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# Alaska Mental Health Trust Workforce Development Initiative

An Overview of Workforce Related Data & Strategies to Address the Gaps

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*Prepared by the Western Interstate Commission for Higher Education  
(WICHE) Mental Health Program*

*For: The Alaska Mental Health Trust Authority Steering Committee*

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## Introduction

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Access to health services in Alaska is seriously challenged by shortages across the professional and paraprofessional workforce. Alaska shares this problem with other rural and frontier States, but the challenges are magnified by the diversity of populations and their wide dispersion across the vast landmass of Alaska.

The Alaska Mental Health Trust Authority (referred to as “the Trust” for the remainder of this document) expressed the desire to develop a comprehensive workforce plan, serving all Trust beneficiary areas, to articulate an agreed upon set of action steps to facilitate the preparation and continuing education of a qualified health workforce. The beneficiaries of The Trust are Alaskans who experience mental illness; developmental disabilities; chronic alcoholism; or Alzheimer's disease and related dementia. While the individuals in these beneficiary areas often experience unique issues and require different approaches to treatment, workforce concerns span all areas.

The Mental Health Trust Authority, in partnership with the State Division of Behavioral Health, and the University of Alaska System brought stakeholders together to strategically discuss and examine the workforce trends and demands in Alaska, including recruitment, retention, education, training, and career opportunities. The goal of this project is to expand upon the current workforce efforts and to increase communication between systems and initiatives to foster a more coordinated strategy that maximizes resources and decreases duplication.

This document is not meant to be exhaustive but will attempt to provide an overview of current workforce efforts for Trust beneficiary areas. The data provided in this report was used to guide the Workforce Steering Committee in identifying priorities for future resources and collaboration and to create a strategic implementation plan with specific deliverables and timelines.

### **A Phased Approach**

The Trust asked the WICHE Mental Health Program (WICHE MHP) to help facilitate this project. The WICHE MHP has a history of work in Alaska, including working on behavioral health workforce initiatives, community readiness assessments, and system of care integration projects. This participatory project unfolded over the following three phases.

**Phase I:** The Alaska Trust Workforce Development Steering Committee was formed to guide this project and includes personnel from the Trust, as well as representatives from many leading institutions and provider agencies that serve Trust beneficiary areas (see the Steering Committee list in Appendix A). The Steering Committee is composed of leaders who are committed to implementing a workforce plan. They bring experience, ideas, and resources to recruit colleagues and execute the plan in their respective institutions.

**Phase II:** In collaboration with the Alaska Trust Authority Workforce Development Steering Committee, the WICHE MHP prepared a report that provided an overview of the current status of workforce development efforts in Alaska. This report describes available data reflecting the current and projected workforce needs and review existing efforts. This narrative served to

inform those engaged in the development of the Alaska Trust Authority Workforce Development Plan with essential background information to support the planning process.

The Steering Committee met Tuesday, April 25, 2006 at the Alaska Psychiatric Institute (API). At this meeting, the Steering Committee discussed the goals and reached agreement regarding the process for developing and vetting the Alaska Trust Workforce Development Plan. The Steering Committee accomplished the following:

- Identified information sources for the data report.
- Identified key stakeholders for inclusion in the Phase III planning process.
- Determined the format for a Phase III Planning Meeting with broad stakeholder involvement.
- Determined the focus areas for Phase III planning.

**Phase III:** WICHE MHP facilitated a day and a half small work group planning meeting, hosted by the Trust, to review the report. WICHE MHP facilitated a planning process to assist the Trust in developing a Workforce Development Plan with strong stakeholder support and consensus. The accomplishments of this phase include:

- WICHE MHP conducted a day and a half statewide meeting on May 24 and 25, 2006 in Anchorage, with a wide array of stakeholders concerned with health workforce development. This meeting developed a set of strategies for the Trust to include in the final plan document.
- The Steering Committee met for two working conference calls to review and edit the strategies generated at the May meeting. Steering Committee members also provided budget estimates for various workforce projects.
- Developed a final strategic planning document (this document) that the Trust can further vet with its constituents and stakeholders prior to formal adoption.

The next sections will cover available data regarding workforce trends in Alaska and results of the strategic planning process including goals, strategies, and action steps.

## Context: Workforce Components and Trends

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At any given time, the need for workforce development in healthcare is determined by the prevalence of disease or disorders and the number and location of professionals to provide services. Prevalence rates are based on epidemiological studies of populations, while the number and location of clinicians is based on the interplay of education and occupation trends. Additionally, a *competent* and *adequate* workforce has the right number of experienced and skilled people in the right jobs at the right time.

Thus, establishing and sustaining an effective behavioral health workforce involves several components:

- A profile of present *population* and demographics;
- An estimation of the *prevalence* of mental illness;
- An analysis of the professional *occupations* available to serve the community;
- A picture of the *higher education* programs designed to supply well-trained professionals.



Each of these four components interrelates, and changes to one often affect the others. For instance, large and rapid increases in population can translate into greater numbers of people with a behavioral health problem (even if percentage remains the same). But it can also mean more people available to enter the behavioral health field as clinicians. Thus, it is important to study previous trends to project future courses. More importantly, these projections allow decision-makers to identify potential avenues of growth, as well as barriers and means of overcoming them.

Alaska has been addressing workforce shortages for the past several years with various committees and initiatives. For example, in 2003, the University of Alaska (UA) system convened a meeting of educators from disciplines spanning the behavioral health field to discuss how they can most effectively address workforce shortages, especially in rural areas. Despite a number of productive efforts in the UA system to develop an effective workforce that is trained in rural behavioral health, educators in Alaska see that more work needs to be done and are committed to formalizing workforce development activities that ensure the needs of Alaskans are

met. Based on the meeting in 2003 regarding behavioral health workforce development in Alaska, educators in University of Alaska behavioral health programs developed recommendations in the areas of collaboration, education, financing, and evaluation and research (See Appendix B). Considerable momentum and progress has been made following this meeting, with the help of the Alaska Mental Health Trust Authority, which supported seven of the programs that were created or continued as a result of the meeting. These programs included the UAA/UAF Joint Ph.D. in Psychology, the Alaska Rural Behavioral Health Training Academy, UAA Masters in Social Work by Distance, UAF Bachelor of Social Work Rural Cohort, UAA Human Services, UAF Human Services, and Residential Services Certificate programs. However, even with the creation of new programs, gaps in the workforce and training still exist. The Trust wanted to continue the momentum that exists in Alaska and to develop a focused strategic plan for the workforce serving Trust beneficiaries.

The report includes data related to Alaska's population, occupations, and educational system. Accordingly, the following sections cover different aspects of these workforce components. The vast majority of data is quantitative, but qualitative data from in-state studies of the healthcare workforce is included as appropriate and relevant. The table below summarizes the sources of data used in this report.

This report also chronicles the planning process for this initiative. Following the data portion of this report, the reader will find the strategic planning document generated by the Trust, the Steering Committee, and multiple stakeholders throughout this process. This portion of the report also provides the final budget for which money will be allocated toward the different goals.

