number of more -rural states reported not filling their 30 slots annually, and most interviewees said they only occasionally recruit a psychiatrist through visa waiver programs.

> *"…We have not had any psychiatry. I think I reviewed. I think we maybe had one in the history of the program."*

Online job databases. Nearly every interviewed expert mentioned using the 3RNET[16] system or other shared databases to widely/nationally share job postings for behavioral health workers.

Innovative State Approaches

The interviews elicited a few out-of-the-box examples of state efforts not seen in other places. Most innovations were variations on more common approaches to recruiting or retaining providers, and most examples meet only some of the five criteria for innovation (significance, novelty, transferability, effectiveness, and sustainability) set out in 2016 by the Behavioral Health Education Center of Nebraska.[17]

Experts shared examples of state programs coordinating with foundations or community employers to fund additional programs that they felt were effective, such as additional loan repayment funds. These innovative loan payment programs were not limited to work in not-for-profit entities, to formal Health Professional Shortage Area designations, or to the traditional limited provider types (e.g., Masters-level licensed drug and alcohol counselors), giving states more flexibility to build their behavioral health workforce. Another program in Michigan allows 3rd and 4th year medical students to agree to employment at a hospital post-residency, and the hospital pays the students a stipend during their residency to help with expenses. One expert described a health system in their state that incentivizes working in higher-need areas by varying salaries with the level of need in an area, which they call a "community need loan." State experts also discussed job marketing efforts, ranging from using print and radio ads to more digitally advanced marketing such as geofencing.

Innovations in pipeline and other education programs included an extended role for a preceptor who would remain in contact with students well after their pipeline program experience to remain connected over time. Some education programs that include rural rotations for advance practice nurses or medical students or physician assistant students included donated supervision by providers in the institution. At least one expert reported seeking foundation funding to pay student nurses during their rural rotation in federally qualified health centers or substance use facilities, or to provide needed transportation and housing allowances for

such rural rotations. In addition, some pipeline programs planned to offer behavioral health-specific training such as mental health first aid training or peer support trainings. One education program in South Carolina created a school-based mental health paid internship for graduate students resulting in a certification in school-based mental health. Another medical residency program developed a telehealth certificate program to attract physicians to the rural residency program.

Often, institutions provide clinical supervision for social workers in training before they are fully independent. One expert described a new expectation that a facility was planning to put in place that if they provide clinical supervision they would require that an individual in supervision work a certain period of time following completion of supervision or pay for the service. Another expert said their state was considering allowing "tiered certification" so that more people could join the behavioral health workforce earlier in their training by reducing requirements for social work, nursing, marriage and family counselors, or others to fill entry-level positions. They would be introduced to the work earlier with a more limited scope of practice at first and under supervision, then move up with experience to get a Masters degree.

For improved work/life balance, a number of experts referred to job sharing and other flexibility for behavioral health workers in rural locations. In Illinois, experts worked with unions to allow providers to move from 8-hour to 12-hour shifts, which helped bring in nurses and psychiatrists to certain geographic areas. One expert expressed interest in using a tool referred to as a "community Apgar score"[18] as a way to assess how attractive a community is to providers and to address strengths, weaknesses, and challenges in terms of recruitment and retention.

The state of Utah received funding from the IBM Health Corps grant to conduct some complex modeling of workforce demand by provider type, by geographic area in the state.

Finally, the authors asked each interviewee how they would allocate additional resources for recruitment and retention of behavioral health providers for another view on what they think is most effective. The most common response was simply to raise provider salaries. Many interviewees discussed the need for not only a living wage, but also additional economic incentives to induce providers to practice in desired areas. The creation of an extended pipeline was also commonly discussed. This idea ranged in scope and substance, from recruitment and mentorship in residency programs to comprehensive public education.

Policy Considerations

Continuing to build the evidence base for what works.

Although some recruitment and retention tactics have an existing evidence base, many others (e.g., loan repayment, visa waiver programs) could benefit from basic measurement and further evaluation. This could be done through partnerships with academics and foundations interested in supporting evidence-based practices, as state governments often do not have the resources to evaluate programs directly or support outside evaluators.

Making state-level data more readily available.

