# Recruitment and Retention of Rural Behavioral Health Care Providers in Nebraska: Perceptions of Providers and Administrators

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## Abstract

A qualitative study of factors affecting hiring and retention of rural behavioral health practitioners was conducted in four rural behavioral health regions of Nebraska. Three semi-structured focus groups were conducted in each of the four regions, comprised of: 1) Licensed Psychiatrists and Licensed Psychologists, 2) Licensed Mental Health Practitioners (LMHPs), and 3) Administrators (including community, hospital, and private practice administrators and directors) who hire behavioral health practitioners. Resulting themes regarding problems hiring or retaining any or all mental health practitioner groups or solutions to these problems were tabulated. Results suggest attention should be focused on problems pertinent to each group as well as issues relevant to all provider groups together. Suggestions were made for possible actions that might be taken to facilitate hiring and retention of each provider group type.

## Review

Nationwide, a shortage of mental health professionals has existed for decades (Mortiz 1979, Tucker 1981, Sierles 1995, Goldman 2001), and the situation is worse in rural communities. In many rural areas, residents have no access to mental health services (Gustafson, 2009) and 85% of federally designated mental health professional shortage areas are rural (New Freedom Commission on Mental Health 2004). Consistent with national statistics, a recent report shows underrepresentation of behavioral health providers in Nebraska, particularly in rural and frontier parts of the state (Nguyen 2013). For example, 88 of Nebraska's 93 counties, with the exception of Mental Health Catchment area 6 (Cass, Dodge, Douglas, Sarpy, and Washington), are designated as federal mental health professional shortage areas (HPSAs). Eighty counties have a ratio of psychiatrist-to-population that is below the federal HPSA ration of 1:30,000. A total of 78 counties have no practicing psychiatrists.

Building and maintaining an adequate behavioral health workforce requires successful recruitment and retention of qualified workers. Identifying recruitment and retention factors specific to behavioral health providers in rural Nebraska is an important step in identifying strategies for increasing the rural behavioral workforce in the state. Changes in the proportion of workers in various behavioral health fields in Nebraska suggest it would be fruitful to ask individuals in specific behavioral health job groups and those hiring behavioral health providers in rural Nebraska what factors they believe draw behavioral health providers to or keep them from working in certain jobs in Nebraska. For example, despite having a possible retention problem overall, nurse practitioners working in rural areas of the state increased from .4 to 3.7 per 100,000 in the past decade, and psychiatric PA's increased to a point that the numbers are equal

in urban and rural areas. Supply statistics alone are not adequate to define the movement of workers from jobs or from the state. The Annapolis coalition says there is need for systematic recruitment and retention strategies (Sowers et all, 2011). As Heskett et al (1994) have pointed out regarding any workforce, focusing only on factors that can be easily quantified is "missing the heart of business, which is people."

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# Methods

## Procedure

This descriptive research study was carried out from a qualitative perspective, based on the use of semi-structured focus groups. Three separate focus groups were conducted in each of the four rural behavioral health regions of Nebraska, each designated as a mental health shortage area. The three groups were: 1) Licensed Psychiatrists and Licensed Psychologists, 2) Licensed Mental Health Practitioners (LMHPs) and Licensed Mental Health Practitioners (LMHPs), and 3) Administrators (including community, hospital, and private practice administrators and directors) who hire behavioral health practitioners.

In total, twelve focus groups were carried out in a four-month period. Each 60 to 90 minute focus group took place in a meeting room located in the regional behavioral health office, a hospital, or a community provider group office, and was conducted without interruption by external factors. The focus groups were conducted by an interviewer who had prior experience as a behavioral health provider and administrator, and were attended by a consistent observer, using a set of nine general, open-ended questions intended to explore the perception of the group in relation to three aspects: (a) factors affecting recruitment or retention of various types of behavioral healthcare providers in their region, (b) benefits of the area and/or rural behavioral health jobs, and (c) solutions identified for improving recruitment and/or retention of various types of behavioral healthcare providers in their region or the state.

The nine general questions included:

1. What do you notice about behavioral health providers in this region, including psychiatrists, psychologists, LMHPs, nurse practitioners, physician assistants, or any other behavioral health provider group?
2. What has been your experience hiring and keeping behavioral health providers in your office/clinic/hospital?
3. For someone in one of these professions, what do you think are the pros and cons of working in this region?
4. How do behavioral health providers connect to others in their field?
5. What do you think would be the primary reasons a person in a behavioral health profession health professional might not stay in this area?
6. What is the best way to get people in these behavioral health professions to work and stay in this area?
7. What issues regarding recruitment and/or retention of behavioral health workers in rural areas are unique to Nebraska?

8. Of the approaches to improving recruitment and retention offered by the World Health Organization* (WHO), which do you think are most applicable to Nebraska?
9. Any other thoughts about why people in behavioral health professions would come here to work or would leave the area?

*See Appendix A for a summary of recommendations offered by the WHO:

The questions presented and subsequent group facilitation allowed each participant many opportunities to indicate factors he or she believes may be influencing recruitment and/or retention of any type of behavioral health provider in their area or the state, encouraged reflection on specific types of behavioral health provider groups, and generated suggested solutions. In the event participants mentioned a specific type of provider group early in a focus group session, participants were asked to possibly discuss others as well. If in response to the WHO recommendations provided at the end of the focus group a participant endorsed a solution not previously mentioned by the group, the participant was asked to clarify and describe the response. An attempt was made to insure each member of the group felt comfortable and had opportunity to express his or her thoughts. When the basis for a comment offered by a participant was unclear, the facilitator specifically asked whether the comment addressed recruitment and/or retention of behavioral health workers, and to which group it applied. The facilitator observed reactions of participants to comments made by individuals in each group, and checked for agreement and/or alternate opinions. Because the remarks made during the focus groups session involved spontaneous reaction to the general questions and the WHO information presented, they are assumed to represent core opinions of providers and administrators living and working in rural Nebraska.

All focus group sessions were audio recorded. Each audio file was transcribed in full, with redaction of names or other information that could directly lead to recognition of a participant. Participants gave their informed consent to be part of the research in accordance with standards of The University of Nebraska Medical Center Institutional Review Board, which approved the study. Participants were assured data would be collapsed across respondents in order to preserve anonymity. Focus groups were conducted with the consent and assistance of the behavioral health regional office director in each area.

### Participants

Participants were psychologists, psychiatrists, licensed mental health practitioners, and administrators who hire behavioral health workers were recruited from four rural regions of Nebraska. Participants were recruited two ways: by invitation letter sent from the behavioral health regional administrator and/or by a letter following identification by the Behavioral Health Education Center of Nebraska or the investigator of other potentially available providers in each region. Focus groups were limited to 12 participants.

## Data analysis

Content analysis of material collected through focus groups took place in four distinct phases: (a) in the first phase, comments were identified in the transcription that related to problems with recruitment/ retention or suggested solutions to recruitment/retention problems. Notation also was made of comments related to benefits of living or working in a particular discipline in the region; (b) in the second phase, each identified comment was encoded according to its central element and the provider group(s) to which it referred, while maintaining the identity of the focus group

making the comment; (c) in the third phase, the central elements for each group referred to were sorted into 11 general categories for ease of further comparison and tabulation: financial, administrative/regulatory, community, clinician, family, patient and clinical, insurance, education/training, supervision, networking, and other; (d) in the fourth phase, similar central elements from each focus group were collapsed into one encompassing theme, and each resulting theme was tabulated according to number and type of focus groups identifying it, as well as the provider group type to which it referred.

