Recommendations		
Iowa's Health and Long Term Care Workforce – Dec 2007 - IDPH	**An Action Plan for Behavioral Health Workforce Development - SAMHSA – Annapolis Coalition 2007**	**Iowa Mental Health and Disability Services Workforce Review – DHS & Annapolis Coalition – March 2008**
Short term recommendations:	MH workforce - Notable lack of racial and cultural diversity and lack of geographic distribution	**Global recommendations**
1. Establishment of the Iowa Health Workforce Center	SA workforce – workforce needs as a result of identified prevalence is staggering – primarily older white female workforce	1. Increase the use of peer supports and peer operated services
2. Expansion of loan repayment programs a. Developing or expanding loan forgiveness and loan repayment programs b. Increasing the number of available Iowa residencies/internships c. Providing technical assistance to communities trying to recruit and/or plan d. Creating mentoring programs, preceptorships, team based approaches and other similar strategies to prevent turnover/increase retention	Trends of SA workforce and behavioral health field – Workforce and treatment capacity insufficient to meet demand, increased co-occurring disorders, increased public financing of treatment and declining private coverage, paradigm shifts, such as recovery model of care, escalation to change practices to best practices and evidence based interventions, need to understand medications, services in nonbehavioral settings, requirements for performance measures and outcomes, and climate of ongoing discrimination.	2. Enhance clinical competence through strengthened infrastructure - creation of an ongoing workforce collaborative, as well as a Center for Clinical Competence and Training Institute 3. Systematically prepare the system to develop, implement and sustain evidence based practices for Iowa.
3. Continue efforts to increase Medicare/Medicaid reimbursement for Iowa so providers are able to pay health professionals at rates that are competitive with other states	MH productivity reduced because of administrative burdens, low pay, absence of career ladders, excessive workloads, tenuous job security, lack of supervision, and an inability to influence the system they work for	4. Provide incentives for recruitment and retention of behavioral and developmental specialists. – establish a pool of dollars to offer financial incentives
4. Raise public awareness of the shortages and impact – expanded public awareness of the shortages and impacts will expand t he conversations around the state on these issues and get more people involved in addressing them.	Pg. 3 – Persons in recovery and their family members are explicitly recognized as pivotal members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help and family caregiving or more formally through organized peer and family support services.	5. Increase opportunities for integration of behavioral and primary care – adults with serious mental health conditions die 25 years younger than their age cohorts with diagnoses and frequency of co-occurring conditions
Long term recommendations	Critical shortage of child & adolescent psychiatrists	6. Systematically evaluate the effectiveness of Iowa's behavioral and disability workforce efforts
1. Continue with item 3 in short term recommends	Shortfall of providers with expertise in geriatrics	
2. Continue with item 2 in short term recommends	SA-50% turnover in front line staff – lack of technology	**A Report Prioritizing a Potential Shortage of Licensed Health Care Professionals in Iowa May 2005**
3. Maintain and improve data collection/tracking/accessibility	SA & MH-lack of cultural diversity, culturally and linguistically incompetent	
4. Sustain recruitment/retention/training programs that are working a. PRIMECARRE – Iowa Loan Repayment Program – 2 yr practice commitment in HPSA - $15,000 to $30,000 per year b. National Health Service Corps Loan Repayment Program and Scholarship Program c. 3R Net – a job search web site devoted exclusively to rural health care recruitment d. The J-1 Visa Waiver Program for foreign medical graduates DMU, U. of Iowa have either scholarship, loan repayment programs or both. Federal grants received to create a total of seven area health education centers (AHEC) – Educating students about career options and to provide clinic training sites for students and CEU opportunities for current practitioners.	**7 strategic goals** *Broaden concept of workforce* 1. Significantly expand the role of individuals in recovery, and their families and ultimately direct, or accept responsibility for t heir own care; provide care and supports to others; and educate the workforce. 2. Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness. *Strengthen the workforce* 3. implement systematic recruitment and retention strategies at the federal, state and local levels *Training stipends, tuition assistance, and loan forgiveness, wages and benefits commensurate with education, experience, and levels of responsibility, comprehensive public relations campaign, career ladders (pg 18 has summary of wants)* 4. increase training and education 5. actively foster leadership throughout workforce	Professions serving the mental health needs of Iowans have the highest combined percentage of licensees age 55 and older and are, therefore, at greatest risk of having a shortage of workers. 1. All licensing boards should collect a uniform minimum data set of employment information regarding their constituents 2. The work of Iowa's Office of Statewide Clinical Education Program should be expanded to include all health professionals. 3. Each profession should develop its own working definition of workforce shortage 4. Professional associations should closely monitor issues within their profession. 5. Health occupational trend data should be used in planning formal and continuing education programs. 6. This study should be replicated using data from non-licensed health professionals.
5. Align licensure scope of practice with scope of practice taught in education programs – so that "mid-level" aka "physician extender" professions are allowed/expected to maximize use of training/skills.	*Structures to support the workforce* 6. enhance infrastructure to support and coordinate workforce development - a human resources and training infrastructure 7. implement national search and evaluation agenda on behavioral health workforce development	47th among states in psychiatrists per capita 64% work in private practice 46th in psychologists per capita 28th in social workers per capita
6. Expand efforts toward wellness and prevention, a health care system rather than a sick care system, to reduce demand.		25 nurse practitioners per 100,000 (33.7 is national) Only 5% in psychiatric/mental health services No national rank on physician assistants
7. Maximize best practices and efficiencies in how professionals deliver services – communicate/share	Recent graduates are unprepared for the realities of practice in real world settings	
84 Iowa counties are MH Professional shortage areas		
Statistics are on pages 19 and 20. Training program for psychiatric physician assistants at Cherokee MHI and U. of Iowa. Training program for psychiatric advanced registered nurse practitioners at U. of Iowa.	Silos create tensions: 1. mental health field vs. addiction field 2. split between treatment and prevention 3. separation between the traditional treatment system and the recovery community	
Graphs of ages of each type of professional and where located in Iowa is in Appendix B.	Tendencies to do what is affordable rather than what is effective	