Most state experts did not have data to know which behavioral health providers were in highest need in their states, so they based their assessments on impressions and experience. Although these may often be correct, knowing the magnitude of the gap in provider adequacy by provider type could help states to more directly tailor efforts to increase and stabilize their behavioral health workforce.

Focusing scholarships on behavioral health–specific learning.

Policymakers could increase the proportion of health training scholarships that are awarded to people specifically studying to become behavioral health providers. If offered early in the education process (e.g., coupling scholarships with pipeline programming) and tied to future service requirements, scholarships could further contribute to encouraging individuals from rural areas to enter behavioral health professions.

References

1. Health Resources and Services Administration. National projections of supply and demand for selected behavioral health practitioners 2013-2025. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf. Published 2016. Accessed November 8, 2019.
2. Rural Health Research & Policy Centers. Supply and distribution of the behavioral health workforce in rural America. 2016; Data brief #160. http://depts.washington.edu/fammed/rhrc/wpcontent/uploads/sites/4/2016/09/RHRC_DB160_Larson.pdf. Accessed November 8, 2019.
3. Wendling A, Phillips J, Short W, Fahey C, Mavis B. Thirty years training rural physicians: outcomes from the Michigan State University College of Human Medicine rural physician program. Acad Med. 2016;9(1):113-119. doi: 10.1097/ACM.0000000000000885.
4. Ballance D, Kornegay D, Evans P. Factors that influence physicians to practice in rural locations: a review and commentary. J Rural Health. 2009;25(3):276-281.
5. Olfson M. Building the mental health workforce capacity needed to treat adults with serious mental illness. Health Aff (Millwood). 2016;35(6):983-990. doi: 10.1377/hlthaff.2015.1619.
6. Behavioral Health Education Center of Nebraska (BHECN). About us. https://www.unmc.edu/bhecn/about/index.html. Accessed November 8, 2019.
7. Aspirus Health Care. Medical Provider Scholarships https://www.aspirus.org/medical-provider-scholarships. Accessed November 8, 2019.
8. Porter S. AAMC Releases Inaugural Report on Residents. 2015. https://www.aafp.org/news/education-professional-development/20150223aamcresidency.html. Accessed November 8, 2019.
9. MIDOCs Consotrium. Report for Governor Rick Snyder and the Michigan Legislature November 2017. https://www.michigan.gov/documents/mdhhs/Section_1870_611236_7.pdf. Published 2017. Accessed November 8, 2019.
10. AHEC Montana. Heads Up camp. http://www.scmtahec.org/high-school/heads-up-camp/. Published 2016. Accessed November 8, 2019.
11. 2018 Farm Bill Primer. Rural Development Programs. https://www.ruralhealthinfo.org/resources/12572. Accessed November 8, 2019.
12. University of New Mexico School of Medicine. Project Echo Model. https://echo.unm.edu/about-echo/model/. Accessed November 8, 2019.
13. American Psychological Association. Idaho Becomes Fifth State to Allow Psychologists to Prescribe Medications. https://www.apa.org/news/press/releases/2017/04/idaho-psychologists-medications. Published April 5, 2017. Accessed November 8, 2019.
14. American Psychiatric Association. 2016 Dissemination of Integrated Care Within Adult Primary Care Settings: the Collaborative Care Model. https://www.integration.samhsa.gov/integrated-care-models/APA-APM-Dissemination-Integrated-Care-Report.pdf. Published 2016. Accessed November 8, 2019.
15. Texas Health and Human Services Commission. Texas Statewide Behavioral Health Strategic Plan: Fiscal Years 2017-2021. https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf. Published 2016. Accessed November 8, 2019.
16. 3RNet. National Rural Recruitment and Retention Network. https://www.3rnet.org/. Accessed November 8, 2019.
17. Herron A, Morrison R. State Solutions in Workforce: Innovations in Developing the Behavioral Health Workforce Webinar. https://www.youtube.com/watch?v=kKbcCBpa_Tw&feature=youtu.be. Published September 21, 2016. Accessed November 8, 2019.
18. Schmitz DF, Baker E, Nukui A, Epperly T. Idaho rural family physician workforce study: the Community Apgar Questionnaire. Rural Remote Health. 2011;11(3):1769.