Initially, a database of statements relating to any of the three aspects for which comments were sought (recruitment/retention, benefits, or solutions) was created for each provider group type referred to by participants. For the first four focus group transcripts, the facilitator and observer who participated in the study independently identified and encoded each relevant comment by identifying the central element in the classification (e.g., "Hard to get CEU's") and the provider group to which it referred. The encodings of the two researchers were compared in order to reach a final result. In the event of disagreement, the coding in question was discussed, and convergence of views was achieved. The researcher who facilitated the focus groups encoded the remaining eight transcripts independently, and the second researcher conducted random sampling of coding, in order to ensure continued reliability of scoring.

Different themes emerged regarding each provider group referred to. Themes mentioned by at least two of the twelve focus groups were tabulated and presented by: 1) Number and percentage of focus groups reporting; 2) number and percentage of regions reporting; 3) number and percentage of focus groups reporting, in which the same type of provider group referred to was represented, and 4) number and percentage of administrator groups reporting.

Finally, data analysis and examination of illustrative stories told by participants across focus groups allowed amalgamation of and inferences about the broader meaning of information presented, as well as identification of areas for further study and/or possible remedial action.

## Results

Transcription of focus group recordings resulted in collection of 1,225 study-relevant statements, which were sorted according to their reference to one of the following types of provider groups: psychiatrists (183 statements), psychologists (74 statements), LMHPs (137 statements), APRNs (35 statements), or all providers (196 statements). Each statement was defined by its central element and further sorted according to its reference to one of three topics: 1) recruitment/retention problems, 2) area/job benefits, or 3) solution to recruitment/retention problems. When two or more subgroups identified the same central element, that element was recorded as a primary theme and was entered into a summary chart. The number of primary themes resulting varied by the provider group type to which the themes referred and by topic (recruitment/retention problems, area/job benefits, or solutions). In order to identify particularly significant primary themes for each provider group type, primary themes identified by at least 41.6% (5 out of 12) of the focus groups and/or 100% of regions were highlighted.

## Benefits of the area and/or rural behavioral health jobs

As displayed in Table I, six primary themes emerged regarding benefits of the area. Because all of these themes were general in nature, they were combined across provider groups. The first three themes listed were mentioned by at least two focus groups as specifically applying to hiring/retaining psychiatrists, but did not reach criteria for highlighting for that group alone. In the combined format, one theme met criteria for highlighting: the rural area being a good place to raise a family. Safety was specifically mentioned as a factor in this theme.

**Table I. Benefits of living in area/ working as rural provider in area**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Small town atmosphere/ values | 2/12 = 16.7 % | 2/4 = 50% | n/a | 1/4 = 25% |
| Good place to raise family/ safe | 6/12 = 50% | 3/4 = 75% | n/a | 1/4 = 25% |
| Short commute to work | 3/12 = 25% | 3/4 = 75% | n/a | 2/4 = 50% |
| Short trip to a larger city with amenities/ shopping | 2/12 = 16.7% | 2/4 = 50% | n/a | 0/4 = 0% |
| Able to see a variety of patients | 3/12 = 25% | 3/4 = 75% | n/a | 1/4 = 25% |
| Good teamwork with colleagues | 4/12 = 33.3% | 3/4 = 75% | n/a | 1/4 = 25% |

## Problems with Recruitment/Retention

Table I presents themes related to problems hiring and retaining rural psychiatrists. Fifteen themes emerged for this group, five that met at least one of the criteria for highlighting, two of which met both. The five themes include pay being too low, loan repayment problems, lack of local cultural amenities, and lack of support for spouse as primary reasons psychiatrists do not take positions in or remain in positions in rural Nebraska. The remaining ten themes presented in Table I are considered in the discussion section.

**Table I. Problems hiring and retaining rural psychiatrists**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Pay is too low/ could be higher | 6/12 = 50% | 3/4 = 75% | 2/4 = 50% | 2/4 = 50% |
| Loan repayment problems | 6/12 = 50% | 3/4 = 75% | 3/4 = 75% | 1/4 = 25% |
| Isolation | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Lack of local amenities/ culture | 5/12 = 41.6% | 3/4 = 75% | 2/4 = 50% | 1/4 = 25% |
| Lack of diversity/racism | 2/12 = 16.7% | 2/4 = 50% | 0/4 = 0% | 1/4 = 25% |
| Special difficulty of foreign providers | 3/12 = 25% | 3/4 = 75% | 2/4 = 50% | 1/4 = 25% |
| Lack connection to area/culture | 3/12 = 25% | 2/4 = 50% | 2/4 = 50% | 0/4 = 0% |
| Top-down mentality | 3/12 = 25% | 2/4 = 50% | 1/4 = 25% | 2/4 = 50% |
| Lack opportunity for children | 4/12 = 33.3% | 2/4 = 50% | 2/4 = 50% | 1/4 = 25% |
| Lack support for spouse/spouse unhappy | 5/12 = 41.6% | 4/4 = 100% | 2/4 = 50% | 3/4 = 75% |
| Burden of seeing all comers/ | 5/12 = 41.6% | 4/4 = 100% | 1/4 = 25% | 2/4 = 50% |

| | | | | |
|---|---|---|---|---|
| no one to share load/ can't specialize/ no downtime | | | | |
| Nowhere to refer | 4/12 = 33.3% | 3/4 = 75% | 0/4 = 0% | 2/4 = 50% |
| Poor Medicaid reimbursement | 4/12 = 33.3% | 3/4 = 75% | 1/4 = 25% | 3/4 = 75% |
| Many options available | 3/12 = 25% | 3/4 = 75% | 1/4 = 25% | 1/4 = 25% |
| Recruitment agency doesn't work/ doesn't know area | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table II presents themes related to problems hiring and retaining rural psychologists. Five themes emerged regarding psychologists, of which two met both criteria for highlighting. These themes include difficulty obtaining loan repayment and the lack of a local or regional internship site as primary reasons psychologists do not come to or remain in rural Nebraska. The remaining three themes presented in Table II are considered in the discussion section.

**Table II. Problems hiring and retaining rural psychologists**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Pay too low | 3/12 = 25% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| No reimbursement for provisional psychologists | 4/12 = 33.3% | 3/4 = 75% | 2/4 = 50% | 1/4 = 25% |
| Loan repayment issues | 5/12 = 41.6% | 4/4 = 100% | 4/4 = 100% | 0/4 = 0% |
| Lack of amenities/ culture/ resources | 3/12 = 25% | 3/4 = 75% | 3/4 = 75% | 0/4 = 0% |
| Lack of local/ regional internship | 5/12 = 41.6% | 4/4 = 100% | 4/4 = 100% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table III presents themes related to problems hiring and retaining rural LMHPs. Eleven themes emerged regarding this group, five that met at least one of the criteria for highlighting, of which three met both criteria. These primary themes include scarcity of supervisors for provisionally licensed mental health providers, lack of dually certified Licensed Alcohol and Drug Counselors (LADCs), barriers to becoming a LADC, difficulty obtaining CEUs, and low pay as primary reasons mental health practitioners are not hired or are not retained in areas of rural Nebraska. The remaining six themes presented in Table III are included considered in the discussion section.