Resource Name	Year	Research Team	Type of Data	# of Agencies/ Respondents	Purpose/ Information Collected
Alaska Alliance for Direct Service Careers Survey	2006	AADSC	Quantitative	40	Agencies responded to a survey that included questions regarding turnover, challenges in recruitment efforts, AADSC media campaign, and use of the AADSC job posting system
Human Services Department Behavioral Health Initiative Year End Report	2006	Dr. Laura Kelly, Melodee Monson			Provided information on the increase in HUMS practicum enrollments, increase in placement agencies, new applicants, student enrollment, and graduates from both AAS and BHS programs.
Status of Recruitment Resources and Strategies II (SORRAS II)	2005	ACRH, UAA	Quantitative	80	SORRAS II collected the same data points from the original study, which surveyed all rural Alaskan health care facilities, but also included select urban facilities, including all the large hospitals in Anchorage, Fairbanks, and Juneau
Factors Influencing Retention and Attrition of Community Health Aide/Practitioners	2004	ACRH, UAA	Qualitative	41	Co-worker support, Access to basic training, Fully staffed clinic, Community support, Family support
The Behavioral Health Workforce in Alaska: A Status Report	2004	WICHE Mental Health Program			Provided an overview of workforce development efforts for behavioral health in Alaska. <a href="http://info.alaska.edu/health/downloads/AK%20report%20Executive%20summary.pdf">http://info.alaska.edu/health/downloads/AK%20report%20Executive%20summary.pdf</a>
Status of Recruitment Resources and Strategies I (SORRAS I)	2003	ACRH, UAA	Quantitative	76	Strategies used by small hospitals, rural clinics, and rural mental health centers to recruit physical, behavioral, and oral health providers. Documented the costs associated with recruiting these professionals.
The 2002 Social Services Job Survey	2003	School of Social Work, Department of Psychology, DHS, CHD; UAA	Quantitative Qualitative	Agency Survey – 70; Alumni Survey – 106; Focus Group – 22	Identify and characterize the social services jobs market in Southcentral Alaska to strengthen UAA educational programs and help University students make informed career decisions.(job types, salaries, educational requirements, and turnover rates; characteristics of successful employees)
Alaska Alliance for Direct Service Careers – Wage and Benefit Research Report	2002	C & S Management Associates	Quantitative	37	Existing wage and benefit levels for direct service professionals in Alaska; and strategies that other states have used to increase compensation levels for direct service professionals
Alaska’s Allied Health Workforce: A Statewide Assessment	2001	ACRH, UAA	Quantitative Qualitative	369	# of employees, vacancies, annual turnover, projected future needs, and recruitment difficulties; Training needs, cross training, suggestions for planning health related coursework

Alaska Department of Labor and Workforce Development <http://www.labor.state.ak.us/>  
Health Resources and Services Administration (HRSA) State Health Workforce Profiles Highlights Alaska <http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/alaska.htm>  
United States Census Bureau <http://www.census.gov>

Acronym Key: Alaska Center for Rural Health (ACRH), University of Alaska Anchorage (UAA), Department of Human Services (DHS), Center for Human Development (CHD)

## Section I: Population Data and Trends

Major changes in America's general workforce are anticipated between now and the year 2025. This change is brought into sharp focus when comparing the percentage of the population entering the workforce to the percentage leaving it. On average, WICHE states will see a projected 21.7% increase in the number of people between the ages of 18 to 64 entering the workforce by 2025 (the range is a low of -10.9% for North Dakota and a high of 76.4% in Nevada). However, the projected average percent of persons 65 and older (i.e., retirement age) leaving the workforce in WICHE states is a staggering 118% (with a low of 50.5% in South Dakota and a high of 222.5% in Alaska).<sup>1</sup>

As this translates into actual numbers of people, some WICHE states will have more citizens entering than leaving the workforce, while others will have more leaving than entering (see the table below). For instance, California is projected to have a net increase of 1,473,050 in workforce by 2025. Alaska, on the other hand, is projected to have a net decrease in their workforce of 10,384 by 2025. In all, eight WICHE States are projected to have actual numbers of people entering the workforce in excess of the numbers leaving.

Table 1

15 WICHE States	% Change Pop. Ages 18-64 2000 to 2025	% Change Pop. Ages 65+ 2000 to 2025	Net People Entering or Leaving the Workforce
California	24.6	102.6	1,473,050
Arizona	68.9	190.5	861,676
Nevada	76.4	201.3	527,136
Washington	28.7	108.5	347,108
Utah	38.9	113.2	299,775
Oregon	25.3	83.9	173,927
Nation	16.5	81.5	148,799
Idaho	36.8	119.4	112,068
Colorado	17.1	109.0	21,191
Alaska	17.2	222.5	-10,384
South Dakota	-1.8	56.9	-69,531
Wyoming	-4.2	122.9	-83,936
North Dakota	-10.9	50.5	-89,836
Hawaii	6.6	87.3	-90,271
Montana	4.2	104.9	-103,902
New Mexico	3.0	134.4	-252,654

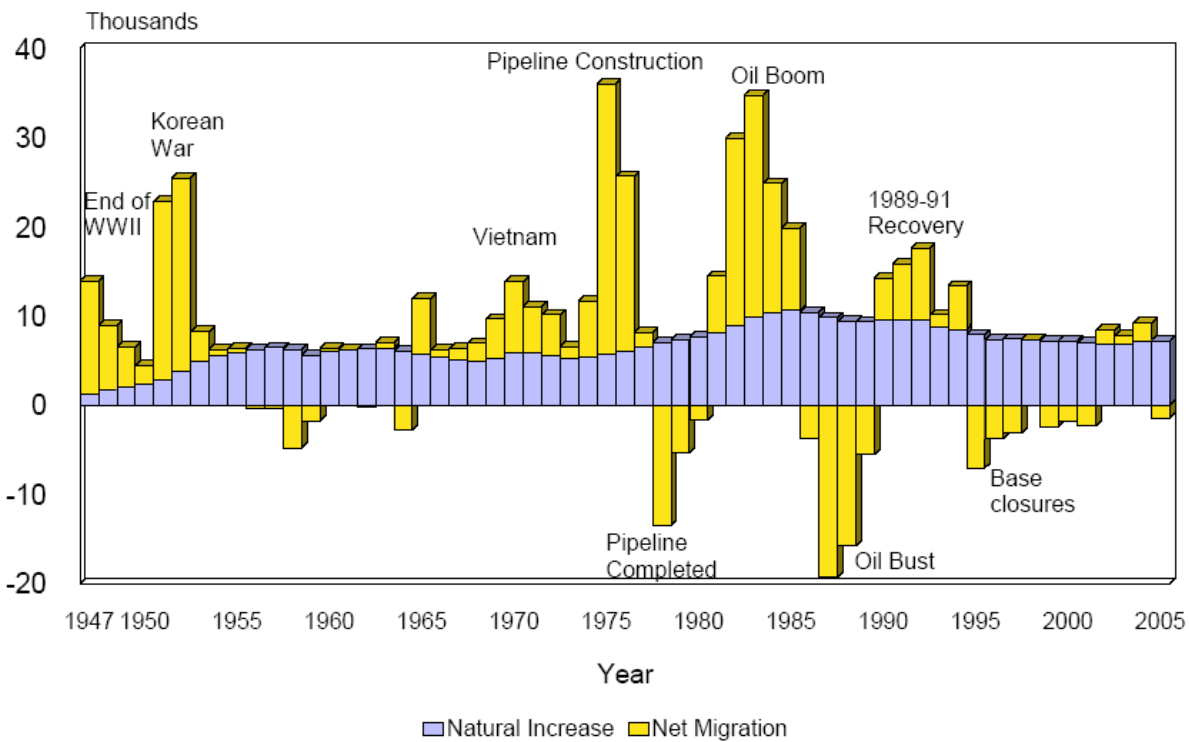
Source: [higheredinfo.org](http://higheredinfo.org)

A number of specific population trends in Alaska help to further explain the overall workforce data presented above. These include major historical events related to population changes, shifts in age and ethnic/racial composition of the population, and migration in or out of the state.

<sup>1</sup> Data is from <http://www.higheredinfo.org/>

The graph below presents data on population changes in Alaska over a 60-year period. As the graph indicates, significant political and/or economic events have led to fairly extreme shifts, up or down, in the state's population. These include wars, the oil pipeline construction and boom (and bust), and military base closures. During these times, there was either a significant immigration or outmigration of, in effect, a temporary population. However, the "natural" increases in population have been much more stable, with a slight but steady increase over the 60-year period.