**Table III. Problems hiring and retaining rural licensed mental health practitioners (LMHPs)**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Low pay | 5/12 = 41.6% | 3/4 = 75% | 2/4 = 50% | 2/4 = 50% |
| Lack of pay for PLMHP status | 3/12 = 25% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Licensing requirements too | 4/12 = 33.3% | 3/4 = 75% | 1/4 = 25% | 3/4 = 75% |

| | | | | |
|---|---|---|---|---|
| strict | | | | |
| Lack of supervisors for PLMHPs | 6/12 = 50.0% | 4/4 = 100% | 2/4 = 50% | 3/4 = 75% |
| Spouse's job determines where live | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Medicaid reimbursement low | 2/12 = 16.7% | 2/4 = 50% | 2/4 = 50% | 0/4 = 0% |
| Lack of dually certified LADCs | 5/12 = 41.6% | 4/4 = 100% | 4/4 = 100% | 3/4 = 75% |
| Barriers to become LADCs | 5/12 = 41.6% | 3/4 = 75% | 3/4 = 75% | 2/4 = 50% |
| Graduate pool not well prepared | 5/12 = 41.6% | 4/4 = 100% | 2/4 = 50% | 4/4 = 100% |
| LMHP licensing barriers and delays | 4/12 = 33.3% | | | |
| Difficulty obtaining CEUs | 4/12 = 33.3% | 4/4 = 100% | 4/4 = 100% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Although nurse practitioners (NPs) were not participants in this study, issues regarding hiring or retaining rural NPs sometimes were referred to by two focus groups and therefore are included in a separate table. Table IV presents themes related to problems hiring and retaining nurse practitioners (NPs). Four themes emerged regarding this group, none of which met the criteria for highlighting. The four themes presented in Table IV are considered in the discussion section.

**Table IV. Problems hiring and retaining rural nurse practitioners (NPs)**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Many options available | 2/12 = 16.7% | 1/4 = 25% | n/a | 1/4 = 25% |
| On call and evening work | 2/12 = 16.7% | 2/4 = 50% | n/a | 2/4 = 50% |
| Lack of local supervisors (collaborating psychiatrists) | 2/12 = 16.7% | 2/4 = 50% | n/a | 1/4 = 25% |
| Low pay | 2/12 = 16.7% | 2/4 = 50% | n/a | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table V presents themes relate to problems hiring and retaining all behavioral health provider groups in rural Nebraska. Themes presented in this table are independent of themes presented relating to a specific provider group type in Tables I-IV. Nine themes emerged regarding all provider types, three that met criterion for highlighting. These themes are low pay, poor state funding, and scarcity of mental health resources. The remaining seven themes presented in Table I are considered in the discussion section.

**Table V. Problems hiring and retaining <u>all</u> rural behavioral health practitioners**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Pay too low | 6/12 = 50% | 4/4 = 100% | n/a | 1/4 = 25% |
| Low state funding/ reimbursement | 5/12 = 41.6% | 4/4 = 100% | n/a | 2/4 = 50% |
| Drive time to meetings | 3/12 = 25% | 2/4 = 50% | | 2/4 = 50% |

| | | | | |
|---|---|---|---|---|
| Difficult to fit community/ lack cultural opps | 4/12 = 33.3% | 3/4 = 75% | n/a | 1/4 = 25% |
| No job opps for spouse | 3/12 = 25% | 2/4 = 50% | n/a | 1/4 = 25% |
| Lack of MH resources | 7/12 = 58.3 | 3/4 = 75% | n/a | 3/4 = 75% |
| Difficulties getting CEUs | 3/12 = 25% | 2/4 = 50% | n/a | 1/4 = 25% |
| Lose people after training | 3/12 = 25% | 2/4 = 50% | n/a | 1/4 = 25% |
| Burn out from too much work | 4/14 = 33.3% | 3/4 = 75% | n/a | 2/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table VI presents two other themes that emerged as general problems, but did not reach criteria for inclusion in any of the provider tables or the table referring to all rural providers: 1) too few providers of all kinds in the region, and 2) delays in credentialing and paneling resulting in a loss of applicants and providers. Specifically mentioned as lacking in availability were psychiatrists, psychologists and licensed drug and alcohol counselors. Also mentioned was lack of infrastructure needed to support a FT psychiatrist in very remote areas. These themes are considered in the discussion section.

**Table VI. Problems hiring/retaining rural behavioral health providers not reaching criteria for inclusion in an individual or all provider groups**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Too few providers of all kinds in the area | 5/12 = 41.6% | 3/4 = 75% | n/a | 0/4 = 0% |
| Delays in credentialing at state level (about some group/s) | 3/12 = 25% | 3/4 = 75% | n/a | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

## Solutions regarding Recruitment/Retention Problems

Table VII presents themes offering potential solutions to perceived problems of hiring and retaining rural psychiatrists in Nebraska. Eleven themes emerged regarding this group, two that met at least one of the criteria for highlighting, one of which met both. These themes include offering more opportunities for loan repayment and development of a psychiatric residency program in rural Nebraska. The remaining nine themes presented in Table VII are considered in the discussion section.

**Table VII. Proposed solutions to problems hiring and retaining rural psychiatrists**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider | Number and % of administrator group |
|---|---|---|---|---|

| | | | reporting | reporting |
|---|---|---|---|---|
| Provide long-term contract/ guaranteed salary | 2/12 = 16.7% | 2/4 = 50% | 2/4 = 50% | 0/4 = 0% |
| Offer family housing | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Offer more opp for loan repayment | 5/12 = 41.6% | 3/4 = 75% | 3/4 = 75% | 1/4 = 25% |
| Change marketing strategies | 3/12 = 25% | 3/4 = 75% | 3/4 = 75% | 0/4 = 0% |
| Target those who like and want rural | 3/12 = 25% | 3/4 = 75% | 3/4 = 75% | 0/4 = 0% |
| Target locally or from Midwest | 2/12 = 16.7% | 1/4 = 25% | 1/4 = 25% | 0/4 = 0% |
| Use telemedicine | 3/12 = 25% | 2/4 = 50% | 0/4 = 0% | 2/4 = 50% |
| Train FPs to prescribe | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Rural residency | 8/12 = 75% | 4/4 = 100% | 4/4 = 100% | 2/4 = 50% |
| Increase networking - state, national | 3/12 = 25% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Reduce on-call requirements | 3/12 = 25% | 2/4 = 50% | 2/4 = 50% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table VIII presents themes offering potential solutions to perceived problems of hiring and retaining rural psychologists. Four themes emerged regarding psychologists, one that met both criteria for highlighting: the need to develop local internship sites offering supervision. The remaining three themes presented in Table VIII are considered in the discussion section.

**Table VIII. Proposed solutions to problems hiring and retaining rural psychologists**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Create local internships w/ supervision | 5/12 = 41.6% | 4/4 = 100% | 4/4 = 100% | 0/4 = 0% |
| Allow med staff privileges | 2/12 = 16.7% | 2/4 = 50% | 2/4 = 50% | 1/4 = 25% |
| Hire local or nearby roots | 3/12 = 25% | 2/4 = 50% | 1/4 = 25% | 1/4 = 25% |
| Offer more loan repayment opportunities | 4/12 = 33.3% | 3/4 = 75% | 3/4 = 75% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table IX presents themes offering potential solutions to perceived problems regarding hiring and retaining rural LMHPs. Ten themes emerged regarding this group, two that met at least one of the criteria for highlighting, of which one met both criteria. These themes include educating local individuals to become mental health practitioners, and offering more ways for LMHPs and LADCs to obtain continuing education. The remaining eight themes presented in Table IX are considered in the discussion section.

**Table IX. Proposed solutions to problems hiring and retaining rural licensed mental health practitioners**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Use loan repayment | 3/12 = 25% | 3/4 = 75% | 2/4 = 50% | 1/4 = 25% |
| Pay for advanced degree/ hardship | 2/12 = 16.7% | 1/4 = 25% | 2/4 = 50% | 0/4 = 0% |
| Wave PLMHP requirement | 2/12 = 16.7% | 1/4 = 25% | 1/4 = 25% | 1/4 = 25% |
| Decrease LADC requirements | 2/12 = 16.7% | 1/4 = 25% | 1/4 = 25% | 0/4 = 0% |
| Grow your own | 7/12 = 58.3% | 4/4 = 100% | 4/4 = 100% | 1/4 = 25% |
| Create more local grad campuses | 2/12 = 16.7% | 2/4 = 50% | 2/4 = 50% | 0/4 = 0% |
| Offer more ways to get CEUs for LMHPs and LADCs | 5/12 = 33.3% | 3/4 = 75% | 2/4 = 50% | 3/4 = 75% |
| Provide supervision and mentoring | 2/12 = 16.7% | 2/4 = 50% | 1/4 = 25% | 0/4 = 0% |
| More practical experience | 3/12 = 25% | 3/4 = 75% | 2/4 = 50% | 1/4 = 25% |
| Reduce/ alter job expectations | 2/12 = 16.7% | 2/4 = 50% | 0/4 = 0% | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Table X presents themes offering potential solutions to perceived problems regarding hiring and retaining rural nurse practitioners. Two themes emerged regarding this group, neither of which met criteria for highlighting, but are considered in the the discussion section.

**Table X. Proposed solutions to problems hiring and retaining rural nurse practitioners (NPs)**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Grow your own from local nurses/ distance education | 4/12 = 33.3% | 2/4 = 50% | n/a | 2/4 = 50% |
| Using APRNs for telemedicine is working | 2/12 = 16.7% | 1/4 = 25% | n/a | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

Themes offering potential solutions to perceived problems regarding hiring and retaining rural behavioral health providers of all types are presented in Table XI. Eleven themes emerged regarding this group, four that met at least one of the criteria for highlighting, of which two met both criteria. These themes included hiring providers based on certain characteristics (particularly having roots in the area), educating individuals from the local area so they will stay to work in the area, creating local internships and residency programs with supervision, and establishing ways to market positive aspects of the area and behavioral health jobs there. The remaining seven themes presented in Table XI are considered in the discussion section.

**Table XI. Proposed solutions to problems hiring and retaining ALL rural behavioral health practitioners**

| | Number and % of focus groups reporting | Number and % of regions reporting | Number and % of groups with same type provider reporting | Number and % of administrator group reporting |
|---|---|---|---|---|
| Competitive pay | 2/12 = 16.7% | 2/4 = 50% | n/a | 0/4 = 0% |
| Loan repayment | 3/12 = 25.0% | 2/4 = 50% | n/a | 0/4 = 0% |
| Highlight positives in marketing | 4/12 = 33.3% | 4/4 = 100% | n/a | 1/4 = 25% |
| Hire based on certain characteristics<br>Hire roots | 8/12 = 66.6%<br><br>5/12 = 41.6% | 4/4 = 100%<br><br>3/4 = 75% | n/a | 2/4 = 50%<br><br>3/4 = 75% |
| Increased access to CEUs | 4/12 = 33.3% | 3/4 = 75% | n/a | 1/4 = 25% |
| Local internships/ residency with supervision | 7/12 = 58.3% | 4/4 = 100% | n/a | 1/4 = 25% |
| Grow your own | 5/12 = 41.6% | 3/4 = 75% | n/a | 2/4 = 50% |
| Bring people to visit<br>Undergrad visits | 3/12 = 25%<br>2/12 = 16.7% | 3/4 = 75%<br>2/4 = 50% | n/a<br>n/a | 0/4 = 0%<br>0/4 = 0% |
| Increase opps for supervision<br>Allow by phone | 3/12 = 25%<br><br>2/12 = 16.7% | 2/4 = 50%<br><br>2/4 = 50% | n/a<br><br>n/a | 0/4 = 0%<br><br>0/4 = 0% |
| Increase networking opportunities | 4/12 = 33.3% | 3/4 = 75% | n/a | 1/4 = 25% |
| Telehealth | 2/12 = 16.7% | 2/4 = 50% | n/a | 1/4 = 25% |

--- = 41.6% or more of all subgroups reporting --- = 100% of applicable subgroups reporting

# Discussion

## Recruitment/retention of all rural Nebraska behavioral health providers

*"Rural Nebraska is a wonderful place to raise a family"*

In general, behavioral health providers and administrators living in rural Nebraska believe that their area provides a particularly positive environment for those providers who wish to raise a family, indicating, for example, that it is safe, free from problems like graffiti, and offering short commutes to work.

Personal isolation is cited as problematic in hiring some behavioral health providers, including lack of area amenities, particularly shopping, and the need to drive long distances for education. Having something to offer the spouse of a professional who is considering coming to the area is sometimes problematic. Similarly, one respondent stated, *"There's not a lot social life out here for single, young professionals… that is one thing we've struggled with."* Those who live relatively closer to a larger town believe they have an advantage in being about to attract providers to their area.

*"Either you kind of have a reason to live around here or you don't."*

General consensus emerged around the likelihood of having greater success in hiring rural behavioral health providers when a provider has roots in the specific area to begin with, or even a rural area elsewhere. Reasons cited included having a better understanding of and appreciation for the culture, and the natural draw of having family in the area. Other factors cited as important to look for when hiring for the rural area are being self–initiating, having the ability to be a good

networker, and loving to serve. One administrator said, *"people who already live here and already value this part of the country and grew up here and those people are less likely to leave… if they leave, there's a percentage of them who will come back. And that's much more likely than anybody is going to want this culture or know about it and then do enough to get here and like it enough to stay."* Finding ways to help local people think about having a career in behavioral health was cited as potentially being helpful in later acquiring them as providers and increasing the number of behavioral health providers in a given region. However, having to travel in order to get the education required is often problematic, as summarized by one respondent: *"We have to send them away to get them trained and then run the risk that they won't come back."*

Respondents from several areas mentioned believing they have positive teamwork among providers in their agencies and with others in the community, and they see this as beneficial in hiring and retaining behavioral health workers. They indicated that they who they can call and can count on each other for assistance with clients. However, many groups reported having too few professional resources and agencies to which they can refer complex patients, and they believe this affects hiring and retention of behavioral health workers. This lack of resources was cited by a majority of focus groups, as was a specific need for prescribers and chemical dependency services. Not having enough providers and services in the area was cited as resulting in requiring providers who are there to see too many cases and manage all types of patients rather than being able to specialize. This was thought to be a deterrent for some applicants as well as overworking those already there. Not being able to get away from one's job for training or vacation without experiencing financial loss or leaving patients without a provider was frequently cited as contributing to provider burn out and to making it difficult to sell behavioral health jobs to potential applicants. Thus, the need to be a self-starter, willing to work hard, and able to do all things were cited as important characteristics to look for in a potential hire.

*"It's like we're a different state"*

The need for competitive pay was emphasized in conversations regarding all provider groups, and inability to provide this reportedly is caused by lack of funding and poor reimbursement rates. One administrator reported, *"Two-thirds of our revenue comes from state, federal, county dollars. so only one-third… is coming from other sources, and that's a scary mix."* Respondents seemed to agree that when revenue dollars are cut according to per capita allowance, it differentially affects rural agencies due to resulting in less monies available for basic programming and infrastructure. For example, one person indicated, *"We get the smallest budget, but we have to travel the most*." Another group indicated "[rural Nebraska" is getting [only] 4% of the overall state behavioral health budget." Lack of funding is reported as problematic even in hiring unlicensed behavioral health providers such as technicians and residential, community support, and foster care workers, due to inability to pay more. They report: "It's very, very difficult to get the bachelor's level." Some areas indicated they pay less than the State of Nebraska's pay scale for comparable workers, and several said they can't compete with retail places in their area that can pay workers more.