### Components of Population Change for Alaska, 1947-2005



Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section, Demographics Unit.

The Census Bureau produced a report on population projections for Alaska for the period 1995 to 2025.<sup>2</sup> In general, Alaska is projected to be the 45th most populous state with 885 thousand people (up from 48<sup>th</sup>). It's rate of population change, at 46.6%, ranks as the 8th largest. However, Alaska's "dependency ratio," (i.e., the number of youth under age 20 and elderly ages 65 and over for every 100 people of working ages 20 to 64) could rise from 65.1 in 1995 to 80.6 in 2025.

<sup>2</sup> Source: Figures are from Series A (the Preferred Series) as reported in Campbell, Paul R., 1996, "Population Projections for States, by Age, Sex, Race and Hispanic Origin: 1995 to 2025," Report PPL-47, U.S. Bureau of the Census, Population Division. Most of these data are available in files found on the Population Projections section of the World Wide Web's Census Bureau Home Page (<http://www.census.gov>).



In terms of ethnic/racial composition, the report estimated that:

- By 2025, non-Hispanic Whites are projected to compose 57.1% of Alaska's population, down from 73% in 1995.
- From 1995 to 2025, the non-Hispanic Asian and Pacific Islander population is expected to grow by 641.1%, leading to a projected to increase from 4.3% to 21.5% of the state population.
- From 1995 to 2025, the Hispanic population is expected to increase by 162.7%, leading to an increase from 3.8% to 6.7% of the state population.
- The non-Hispanic Asian and Pacific Islander growth rate ranks 1<sup>st</sup> largest, while the Hispanic growth rate ranks 11th largest.

Another significant trend that relates to those noted is the relative immigration versus outmigration of people to and from Alaska. A report<sup>3</sup> from the Census Bureau describes state-to-state migration patterns for the years 1995 to 2000. During that period, Alaska had an outmigration of 126,000, mainly to other states in the West. Specifically, Arizona, California, Oregon, Texas, and Washington all received inflows of more than 5,000 people from Alaska. Despite a significant number of people coming to the state, Alaska had a net outmigration of 30,000, mostly concentrated in the western states of Arizona, Oregon, and Washington. As the table below indicates, the largest inflow of population came from California, while the largest outflow went to Washington.

**Table 2: Largest Migration Inflow and Outflow by State: 1995 to 2000**

<b>Alaska</b>	<b>Largest inflow was from:</b>	<b>Size of inflow</b>
	California	12,518
	<b>Largest outflow was to:</b>	<b>Size of outflow</b>
	Washington	16,635

Source: U.S. Census Bureau, Census 2000. <http://www.census.gov/prod/2003pubs/censr-8.pdf>

On the positive side, more recent data indicates that outmigration was down significantly from 2000 to 2004. Whereas Alaska had an annual average loss of 3,035 people from 1990 to 2000, the state's annual loss from 2000 to 2004 was only 730 people. If this trend maintains for the rest of the decade, then Alaska would have reduced its outmigration by over 400% in 10 years.

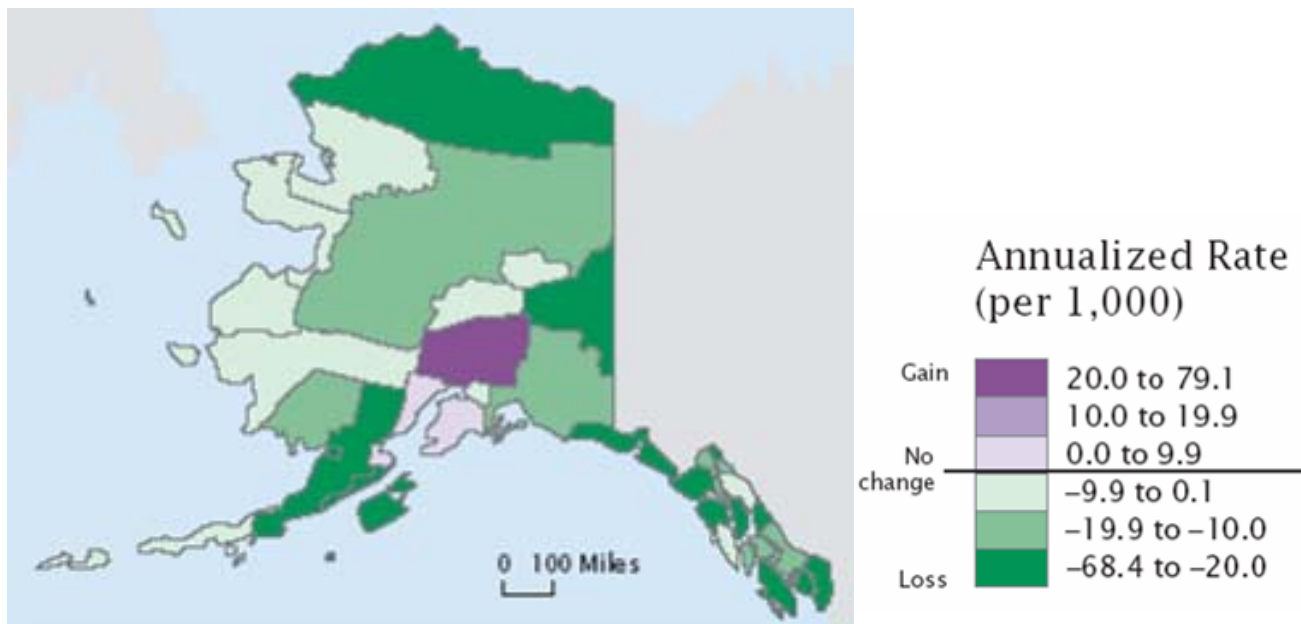
**Table 3: Total and Average Annual Domestic Net Migration for States: 1990–2000 and 2000–2004**

<b>State</b>	<b>Total number</b>		<b>Average annual number</b>	
	<b>1990–2000</b>	<b>2000–2004</b>	<b>1990–2000</b>	<b>2000–2004</b>
<b>Alaska</b>	–30,354	–2,918	–3,035	–730

Source: U.S. Census Bureau, Population Estimates Program, 2004. <http://www.census.gov/prod/2006pubs/p25-1135.pdf>

<sup>3</sup> Marc J. Perry. State-to-State Migration Flows: 1995 to 2000; *Census 2000 Special Reports*; Issued August 2003

The map below shows annual rates of migration for Alaska in different areas of the state.



<http://www.census.gov/prod/2006pubs/p25-1135.pdf>

## Section II: Occupational Data and Trends for the Health Services Sector

This section will describe data and trends regarding the health service sector as a whole, a profile of the healthcare workforce, number of workers and projected needs, vacancy rates, qualifications and hiring issues, as well as data on recruitment and retention.

### Healthcare Services Sector

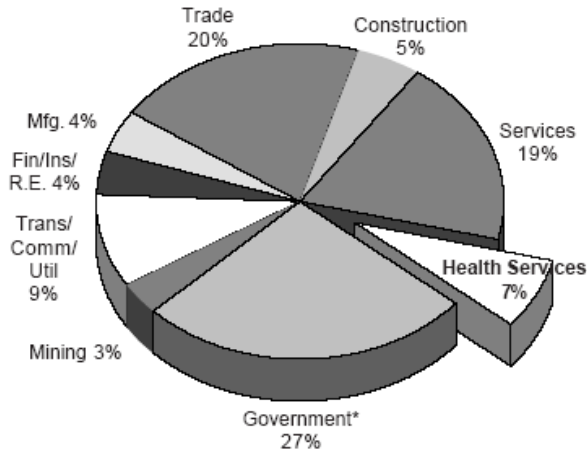
In terms of the health service sector overall, the Department of Labor in Alaska reported that the health services industry is the fastest growing, and one of the larger sectors of Alaska's economy. It's a billion-dollar industry, and it employs about 22,000 people.<sup>4</sup> As the pie charts on the next page indicate, health services compose 7% of the states employment, with 60.9% of jobs in healthcare offered through hospitals or doctor's offices. In terms of income, health services and hospitals are above the state average for annual average earnings.