*"There's an awful lot of Medicaid, and it doesn't even pay."*

Capturing the sentiment of several focus groups was the comment of one provider: *"If you come here and have to do battle with Magellan… with their unrealistic expectations, you would get tired of it and say, I'm moving somewhere where there's lots of support services*." Participants reported that, due to requirements changed at the state level, additional staff, training, consultants,

and programming are required "just… to attempt to get your reimbursements, to attempt to get claims sent in with authorizations, and the case management things as well." Along with very low reimbursement rates, the amount of paperwork required was most frequently cited as problematic. *"We have to have time/support stats… If you thin the support staff out, you burnout your therapist because they're having to do it."* Also cited as problematic was the requirement by Magellan that patients come in a day ahead of their appointment to fill out paperwork. "*We have people that drive two hours to get to our agency… so how can you ask them to come in and do paperwork a couple days before their intake?"* Sentiment was both exasperated and angry. "*They always want you to do all these extra things, but we don't have all those extra things around here. So you spend more time as a clinician, either talking to them or dealing with them or convincing them we can't do it that way. We spend time arguing with them."* On the national level, "*when they took out 90808 [the 90 minute procedure code]– well, what about my people that drive 90 miles to their appointments? They're not coming here for a short appointment, because they're not going to come back for three weeks. It's not considering the clients who are needing a 75 minute session."*

One administrator summed the problem up by saying, *"regulations about employers – the regulations they need to meet their criteria for Medicaid, private insurance – keep changing all the time, so it's demanding differences of licensure all the time."* Regarding delays in receiving reimbursement payments, one participant contended the problem has to do with Medicaid on the state level being defunded: "*… there's less people in Medicaid to do that work… so there's more errors, there's less infrastructure in Lincoln, and it's just trickles down."* That person added, *"they… catch a cold and it gives us pneumonia."*

*"[Licensure] can take anywhere from six to eight weeks. It doesn't matter if you're from a NE school or not."*

Delays in processing of licensure applications at the state level, as well as credentialing with Magellan, were cited as problematic in trying to hire most provider types. One respondent stated, *"Usually, when we interview people, they want to start tomorrow, and we've got to wait, usually at least 90 days… and that's if the credentialing turns around because you have to do Medicaid first and then Magellan, and they won't start one until one's done. So we've actually lost a mid-level hire over that."* Another indicated that during the wait time, a provider can't see patients. "*…you can't bill, and we're not getting reimbursed"*

*"If we're limited on supervisors… we're not going to get new people."*

Once educational requirements have been met, many provider groups report that trainees have difficulty obtaining the supervision required for licensure, including psychologists, psychiatrists, mental health practitioners, and nurse practitioners. Profession-specific issues are discussed later in this report, but many respondents spoke of having a dearth of local training sites and a need to create them in order to increase hiring and retention. "*We have to build this system where we have lots of supervisors to be able to let newer people come to the area."*

*"…Place them out here for three or four years… then you have a much more likelihood of them staying."*

General agreement emerged that hiring potential would be increased for all provider types if students and trainees could be placed in the area long enough to get used to it and like it. However, all groups agreed this is not effective through a period offering only brief exposure. *"A year-long internship, a year-long residency, a post-doc, a year-long, would give them a chance to see what is rural life like. And if they come with kind of biases against it, it does give them time to overcome some of that, and maybe realize the benefits."* Many felt development of a center of excellence in a few key rural areas, offering a conclave of provider services and supervision, would be helpful in hiring and keeping rural behavioral health professionals. *"You've got to have some places where there's an infrastructure of professionals and services… where there's a nucleus of professionals, and encourage people to stay in those areas"*

*"To know I have this free spot and all I have to do is say I'm going to work [a few] years in a rural community, that's huge."*

Loan repayment is thought to be helpful in recruiting and in keeping behavioral health providers in rural areas, but reportedly presents some problems for all provider types except nurse practitioners, about whom loan repayment was not mentioned at all. Issues regarding loan repayment are discussed in later sections of this paper. Generally, some agencies reportedly do not want to invest in offering loan repayment, and for some providers, having to sign up to work in a rural area for a long time is thought to be a deterrent. One administrator said, if "we pay people's student loans for a two-year commitment in a rural health shortage area… there's still risk on our end." Consistent with the already mentioned assumption that behavioral health workers are more likely to stay in an area they have ties to, one administrator reported regarding helping with student loan repayment, *"I know from an administrative perspective, if it's not somebody that has roots here, I'm not going to risk them the two years"*

*"Exposing people in the rural area to counseling as an option … might start them on that path that … leads to somebody being home grown and wanting to be here."*

Some respondents indicated they believe there is a need "*be more intentional about recruitment at the … college level."* Several groups referred positively to BHECN and UNMC's Ambassador program, which one said, "*is trying to get high school students mentored with maybe college students to try to get them to go into the career."* One provider stated that, nationally, there are pockets of graduate programs providing a rural track with curricula focused on the rural experience, including New Mexico and Alaska. That individual, who trained in New Mexico, said the program involved a multidisciplinary group of providers going to live in an area for several months, including nursing students, family residents, psychiatry residents, and pharmacists. *"They see patients in that area and everything is there. We were able to recruit some of them."*

## Recruitment/retention of psychiatrists

Many rural providers and administrators report that the competition for psychiatrist applicants is high, due to short supply countrywide and having to compete with high salary offers in more desirable places, the draw of private practice, and local agencies that are also trying to hire them. Two areas reported having had psychiatrist positions open for periods up to eight years, even

when using a recruitment agency, with few applicants brought in. One reported having had to bring in at least 12 applicants before finally hiring a psychiatrist.

As with the general population of behavioral health professionals, isolation in rural areas was cited as a significant deterrent for some psychiatrists. Specifically named were lack of cultural opportunities, including for children. Primary strategies recommended to address this included hiring the right person (particularly someone from the area), that the person stay in the area for several years requiring (through residency, contract, or loan repayment), and addressing factors affecting burnout from high demand and level of responsibility.

Professional isolation reportedly means more work for psychiatrists, including having to see all comers, often being the only one on call or doing hospital rounds. The burden of not having others with whom to share the load, and consequently little downtime, were thought to be reasons applicants do not take jobs in rural areas and factors having contributed to losing providers in the past.

Numerous subgroups indicated that keeping a psychiatrist's spouse happy is a significant problem in recruiting and retaining psychiatrists. One suggested solution was to connect the spouse with boards and other professional people. However, lack of opportunities for employment for a spouse also was cited as problematic. "*Some of these folks are married to people that have really specific degrees – aerospace engineering. What are you going to do here?"*

Although one administrative subgroup reported pay for psychiatrists is good in their area, the general perception was that that remuneration for psychiatrists in rural Nebraska is not high enough to attract them and is lower than in Omaha or Lincoln, not to mention other parts of the country. Some groups indicated that applicants likely expect higher pay for working in a rural area and suggested offering more money might make a difference; however, others reported they doubted this would help. One group reported that the low cost of living in a rural area results in providers making more money, but others stated they thought cost of living was higher in their area than in a major city. Knowing actual statistics regarding the difference in cost of living between rural and urban areas might be useful in responding to such perceptions of applicants, as well as those who interview them for rural positions.

A suggestion from one group regarding compensation was that potential hires be offered a long-term contract and a guaranteed salary. Another group suggested paying double for residents; another suggested offering hardship pay. One group indicated that offering family housing is attractive.

A general perception among the focus groups was that agencies struggle to be able to create positions for psychiatrists - or to offer salaries high enough attract them - due to low reimbursement rates provided by Medicaid, as many of their catchment areas serve a predominance of individuals receiving these benefits. Several groups reported that psychiatrists are expected to see large numbers of clients in order to cover overhead expenses, without having enough colleagues to share the burden of "seeing all comers," handling call services, providing hospital rounds, etc. Many contended that potential employees see this as undesirable and that it contributes to burnout and loss of providers already hired. Several regions indicated that low Medicaid reimbursement resulted in some programs not being able to survive and patients not being served adequately. Respondents indicated that reimbursement rates are so low that *"it's hard for organizations to absorb the costs with having a doc on staff."* Respondents indicated that one problem is that Medicaid requires prior authorization for medications, which is a strain on providers. "*They're shocked by … the amount of time that has to be spent not in direct client*

*care because of it."* Another noted, "*You can't bill if you go to an emergency room for Medicaid because they don't pay for that."* Even in private practice, some said, low Medicaid reimbursement "*… pays enough to pay the ancillary staff, but not enough to pay the physician."* One provider said, "*I couldn't keep the doors open; it costs too much."* One person summed up the sentiment by saying: *"Medicaid might have more psychiatrists if you could bill for their services and cover their [costs]"*

Although one respondent reported loan repayment was not enough to bring psychiatrists to the area and another reported a psychiatrist had moved soon after his loan was repaid, many respondents felt that loan repayment was a draw for bringing psychiatrists to rural areas, particularly early in their career. They reported that this offers a chance for the psychiatrist to integrate into the community, possibly start a family, and consequently want to stay. However, some felt that loan repayment takes a long time to get set up and providers have to work during the time they are waiting to become licensed before it begins, which are deterrents to using this strategy for attracting providers. Many subgroups, including most of the groups of psychiatrist respondents, felt that agencies and personnel departments need to be educated about the loan repayment program(s) and additional opportunities offered.