According to a Health Resources and Services Administration (HRSA) workforce profile on Alaska,<sup>5</sup> health services employment in Alaska grew 74% between 1988 and 2000, while the state's population grew by 16% during that period. This is a net per capita growth of 50% in health services sector employment, more than double than the national rate of growth (21%).

<sup>4</sup> <http://www.labor.state.ak.us/research/trends/apr03ind.pdf>

<sup>5</sup> <http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/alaska.htm>

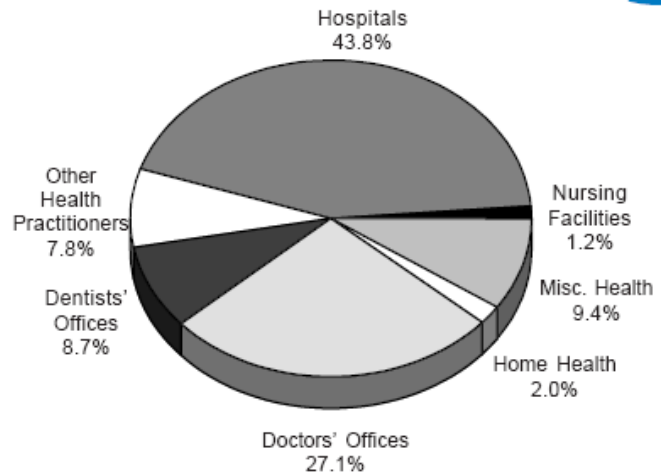
## 2 Health Services is a Big Player In Alaska's employment picture



\*Public health care employment was subtracted from government and added to health services

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

## Where the Jobs Are In Alaska's health services - 2002\*

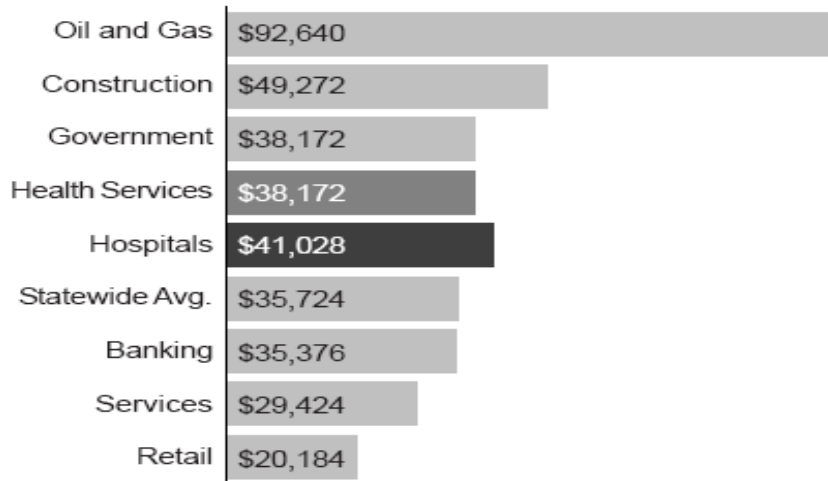


\*Average of first nine months

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

## 10 Health Services Industry Earnings - above average

Average annual earnings —2001



Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

Other data from the HRSA Profile breaks down certain trends for different professionals. Presented here are some data for healthcare workers<sup>6</sup>:

## Medicine

There were more than 1,000 active patient care physicians in Alaska in 2000, or 166 physicians per 100,000. This falls well below the national ratio of 198 physicians per 100,000 (40<sup>th</sup> in U.S.). Alaska had 71 active primary care physicians per 100,000 population in 2000, slightly higher than the rate of 69 per 100,000 for the entire country. The number of physicians in Alaska grew 49% between 1989 and 2000, while the population grew 15% over this period. This is a net per capita growth of 30%, compared to the national per capita increase of 17%. There were 95 physician assistants practicing in Alaska in 2000. This was equal to 15.1 physician assistants per 100,000 population, slightly higher than the national rate of 14.4. Alaska ranked 22nd in the nation in physician assistants per capita.

## Nursing

There were 782.9 RNs per 100,000 population in 2000, higher than the national rate of 780.2. However, Alaska ranked last among the states in the per capita employment of Licensed Practical/Vocational Nurses (LPNs), with 66.9 LPNs per 100,000 population as compared to the national rate of 240.8 per 100,000. Alaska also ranked last in the number of LPNs employed in the state in 2000 with 420 workers. There were 420 nurse practitioners in Alaska in 2000. This was equal to 66.9 per 100,000 population, giving Alaska one of the highest ratio of nurse practitioners per capita in the nation.

## Pharmacy

There were 320 pharmacists and 320 pharmacy technicians and aides practicing in Alaska in 2000. Alaska had 51 pharmacists and 51 pharmacy technicians and aides per 100,000 population in 2000, which ranked them 49th and 50th, respectively, among the 50 states.

## Aides

There were 630 home health aides and 1,370 nursing aides, orderlies, and attendants working in Alaska in 2000. Alaska had 100.4 home health aides and 218.3 nursing aides, orderlies, and attendants per 100,000 population in 2000 (44th and 50th, respectively, among the 50 states).

### Nurses working in Alaska in 1997 *Where were they in 2002?*

Given the difficulty in filling nursing positions, the need to retain incumbent workers has received increasing attention. DLWD analyzed 1997 and 2002 administrative data to help shed light on the career attachment of Alaska's nurses.

#### Of the RNs working in Alaska in 1997 — In 2002

- 47% Working as RNs in Alaska
- 8% Working in other health related occupations (such as medical and health services managers)
- 5% Working in non-health related occupations
- 40% Not working in Alaska wage and salary jobs

#### Of the LPNs working in Alaska in 1997 — In 2002

- 35% Working as LPNs in Alaska
- 14% Working in other health occupations (such as nursing aides & orderlies)
- 6% Working in non-health related occupations
- 43% Not working in Alaska wage and salary jobs

<sup>6</sup> <http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/alaska.htm>

## Healthcare Workforce Projections and Non-Resident Workers

Table 4 (below) presents data from the Alaska Department of Labor on 30 healthcare professions in terms of number of professionals in 2002, projected workforce changes by 2012, as well as the number and percent of nonresident workers in a given occupation. This table is arranged alphabetically. Tables 5 through 8 present the top 10 professions organized by 1) highest actual (“numeric”) number of workers by 2012, 2) percent of change in workforce, 3) number of nonresident workers, and 4) percent of occupation that is nonresident (for all 30 occupations, see the tables in Appendix C).

Overall, in the period between 2002 and 2012, Alaska is projected to have an increase of 5,454 professionals across the 30 occupations indicated. This equates to a 28% increase. The largest numeric change (1,666) in this period is for registered nurses, followed by personal and home care aides (621) and home health aides (473). Educational, vocational, and school counselors are expected to have a *decrease* in positions of 13, followed by general pediatricians (10), social scientists and related workers (15), and psychiatrists (17). The top three occupations with the highest percent of change are pharmacists (48.6%), personal and home care aides (41.7%), and home health aides (40.3%). The lowest percents of changes are for educational, vocational, and school counselors (-2.7%) and social scientists and related workers (6.3%).

The report indicated that there were 2,479 nonresident workers across the 30 occupations. The profession with the highest number of non-resident workers is registered nurses (685), while the lowest number is for marriage and family therapists (2), followed closely by social scientists and related workers (3), psychiatric aides (4), medical and public health social workers (7), and psychiatrists (8). The top three highest percents of nonresident workers is general pediatricians (34.1%), pharmacists (25.8%), and physician assistants (23.9%); the lowest three percents were for psychiatric aides (3.3%), marriage and family therapists (3.9%), and medical and public health social workers (4.0%).