Several areas reported that foreign providers have particular difficulty adjusting to jobs in the rural area. They cited problems with learning the culture, speech not being understood by patients, and an experience of racism in some areas as problems. Also mentioned in one group was the perception that foreign providers have a cultural expectation of a top–down hierarchy (which was also attributed by some to psychiatrists in general), resulting in dissatisfaction and perhaps distancing by colleagues.

Although not a solution to hiring or retaining psychiatrists, telemedicine was presented as a solution to the problem of not having enough prescribers, and was reported to be working well for medication management in one area. However, the time involved in setting up and doing paperwork on the receiving end necessary for reimbursement through Magellan was mentioned as a problem, along with a need to streamline the process and regulations regarding the telehealth. One suggestion was that Magellan consider paying local staff for their time in setting up and doing paperwork as a cost offset. Proportionately, in small rural practice, where large numbers of patients are using Medicaid benefits, the cost of hiring staff to do necessary paperwork or of giving time off to providers to do their own authorizations, etc., is reportedly prohibitive and impinges on the bottom line significantly enough to cause inability to pay providers enough to attract or keep them, or to prevent burnout from too much work. Again, according to many groups, Magellan requires a huge amount of paper. Administrators indicated that if they hire office staff to do the paperwork, they don't have money to pay the psychiatrists, but if they don't hire staff to do the paperwork, the psychiatrists do it and can't see patients during that time.

The strongest recommendation for improving recruitment of psychiatrists to the rural areas of Nebraska was development of one or more rural residency programs. A majority of subgroups made this recommendation, as well as all psychiatrist groups, and it came from all regions. Many emphasized the importance of familiarizing a potential candidate with the area, and the need to include the family, when possible, in order for them also to integrate into the community. One offered that, in other states, *"wherever they make their students have a rural posting in psychiatrics… that's how they retain their psychiatrists."* Respondents felt having a rural residency would work because it would get residents to the local area and allow an opportunity for them to engage, as well to learn "hands–on" how to work with community workers. It was strongly urged that residency program placements be for a period of several years. Focus group members felt that until the resident lives it, he or she is not going to know. One said,

hopefully,*"by the time your J-1 is over and you're able to leave, you have roots in the community, your kids have already been in the school year for the last four years, you've already made friends, you've established a practice."* Some respondents reported feeling positive about the potential connection with the UNMC residency program, stating they believe it is *"really getting some exposure with Nebraska-trained folks because they might be more likely to stay and work with us."*

Regarding marketing to potential psychiatrist applicants, some groups reported felt that national recruiters are not effective. *"They don't get small-town life… they're not going to highlight the things that someone would be attracted to here."* One suggestion that emerged from two regions was to create a video specific to the area that would highlight the community, including key providers and resources in the area. One suggested emphasizing amenities in and close to the area. Based on comments regarding benefits of living in a rural area, this likely should include reference to general safety and lack of traffic, as well as proximity to any larger cities from the area. Some groups felt that marketing approaches needed to be specific about the job as well as the area, and that other staff members coming in contact with interviewees needed to know the benefits and feel positive about them, themselves. One group indicated they had solved the problem of psychiatrist call coverage by hiring moonlighters, and thought that needed to be advertised. Another group member said, "*…one of the questions [from residents] was do we go on call, and how often."* Another group indicated their rural area is competitive salary wise with the rest of the country but that few people know this.

A related suggestion emerging from a psychiatrist focus groups was that the rural areas should come together to afford positions that would offer a variety of settings to psychiatrists, a fixed schedule, relief from weekend or holiday call, and time off. One person said, *"All these small communities… they've got to come together and say… I've got enough for one day, so I can chip in for you. One person moonlighting in different places, that is the only, only way."* Such perks offering relief from being the only provider in town and/or the lack of variety were thought to be important in marketing to prospective candidates. Also mentioned as important for marketing was any opportunities for extra pay. One psychiatrist group suggested that marketing for a psychiatrist to work in frontier areas of the state may need to focus on candidates who want to take on the challenge of more of a Peace Corp kind of mission where they are going to be trailblazing and establishing. *"That's a whole different campaign and it needs to be marketed to a different group of people."*

## Recruitment/retention of psychologists

Some regions mentioned needing more psychologists in their area, particularly for testing services. Others reported they have a psychologist in the area, but in private practice, not in hospital or community agencies. Lack of local amenities, problems with reimbursement, and low pay again were named as reasons it is difficult to hire psychologists. However, the primary reason identified as responsible was the lack of a rural regional psychology internship program. Numerous respondents indicated that the closing of the Norfolk regional Center, which was Nebraska's only rural psychology internship program, resulted in a dearth of students who have experienced a rural area and in students leaving the state for training elsewhere, thus becoming lost to the Nebraska pool of providers. Losing this training center reportedly also further reduced the opportunity for provisionally licensed psychologists to obtain their required year of supervision in a rural Nebraska location, thus decreasing the likelihood of them applying for a position in rural Nebraska post-licensure.

The most cited solution for increasing psychologist hiring and retention in the rural areas, proposed by all regions, was creation of a rural psychology internship site that would provide supervision to pre-doctoral interns, and ideally, also post-doctoral provisionally licensed psychologists. One group indicated the goal should be, *"to build a core of fully-licensed psychologists… so that you would have enough supervisors to bring interns or post-docs in, because they need to be onsite."* Providing post-doc supervision was deemed important because, otherwise, "*people would finish their internship here… then they'd have to leave … if they want to go do an actual true APA [approved internship]*." One group also recommended granting psychologists medical staff privileges in rural hospitals, as this would expand available attending providers and fix the problem of psychologists not being paid by Medicaid for the same services provided by psychiatrists on an inpatient basis. Not having medical staff privileges, one psychologist stated, *"… that's going to be discouraging to some [applicants]."*

Lack of reimbursement by some insurers, particularly Medicaid, for services provided by a provisionally licensed psychologist (one having a doctoral degree but still needing a year of postdoctoral supervision for full licensure), was cited as problematic by focus groups from several regions, because it results in reluctance on the part of agencies to hire them, as they would have to hire someone to supervise the person for the required full post-doctoral year. Psychologists in private practice, who are reportedly otherwise willing to supervise, also are unable to be reimbursed for time spent providing supervision. One person asked, *"How do these poor souls get exposure to clients in a supervised setting if what they're doing can't be reimbursed? Somebody has to eat that hour."* Also mentioned was increased professional liability for the supervising psychologist. Some suggested it would be helpful "*if … the psychologist as a post-doctoral clinician can move directly to full licensure the way MDs do, rather than being provisionally licensed."* One individual suggested there needs to be "*some kind of external funding for internship."*

Three of the four regions recommended offering psychologists more opportunities for loan repayment as a strategy for increasing hiring and retention of psychologists in rural areas. Although loan repayment was cited as having been successful in bringing some psychologists back to rural Nebraska, all four regions reported difficulties creating loan repayment opportunities. Specifically mentioned were problems getting into the federal loan program and unwillingness or inability of agencies or practice groups to take on the shared the repayment burden. One psychologist group reported it is daunting to have to work two years before loan repayment kicks in. Another suggested extending fee repayment periods longer, based on the number of years a psychologist practices in the rural area. One group said that participating in the iHOP program, which reportedly recruits local students to go to pharmacy, medical, dental, or PA school, should be made available to those wanting to become a psychologist.

## Recruitment/retention of licensed mental health practitioners

In all four regions, a preference was expressed for hiring individuals who are from the region, and "growing your own" LMHPs was the most strongly recommended solution to increasing mental health practitioner presence in rural Nebraska. However, having limited training options, most of which require long distance travel to classes, was cited as problematic. Some LMHP respondents reported that on-line classes are available, often through out of state programs, but others did not know which coursework or degrees could be obtained in this manner. *"If I were wanting to get*

*my drug and alcohol license or if I wanted to get my LMHP today, how would I do that? I don't even know, I really don't."* Many mental health practitioners reportedly have a spouse whose job determines where they live, another reason why many respondent saw that bringing advanced education and training to them was seen as the best answer.

Finding a pool of applicants for mental health practitioner jobs reportedly is less problematic than finding well-trained individuals (which will be discussed later) or those who are dually certified as Licensed Drug and Alcohol Counselors (LDACs). All four regions reported these problems, and two regions reported having closed or having been unable to open a chemical dependency program because it could not meet the Medicaid requirement that therapists be dually certified. One stated,*"… we wanted to have … a CDIOP [outpatient] program for adolescents… We could not find anybody, so… it went away. "*

Factors cited as barriers to finding LMHP's with the LADC credential included inability of mental health practitioners to obtain the coursework or supervised experience required for LADC licensure, and the cost of the training process. Costs include coursework fees, travel to classes, time away from work, and continuing education requirements. Two focus groups reported that some providers feel there is too much additional training required for LADC certification beyond independent licensure as a LMHP, whose scope of practice technically includes chemical dependency treatment. Accessibility was cited as a problem in many rural areas: *"If I were wanting to get my drug and alcohol license or if I wanted to get my LMHP today, how would I do that? I don't even know, I really don't."* One group indicated that a lot of LMHPs do not want to acquire LADC certification because *"[one] has to have lots more continuing education and… pay double, triple the licensure fees in order to maintain… they don't want to jump through the hoops to get that license."* Others stated that obtaining the ongoing continuing education required for both licenses is difficult and needs to be streamlined, as there is only a small amount of overlap.

All areas indicated that many mental health practitioner applicants for their positions have not been adequately trained during their masters programs. One said that, currently, *"those…who pursue their education close to where they live… are very ill prepared."* Two administrative groups said they are reluctant to hire PLMHPs because they require intensive supervision. Respondents indicated they believe professional schools need to do a better job "teaching the work as it is in today's world," including how to work with managed care companies and chemical dependency. They also indicated that, "*if the scope of practice is going to include substance addiction, then the schools that give out Master's in Counseling degrees need to have a track that trains people for that."*

Beyond securing masters level coursework, gaining practicum experience needed for mental health practitioner licensure reportedly is difficult for several reasons, including a lack of providers to supervise interns. *"They have none in this area, so, often times, [the trainees] are in settings that aren't the best just because they have to get their hours*." One group suggested allowing psychologists to train LMHPs (currently, psychologists can supervise PLMHPs for licensure, but if the PLMHP wants a discipline-specific credential, e.g. licensure as a marriage and family therapist, social work, or counseling, they are required by the NE licensing board to be supervised by a member of that discipline). Reportedly, Magellan requires a supervisor to be on site. *"But what do you do in a rural setting when at your work site your supervisor is in a completely different area?"* one LMHP said. *"How do you do that?... there need to be modifications."* Even when there are potential supervisors on-site, however, they reportedly often are unwilling to supervise provisionally licensed mental health practitioners (PLMHPs) due to inability to receive third party payer reimbursement for their services and the amount of time it

takes out of the supervisor's billable practice. One administrator explained, *"I try not to hire a provisional LMHP because there are so many payers that don't pay you for that."* Also cited was concern of supervisors regarding professional liability for the intern's actions. Administrators expressed concern that a provisionally licensed therapist will leave immediately after this year of intensive supervision, which is an expensive investment on the part of the agency. Three out of four subgroups of LMHPs reported that licensing requirements in their field are too strict; two said the PLMHP requirement should be waived. This opinion represents a significant divergence from administrative concerns that the LMHPs are not adequately trained. Some groups recommended decreasing LADC requirements or allowing LADCs with the PLMHP credential to do CD evaluations.

All regions recommended providing more training opportunities to local individuals as an important way to improve availability and retention of LMHPs in their regions. Mentioned as problematic is the lack of social work training programs in rural Nebraska, as training as a social worker is a requirement for Medicare reimbursement, i.e., Medicare will only pay for services provided by a LMHP who is a social worker [note: availability of social work training may improve with the branch of a social work program opening in Kearney]. Only two counseling programs in NE reportedly are accredited by the Council for Accreditation of Counseling and Related Educational Facilities (CACREF) accredited, Kearney and UNO. Increasing availability of CACREF accredited schools locally was cited as a solution to this problem. CACREF certification is seen as important in order to make licensing easier. *"You can also get [a masters degree] online through Chadron, out at Mid-Plains [Community College] here in North Platte, except I don't think they're CACREF accredited."*

As with other types of providers, long delays reportedly occur once provisionally licensed mental health practitioners submit their applications to the state for full licensure, which also creates financial difficulty for the agencies wanting to hire them, as they are unable to bill for practitioners' services until they are licensed.

Loan repayment was recommended by three regions as helpful in recruiting LMHPs. One administrator group said they were a site for the National Health Service Corps and have used it for mental health practitioners. "*They've all just stayed, even after their loans are done*."

Providing therapy via telehealth to other parts of the state was mentioned as a way for LMHPs to get full faster when hired. Then, the *agency doesn't lose revenues because they can bill for telehealth services.* PLMHPs reportedly can be paid by insurance companies for their telehealth services to other parts of the state. [note: This may be incorrect as it seems to run counter to complaints that PLMHPs can't be reimbursed for direct services.]

## Recruitment/retention of rural nurse practitioners

Respondents indicated that it is difficult to find psychiatric APRNs to hire due to applicants having many other options, including local competition. On call requirements and evening work reportedly are deterrents for APRNs. A lack of local supervising psychiatrists and need for medical authorizations were reported as problematic. Although some rural individuals reportedly have been trained as APRNs, distance learning is thought to be largely unavailable, requiring nurses to travel for their education. Increasing distance education opportunities for nurses, paying

for training (as some rural hospitals reportedly do), and offering loan forgiveness were recommended as solutions.

## What can BHECN do?

This study represents an important first step in identifying problems and potential solutions specific to hiring and retaining behavioral health practitioners in rural Nebraska. Specific themes emerged regarding different types of licensed practitioners; and some themes were universally applicable. In the business world, involving employees who are directly engaged in a problematic situation in developing interventions is important to finding effective solutions (Halbesleben, J. R. B., & Wheeler, A. R. (2008). Likewise, BHECN study and/or implementation of the following suggested activities would benefit from involvement of rural Nebraska behavioral health providers.

1. Work with the Nebraska legislature and Medicaid to increase reimbursement and streamline requirements for service provision by providers of all types. Nebraska may have a problem retaining providers in the state, but there also appears to be a problem retaining providers in the public system, where certain populations can access them, such as Medicaid recipients. Increasing agency funding and reimbursement for services likely would increase the number of positions able to be offered, while reducing workload and increasing salaries to assist in attracting and keeping providers. Review suggests that organization and systems level approaches are needed to addressing burnout, not just individual approaches. (Paris & Hoge, 2010)

2. Explore reimbursement for provisional status employees who are under supervision and develop funding streams for supervisors.