Table 9 summarizes data from tables 5 to 8 and presents the occupations that occur most frequently in the top 10 in terms of highest numeric increase and percent by 2012, as well as the highest number and percent of nonresident workers. Four professions appeared in all four top 10 lists: pharmacists (avg. rank = 3.0), home health aides (avg. rank = 4.0), registered nurses (avg. rank = 4.8), and social and human service assistants (avg. rank = 7.0). Two occupations appeared in three out of the four top ten lists: personal and home care aides (avg. rank = 2.7) and physician assistants (avg. rank = 5.7).

**Table 4: Workforce Projections and Nonresident Workers**

<b>Health Care Occupations Working in All Industries</b>						
<b>Occupation</b>	<b>Employment Total (2002)</b>	<b>Projected Employment Total (2012)<sup>7</sup></b>	<b>Numeric Change</b>	<b>Growth Rate %<sup>10</sup></b>	<b>Nonresident Workers</b>	<b>Non-Resident Workers %<sup>13</sup></b>
Child, Family, and School Social Workers	764	894	130	17.0	51	8.1
Clinical, Counseling, and School Psychologists	315	384	69	21.9	11	13.1
Counselors, All Other	683	843	160	23.4	43	11.0
Educational, Vocational, and School Counselors	476	463	-13	-2.7	21	4.5
Healthcare Support Workers, All Other	470	614	144	30.6	142	6.8
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Licensed Practical and Licensed Vocational Nurses	521	609	88	16.9	72	13.7
Marriage and Family Therapists	73	91	18	24.7	2	3.9
Medical and Public Health Social Workers	253	340	87	34.4	7	4.0
Mental Health and Substance Abuse Social Workers	469	648	179	38.2	34	6.9
Mental Health Counselors	302	396	94	31.1	16	6.2
Nursing Aides, Orderlies, and Attendants	1,704	2,148	444	26.1	144	7.0
Occupational Therapists	155	186	31	20.0	15	10.1
Pediatricians, General	64	74	10	15.6	15	34.1
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
Personal Care and Service Workers, All Other	266	344	78	29.3	115	11.3
Pharmacists	364	541	177	48.6	262	25.8
Physician Assistants	185	251	66	35.7	79	23.9
Psychiatric Aides	379	411	32	8.4	4	3.3
Psychiatric Technicians	125	151	26	20.8	16	6.8
Psychiatrists	83	100	17	20.5	8	11.3
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Rehabilitation Counselors	346	460	114	32.9	29	7.0
Social and Community Service Managers	626	738	112	17.9	24	5.5
Social and Human Service Assistants	1,123	1,501	378	33.7	80	11.4
Social Scientists and Related Workers, All Other	238	253	15	6.3	3	9.4
Special Education Teachers, Middle School	232	251	19	8.2	12	7.3
Special Education Teachers, Preschool, Kindergarten, and Elementary School	604	664	60	9.9	66	9.3
Special Education Teachers, Secondary School	327	354	27	8.3	23	7.5
Substance Abuse and Behavioral Disorder Counselors	513	645	132	25.7	38	10.3
<b>Totals</b>	<b>19,325</b>	<b>24,779</b>	<b>5,454</b>	<b>28%</b>	<b>2,479</b>	

**Table 5: Workforce Projections and Nonresident Workers by Numeric Change**

Health Care Occupations Working in All Industries						
Occupation	Employment Total (2002)	Projected Employment Total (2012) <sup>7</sup>	Numeric Change	Growth Rate % <sup>10</sup>	Nonresident Workers	Non-Resident Workers % <sup>13</sup>
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Nursing Aides, Orderlies, and Attendants	1,704	2,148	444	26.1	144	7.0
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Substance Abuse and Behavioral Disorder Counselors	513	645	132	25.7	38	10.3

**Table 6: Workforce Projections and Nonresident Workers by Growth Rate %**

Health Care Occupations Working in All Industries						
Occupation	Employment Total (2002)	Projected Employment Total (2012) <sup>7</sup>	Numeric Change	Growth Rate % <sup>10</sup>	Nonresident Workers	Non-Resident Workers % <sup>13</sup>
Pharmacists	364	541	177	48.6	262	25.8
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Mental Health and Substance Abuse Social Workers	469	648	179	38.2	34	6.9
Physician Assistants	185	251	66	35.7	79	23.9
Medical and Public Health Social Workers	253	340	87	34.4	7	4.0
Social and Human Service Assistants	1,123	1,501	378	33.7	80	11.4
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Rehabilitation Counselors	346	460	114	32.9	29	7.0
Mental Health Counselors	302	396	94	31.1	16	6.2

**Table 7: Workforce Projections and Nonresident Workers Organized by Nonresident Workers**

<b>Health Care Occupations Working in All Industries</b>						
<b>Occupation</b>	<b>Employment Total (2002)</b>	<b>Projected Employment Total (2012)<sup>7</sup></b>	<b>Numeric Change</b>	<b>Growth Rate %<sup>10</sup></b>	<b>Nonresident Workers</b>	<b>Non-Resident Workers %<sup>13</sup></b>
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	<b>685</b>	14.8
Pharmacists	364	541	177	48.6	<b>262</b>	25.8
Home Health Aides	1,173	1,646	473	40.3	<b>246</b>	11.9
Personal and Home Care Aides	1,488	2,109	621	41.7	<b>216</b>	8.9
Nursing Aides, Orderlies, and Attendants	1,704	2,148	444	26.1	<b>144</b>	7.0
Healthcare Support Workers, All Other	470	614	144	30.6	<b>142</b>	6.8
Personal Care and Service Workers, All Other	266	344	78	29.3	<b>115</b>	11.3
Social and Human Service Assistants	1,123	1,501	378	33.7	<b>80</b>	11.4
Physician Assistants	185	251	66	35.7	<b>79</b>	23.9
Licensed Practical and Licensed Vocational Nurses	521	609	88	16.9	<b>72</b>	13.7

**Table 8: Workforce Projections and Nonresident Workers Organized by % Nonresident Workers**

<b>Health Care Occupations Working in All Industries</b>						
<b>Occupation</b>	<b>Employment Total (2002)</b>	<b>Projected Employment Total (2012)<sup>7</sup></b>	<b>Numeric Change</b>	<b>Growth Rate %<sup>10</sup></b>	<b>Nonresident Workers</b>	<b>Non-Resident Workers %<sup>13</sup></b>
Pediatricians, General	64	74	10	15.6	15	<b>34.1</b>
Pharmacists	364	541	177	48.6	262	<b>25.8</b>
Physician Assistants	185	251	66	35.7	79	<b>23.9</b>
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	<b>14.8</b>
Licensed Practical and Licensed Vocational Nurses	521	609	88	16.9	72	<b>13.7</b>
Clinical, Counseling, and School Psychologists	315	384	69	21.9	11	<b>13.1</b>
Home Health Aides	1,173	1,646	473	40.3	246	<b>11.9</b>
Social and Human Service Assistants	1,123	1,501	378	33.7	80	<b>11.4</b>
Personal Care and Service Workers, All Other	266	344	78	29.3	115	<b>11.3</b>
Psychiatrists	83	100	17	20.5	8	<b>11.3</b>