3. Look for creative ways to pool resources of regions and/or agencies to offer attractive shared positions to psychiatrists that would reduce on-call requirements and weekend and holiday work for others. This study identified considerable overextension of the mental health workforce, including psychiatrists. Actions should be taken to help mitigate this impact. “Although competitive compensation with help to attract the best talent, only a humane culture with flexible policies and practices will keep them.” (Myers & Dreachslin, 2007).

4. Explore ways to increase supervision and training to LMHPs and LADACs. This may include studies of technological solutions, addressing regulatory barriers at the state level, and study of the impact of requirements imposed by of public and private payers. Studying strategies for deploying remote or itinerant psychologists and LIMHPs to provide supervision also would contribute to addressing this problem.

5. Develop a rural pre-doctoral psychology internship program that also provides supervision at the provisional (post-doctoral) psychology licensure level, as well as possible supervision for LMHPs.

6. Work with training programs, payers, and licensing boards to develop supervision and training guidelines to address concerns affecting hesitancy and/or inability to hire mental health practitioners, specifically:

- Identify additional professionals who could provide supervision and training to PLMHPs, LMHPs and LADCs
- Define knowledge or education-based criteria that would allow more highly educated mental health professionals to receive reimbursement for treating substance use disorders without requiring a separate LADC credential.
- Allow appropriate electronic methods of supervision for PLMHP/LMHP and LADC training

7. Fund trainers to travel regionally to offer CEUs for behavioral health providers

8. Improve distance learning programs

9. Work with masters training programs to determine where gaps exist in preparation for internship positions. Work with training programs to add training about rural mental health and substance abuse.

10. Partner with professional groups and licensing boards to address delays in licensing of all provider groups at the state level.

11. Develop a rural residency program for psychiatrists.

12. Distribute information to all providers, mental health training programs, and mental health agencies regarding how to utilize loan repayment options. Consider development of additional funding sources to extend repayment periods and assist agencies in taking on this financial burden.

13. Obtain grants to help with targeted marketing

    - Utilize video interviews and photography, featuring locale, amenities, resources, other providers. To prevent later attrition, Barney (2002) encourages being honest and informative about the organization, its culture, policies, and work expectations. Research suggests utilizing culturally sensitive images to highlight individual identity in the workplace (Taber & Hendrick 2003; Thomas 2006).
    - Train providers and administrators to recognize and convey the strengths and benefits of rural areas to potential recruits, including the felt value of positive teamwork. Research also suggests has indicated that people stay when they feel they are making a difference, when their work is meaningful, when they believe their potential is being fulfilled, and when they feel a sense of community (Barney, 2002).
    - Develop strategies to market the fact that pay is competitive (when it is) and cost of living is low (if it is).
    - Present marketing materials in colleges and training programs in rural states, particularly those bordering Nebraska

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## Appendix A

### Summary of Behavioral Health Provider Recruitment/Retention Recommendations adapted from the World Health Organization (WHO)

1. Target educational admission policies to enroll those with rural background
2. Locate schools, campuses, residency programs outside of major city areas
3. Expose undergrads to rural community experiences
4. Include rural health topics in educational curricula
5. Design continuing education programs that meet needs of rural health workers
6. Use fiscal incentives

7. Improve living conditions/ infrastructure
8. Provide good and safe working environment
9. Implement outreach activities to facilitate cooperation between areas
10. Develop and support career development programs
11. Support development of professional networks
12. Adopt public recognition measures

## Appendix B: Comparison of Provider Training Requirements in Behavioral Health

### PROVIDER TRAINING IN BEHAVIORAL HEALTH*

| Undergraduate - Number of Years | | | | |
|---|---|---|---|---|
| **Discipline** | **Psychologist[1]** | **Psychiatrist** | **LMHP** | **LADC** |
| **1** | 4 year Undergraduate Bachelor's (BA/BS) | 4 year Undergraduate Bachelor's (BA/BS) | 4 year Undergraduate Bachelor's (BA/BS) | 270 hrs. substance abuse relevant courses |
| **2** | | | | 300 hrs supervised training in "12 core functions." |
| **3** | | | | 6,000 hrs paid supervised experience |
| **4** | | | | |

| Graduate - Number of Years | | | | |
|---|---|---|---|---|
| **Discipline:** | **Psychologist[1]** | **Psychiatrist** | **LMHP** | **LADC** |
| **Year 1** | Scientific [2] & Clinical[3] Coursework | Natural Sciences | Masters or Doctoral Training | |
| **Year 2** | Research Coursework Clinical Practicum[4] | Psychopharm | Graduate Program | |
| **Year 3** | **Master's Degree** Clinical Practicum[4] Coursework | Clerkships (Varies) | **Masters Degree**[7] | |
| **Year 4** | Advanced Scientific & Clinical Courses & Practicum/Research | Electives **M.D. Awarded** | **LIMHP**[8] | |
| **Year 5** | Specialized Courses PhD Research Clinical Practicum[4] | Psychiatric Residency (6 mo. on Med.) | | |
| **Year 6** | Internship[5] Completion of Dissertation **Ph.D. Awarded** | Psychiatric Residency | | |
| **Year 7** | Two Year Post-Doctoral Supervised Clinical Experience | Psychiatric Residency | | |
| **Year 8** | Post Doctoral Supervised Experience | Psychiatric Residency **Board Certification** | | |
| **Year 9** | **Licensure** --- Two-year Psychopharm Training[6] | | | |
| **Year 10** | **Certified Medical Psychologist** | | | |

Footnotes:

1. Training programs may vary in terms of mission, emphasis and residency time, but must meet APA accreditation standards for doctoral training. For example, master's degree is not necessarily required in route to doctoral degree.
2. Minimum science curriculum: biological basis of behavior; cognitive and affective aspects of behavior; social aspects of behavior; history and systems; individual differences; human development; psychological measurement; research methods; techniques of data analysis; professional standards and ethics.
3. Minimum clinical curriculum: dysfunctional behavior/psychopathology; substance abuse; psychological aspects of measurement including empirically supported procedures; efficacious and empirically supported intervention/psychotherapy processes and theories; efficacious and empirically supported individual/group assessment/diagnostic techniques/instruments and theories; theories of consultation, evaluation and supervision; cultural and individual diversity in professional activities.
4. Practicum settings must provide adequate professional supervisors, access to clients and facility support for face-to-face supervised clinical experience utilizing empirically supported procedures and abiding by appropriate professional standards of service.
5. Internship must be one year, full time training, no less than 12 months and no more the 24 months. Training must consist of direct contact with service recipients involving face-to-face delivery of psychological services and a minimum of 4 hours of supervision per week, at least 2 hours of which consist of individual face-to-face supervision. Evidence of scholarly inquiry into professional services and consideration/knowledge of issues of cultural and individual diversity are required. Interns are required to demonstrate an intermediate to advanced level of professional skills as a result of predoctoral internship training.
6. (Description of psychopharm training requirements)
7. LMHP requirements: Masters or doctoral degree from CSWE, COAMFTE, or CACREP approved program, or masters degree with primarily mental health content approved by CHEA.
8. LIMHP requirements: Masters or doctoral degree from CSWE, COAMFTE, or CACREP approved program, and 3000 hours of experience obtained $\geq$ 2 years and $\leq$ 5 years supervised by a physician, psychologists or LIMHP practitioner, or masters degree with primarily mental health content approved by CHEA and 7000 hours of experience obtained $\geq$ 10 years supervised by physician, psychologist, or LIMHP provider.

* Document created by James Cole, Ph.D.

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