**Table 9**

<b>Occupation</b>	<b># of Times in Top 10</b>	<b>Ranks</b>	<b>Avg. Rank</b>
Pharmacists	4	7,1,2,2	<b>3.0</b>
Home Health Aides	4	3,3,3,7	<b>4.0</b>
Registered Nurses (Only some in BH)	4	1,8,1,9	<b>4.8</b>
Social and Human Service Assistants	4	5,7,8,8	<b>7.0</b>
Personal and Home Care Aides	3	2,2,4	<b>2.7</b>
Physician Assistants	3	5,9,3	<b>5.7</b>
Nursing Aides, Orderlies, and Attendants	2	4,5	<b>4.5</b>
Mental Health and Substance Abuse Social Workers	2	6,4	<b>5.0</b>
Physician Assistants	2	9,3	<b>6.0</b>
Healthcare Support Workers, All Other	2	9,6	<b>7.5</b>
Licensed Practical and Licensed Vocational Nurses	2	10,5	<b>7.5</b>
Personal Care and Service Workers, All Other	2	7,9	<b>8.0</b>
Pediatricians, General	1	1	<b>1.0</b>
Medical and Public Health Social Workers	1	6	<b>6.0</b>
Clinical, Counseling, and School Psychologists	1	6	<b>6.0</b>
Counselors, All Other	1	8	<b>8.0</b>
Rehabilitation Counselors	1	9	<b>9.0</b>
Substance Abuse and Behavioral Disorder Counselors	1	10	<b>10</b>
Mental Health Counselors	1	10	<b>10.0</b>
Psychiatrists	1	10	<b>10.0</b>

Despite the projected workforce increases between 2002 and 2012, there are presently vacancies in a number of behavioral health professions (see table 10 below).<sup>7</sup> A study including 32 facilities (hospitals and nursing homes) and 256 other Alaska health care organizations found that four of 21 occupations listed having a 20% or higher vacancy rate, with village counselors having the highest rate at 36%. Seven occupations have between 10-14% vacancy rates, while the remaining 10 have 0-9% vacancy rates. Respondents from six professions reported no vacancies: behavioral health clinicians, developmental specialists, family crisis workers, licensed marital and family therapists, and social work assistants. The occupations with the highest number of vacancies are social workers (24) and counselors (21).

## **Required and Desired Qualifications of Professionals**

The State of Alaska establishes qualifications for licensed occupations. However, for other, non-licensed occupations, minimum and desired educational qualifications are typically set by hiring organizations. Data from the Alaska Department of Labor and two studies regarding professional qualifications for a variety of healthcare workers provides insight into where the workforce in the state stands in this regard.

<sup>7</sup> The study did not look at physical healthcare professions.

**Table 10**

<b>BEHAVIORAL HEALTH VACANCY RATES - HEALTH PROFESSIONS 2005 SURVEY</b>			
<b>Behavioral Health</b>	<b>Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Village Counselor	28	10	36%
Psychologist	37	10	27%
Psychiatric Nurse Practitioner	15	4	27%
Psychiatrist	20	4	20%
Family Services Worker	7	1	14%
Mental Health Specialist	65	9	14%
Social Worker	169	24	14%
Chemical Dependency Counselor	8	1	13%
Counselor	179	21	12%
Behavioral Health Aide	65	7	11%
Human Services Worker/Personnel	104	10	10%
Psychiatric Nurse	32	3	9%
Psychiatric Technician	16	1	6%
Psychiatric Aide	101	6	6%
Residential Aide	40	2	5%
Behavioral Health Clinician	2	0	0%
Developmental Specialist	1	0	0%
Family Crisis	6	0	0%
Family Service Aide	4	0	0%
Licensed Marital and Family Therapist	1	0	0%
Social Work Assistant	1	0	0%
<b>TOTAL</b>	<b>901</b>	<b>113</b>	<b>13%</b>

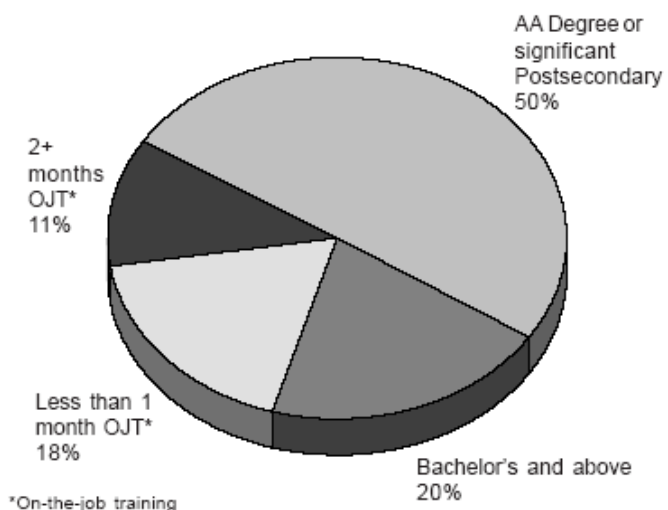
**Note: 2005 survey results from 32 facilities (hospitals and nursing homes), and 256 other Alaska health care organizations.**

The Department of Labor produced the following data on the level of education needed for a range of healthcare jobs by 2010. As the chart indicates, 79% of healthcare jobs will require an AA degree or less (with on the job training). The remaining jobs (20%) will require a Bachelor's degree or higher.

This data is somewhat consistent with the 2002 Social Services Job Survey, which presents data on the minimum versus desired educational qualifications for social service jobs.

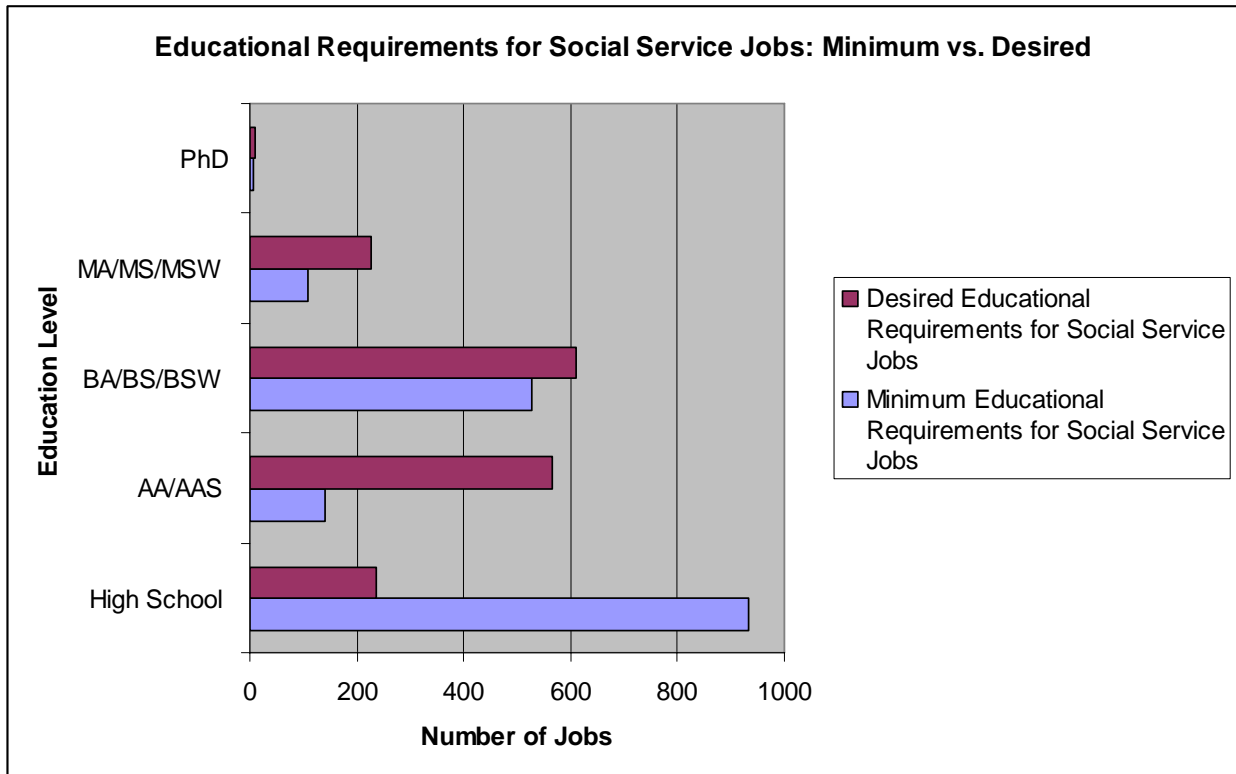
As the chart below indicates, about 63% of social service jobs have a

## 11 Future Alaska Health Care Jobs By education level required - 2010



Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

minimal educational requirement of an AA degree or lower, with the remainder having a Bachelor's degree or higher as the minimal requirement. However, about 93% of social service jobs require a Bachelor's or less. The chart also indicates that there is a disparity between the minimum qualifications and what is desired for the range of social service jobs. It is clear from the data that having an AA or Bachelor's degree is desired for a majority of these jobs.



As related to minimal and desired qualifications for either general healthcare or social service jobs, the AADSC Wage and Benefit Research Report (2002; C & S Management Associates) looked at the percent of agencies that use experience as a substitute for education and hire below minimum qualifications (see table 11 below). Across 37 healthcare provider agencies who participated in the study and reported on 25 different professional positions, an average of 59.1% hire below minimum qualifications and 68% allow experience as a substitute for training. This does not include data regarding clinical psychologists or occupational therapists, as their qualifications and related hiring are fixed.

The report indicates that the variation in qualification levels for some professions is to be expected. “For example, the clinical supervisor for a very large, urban mental health center would naturally be expected to have either a masters or doctoral degree. By contrast, a small, rural substance abuse program with only two or three employees might well have a substance abuse counselor certificate rather than a degree...What is not clear from the data is the extent to which hiring below minimum standards is being done in order to hire at a lower wage rate due to budgetary constraints or whether it is a reflection of the availability of the professionals.”

**Table 11: Percent of Agencies using Experience as a Substitute for Education and Hire Below Minimum Qualifications by Profession**

Profession	Experience as Substitute	Hiring Below Minimum Qualifications
Advocate	100.0%	100.0%
Client Evaluator	100.0%	100.0%
SA Prevention Professional	100.0%	100.0%
CD Counselor I	100.0%	87.5%
CD Clinical Supervisor	100.0%	66.7%
Case Manager/Coordinator	100.0%	60.0%
MH Clinical Associate	100.0%	50.0%
CD Counselor II	100.0%	50.0%
Eligibility Worker	100.0%	50.0%
Paraprofessional Counselor	100.0%	33.3%
Team Leader/Coordinator	80.0%	60.0%
Infant Learning Educator	80.0%	60.0%
Program Manager	70.0%	60.0%
Individual Support Worker	66.7%	41.7%
LPN	66.7%	66.7%
Administrator	61.1%	50.0%
RN	50.0%	50.0%
Recreation/Activity Therapist	50.0%	50.0%
Infant Learning Associate	50.0%	75.0%
Clinical Director/Supervisor	40.0%	20.0%
Vocational Specialist	33.3%	66.7%
Respite Worker	28.6%	42.9%
Licensed Clinician	12.5%	37.5%
Clinician/Therapist/Counselor	10.0%	50.0%
Clinical Psychologist	0.0%	0.0%
Occupational Therapist	0.0%	0.0%
Infant Learning Therapist	0.0%	50.0%

## Recruitment Data

The Status of Recruitment Resources and Strategies (SORRAS) is a study conducted by the ACRH and University of Alaska, Anchorage (UAA), with two versions. SORRAS I looked at strategies used by small hospitals, rural clinics, and rural mental health centers to recruit physical, behavioral, and oral health providers. It also documented the costs associated with recruiting these professionals. SORRAS II collected the same data points from the original study, but also included select urban facilities (e.g., all the large hospitals in Anchorage, Fairbanks, and Juneau). The data in tables 12 to 20, as well as charts in this section, come from the SORRAS studies and provide an overview of various aspects of recruitment in Alaska, such as costs, commonly used strategies, most and least effective strategies, as well as barriers to recruitment.

The total cost of recruitment strategies for SORRAS II for all facilities was \$24,119,465 compared to \$12,050,693 in SORRAS I, however the first study only included rural facilities. Other disparities include the amount of money spent on recruitment by rural facilities in Year 2 (\$14,881,485) compared to Year 2 urban facilities (\$9,237,980). In particular, the Regional Tribal Health Organization Rural Facilities spent \$9,514,116 compared to similar organizations

in urban areas (\$3,645,669). Additionally, Community Health Centers in rural areas spent almost 8 times more on recruitment strategies than Community Health Centers in urban areas.

In both Year 1 and Year 2, facilities spent the most money on “cost of locums” of all recruitment strategies. The next highest expense from both studies was spent on “staff time.” Urban facilities in Year 2 spent considerably more money on “recruiting firms” than rural facilities. Money spent on “cost of locums” was considerably higher in rural facilities in Year 2.

The mean average cost per hire from Year 1 and Year 2 are fairly consistent. However, Year 2 Rural facilities spent approximate \$11,000 more on average per hire. Average recruitment activity costs and average recruitment related staff time were considerably higher in Year 2 Urban facilities compared to Year 2 Rural facilities.

Across organization types, in Year 2, Regional Tribal Health Organizations spent the most (i.e., mean average cost) per hire, followed by Non-tribal Hospitals, and Community Health Centers. Unaffiliated Tribal Health Organizations spent the least amount on average per hire although their average number hired in proportion to the average number recruited was also considerably lower.

In Year 1, facilities spent the most hiring psychiatrists. In Year 2, facilities spent the most on hiring Clinical Psychologists. Year 2 Rural facilities consistently spent a higher amount on recruitment costs in all provider categories compared to Urban facilities.

This table indicates the cost per hire for Alaska compared to the Continental United States. In both categories (i.e., Rural Alaska Hospitals and All Other Rural Alaska Facilities including Clinics and Mental Health Centers), Alaska’s cost per hire was considerably higher when compared the Continental United States.

**Table 12**

<b>Total Recruitment Strategy Cost Breakdown by Organization Type</b>				
	<b>Year 2 All Facilities</b>	<b>Year 2 Urban Facilities</b>	<b>Year 2 Rural Facilities</b>	<b>Year 1 All Facilities (Rural)</b>
Non-tribal Hospital	\$8,274,817	\$4,899,550	\$3,375,267	\$2,111,385
Regional Tribal Health Corporation	\$13,160,439	\$3,645,669	\$9,514,770	\$8,238,608
Unaffiliated Tribal Health Organization	\$322,116	\$0	\$322,116	\$395,234
Community Health Center	\$1,021,435	\$133,000	\$888,435	\$439,918
Other Rural Health Providers	\$181,826	\$0	\$181,826	\$270,150
Behavioral Health Providers	\$1,158,832	\$559,761	\$599,071	\$595,398
<b>Total</b>	<b>\$24,119,465</b>	<b>\$9,237,980</b>	<b>\$14,881,485</b>	<b>\$12,050,693</b>

**Table 13**

Total Recruitment Cost Breakdown by Strategy Type	Year 2 All	Year 2 Urban	Year 2 Rural	Year 1 All
	Facilities	Facilities	Facilities	Facilities (Rural)
	Total	Total	Total	Total
Recruiting firms	\$1,434,248	\$1,060,000	\$374,248	\$588,164
Advertising	\$1,234,945	\$713,864	\$521,081	\$301,534
Website management	\$91,499	\$5,000	\$86,499	NA
Membership organization	\$22,900	\$7,600	\$15,300	NA
Recruitment related staff travel	\$242,616	\$91,000	\$151,616	\$55,681
Travel/accommodations for on-site interview	\$474,705	\$205,615	\$269,090	\$240,070
Moving expenses (inc. travel)	\$2,751,820	\$1,506,500	\$1,245,320	\$792,156
Cost of locums	\$12,914,085	\$3,926,880	\$8,987,205	\$4,944,266
Training and orientation	\$837,166	\$466,077	\$371,089	\$258,134
Other costs	\$118,000	\$8,000	\$110,000	\$1,265,818
Staff time	\$3,997,481	\$1,247,444	\$2,750,033	\$3,604,870
<b>Grand Total</b>	<b>\$24,119,465</b>	<b>\$9,237,980</b>	<b>\$14,881,481</b>	<b>\$12,050,693</b>

**Table 14**

Recruitment Cost Compared to Y1				
	Y2 All	Y2	Y2	Y1 All
	Facilities	Urban Facilities	Rural Facilities	Facilities (Rural)
Average recruitment activity costs	\$304,879	\$887,837	\$212,832	\$148,172
Average recruitment related staff time	\$62,461	\$138,604	\$50,001	\$48,714
Average number hired	10.30	57.22	4.35	4.45
<i>Total number hired</i>	<b>824</b>	<b>515</b>	<b>309</b>	<b>285</b>
Average number recruited	13.71	72.33	6.17	4.83
<i>Total number recruited</i>	<b>1083</b>	<b>651</b>	<b>432</b>	<b>338</b>
<b>Mean average cost per hire</b>	<b>\$34,413</b>	<b>\$25,004</b>	<b>\$36,074</b>	<b>\$38,018</b>
Mean average cost per recruit	\$27,927	\$20,514	\$29,162	\$31,353

**Table 15: Data from SORRAS II**

Average Recruitment Cost by Organization Type							
	All Facilities	Non-tribal Hospital	Regional Tribal Health Organization	Unaffiliated Tribal Health Organization	Community Health Center	Other Rural Health Providers	Behavioral Health Providers
Avg. recruitment activity costs	\$304,879	\$454,772	\$832,058	\$29,844	\$63,570	\$20,143	\$50,483
Avg. related staff time	\$62,461	\$96,882	\$107,973	\$13,894	\$38,574	\$10,161	\$38,658
Avg. number hired	10.30	28.40	19.13	1.15	3.36	1.00	2.94
<i>Total number hired</i>	<i>824</i>	<i>426</i>	<i>287</i>	<i>15</i>	<i>37</i>	<i>9</i>	<i>50</i>
Average number recruited	13.71	34.00	28.07	2.38	4.7	1.33	3.65
<i>Total number recruited</i>	<i>1083</i>	<i>510</i>	<i>421</i>	<i>31</i>	<i>47</i>	<i>12</i>	<i>62</i>
<b>Mean average cost per hire</b>	<b>\$34,413</b>	<b>\$39,132</b>	<b>\$52,919</b>	<b>\$11,860</b>	<b>\$34,326</b>	<b>\$17,768</b>	<b>\$25,505</b>
Mean average cost per recruit	\$27,927	\$35,596	\$31,284	\$26,238	\$27,608	\$16,714	\$22,971

**Table 16**

Average Recruitment Cost Per Hire by Provider Type	Year 2 All Facilities	Year 2 Urban Facilities	Year 2 Rural Facilities	Year 1 All Facilities (Rural)
	Avg.	Avg.	Avg.	Avg.
Physician	\$126,782	\$119,307	\$135,752	\$73,739
Pharmacist	\$71,322	\$39,852	\$105,939	\$63,886
Midlevel	\$25,655	\$6,115	\$37,724	\$32,201
Registered Nurse	\$17,688	\$10,527	\$36,096	\$42,575
Dentist	\$35,542	\$33,477	\$36,001	\$27,315
Dental Hygienist	\$3,225	\$947	\$7,130	\$40,572
Psychiatrist	\$106,117	\$65,301	\$177,546	\$237,678
Clinical Psychologist	\$374,987	\$0	\$357,379	\$34,563
LCSW	\$33,931	\$13,986	\$35,926	\$20,566
Masters Level Therapist	\$22,541	\$3,709	\$28,818	\$16,571
<b>Grand Total</b>				

**Table 17: Cost Per Hire in Alaska versus Continental U.S. (SORRAS II Data)**

Cost Per Hire: Alaska Versus Continental U.S.				
	Rural Alaska Hospitals	Continental U.S. <sup>1</sup>	All Other Rural Alaska Facilities (Clinics, Mental Health Centers)	Continental U.S. Clinics (Nursing and Specialty Services) <sup>1</sup>
Total cost*	\$3,709,869	224,835,814	\$2,184,411	\$127,310,190
Total hires	204	61,397	105	27,174
<b>Cost Per Hire</b>	<b>\$18,186</b>	<b>\$3,662</b>	<b>\$20,804</b>	<b>\$4,685</b>

\*These figures excludes the cost of locums and new recruit training

<sup>1</sup> Staffing.org study

## Recruitment Strategies

Data presented in tables 18 to 20, as well as charts below, present the top 10 most common recruitment strategies, most and least effective strategies, barriers to recruitment, and factors that would make recruitment better.

The top two most common strategies used to recruit providers in both the SORRAS I and II are word of mouth/networking and emphasizing the rural lifestyle. Other strategies falling in the top seven include introductions/spending time with staff, on-site visits, as well as emphasizing a good community and positive working environment.

**Table 18: Top 10 Most Common Strategies Used to Recruit Providers**

Strategy	SORRAS I		SORRAS II	
	% of Agencies Reporting Use	Rank	% of Agencies Reporting Use	Rank
	Word of mouth/networking	92%	1	89%
Emphasize rural lifestyle	91%	2	88%	2
Introductions/spend time with staff	83%	3	83%	4
Conduct on-site visit	79%	5	81%	5
Emphasize good community	79%	6	79%	7
Positive working environment	79%	7	86%	3
Emphasize community need	72%	9	71%	9
Newspaper ads	80%	4	NA	NA
Use websites	79%	8	NA	NA
Emphasize time off/vacation perks	72%	10	NA	NA
Arrange tour of community	NA	NA	79%	6
Mission of the organization	NA	NA	78%	8
Emphasize medical benefits	NA	NA	71%	10

The reports indicate that different recruitment methods were used for different types of providers. For instance, journal ads were most commonly used to recruit pharmacists (75%), clinical psychologists (62%), psychiatrists (58%), and physicians (50%). Newspaper advertising was used commonly across the board, but was used frequently in the recruitment of LCSWs (81%) and Masters Level Therapists (81%). Professional recruiting firms were used especially to recruit physicians (42%) and pharmacists (31%). Direct mail was used most often in the recruitment of physicians (25%).



The list of most effective recruitment strategies includes most if not all of the strategies indicated above. In both the SORRAS I and II, websites and word of mouth/networking were considered the top two most effective strategies. Current staff was often considered the best resource for recruiting other providers. About a third of the internet resources mentioned was a State of Alaska resource (e.g., “State of Alaska website,” “State of Alaska Job Website”). Others that fell mostly in the top six were newspaper ads, emphasizing the quality of life, financial/benefit incentives, and hiring from temporary to full time status. The report also indicated that smaller facilities, such as CHCs, private clinics, and independent THOs were more likely to cite newspaper advertising as their most effective recruitment strategy.

**Table 19: Most Effective Recruitment Strategies**

Strategy	SORRAS I		SORRAS II	
	% of Agencies Reporting Use	Rank	% of Agencies Reporting Use	Rank
	Websites	28%	1	18%
Word of mouth/networking	26%	2	18%	1
Newspaper ads	16%	3	10%	4
Emphasize quality of life	11%	4	9%	6
Financial/benefit incentives	9%	5	8%	8
Hiring temp to full-time	8%	6	9%	5
Professional association	7%	7	NA	NA
Onsite visit	7%	8	11%	3
Good work environment	7%	9	8%	7
Journals	5%	10	4%	12
ANTHC	5%	11	5%	11
Job fairs	3%	17	5%	10
Build personal relationship	NA	NA	5%	9

**Table 20: Least Effective Recruitment Strategies**

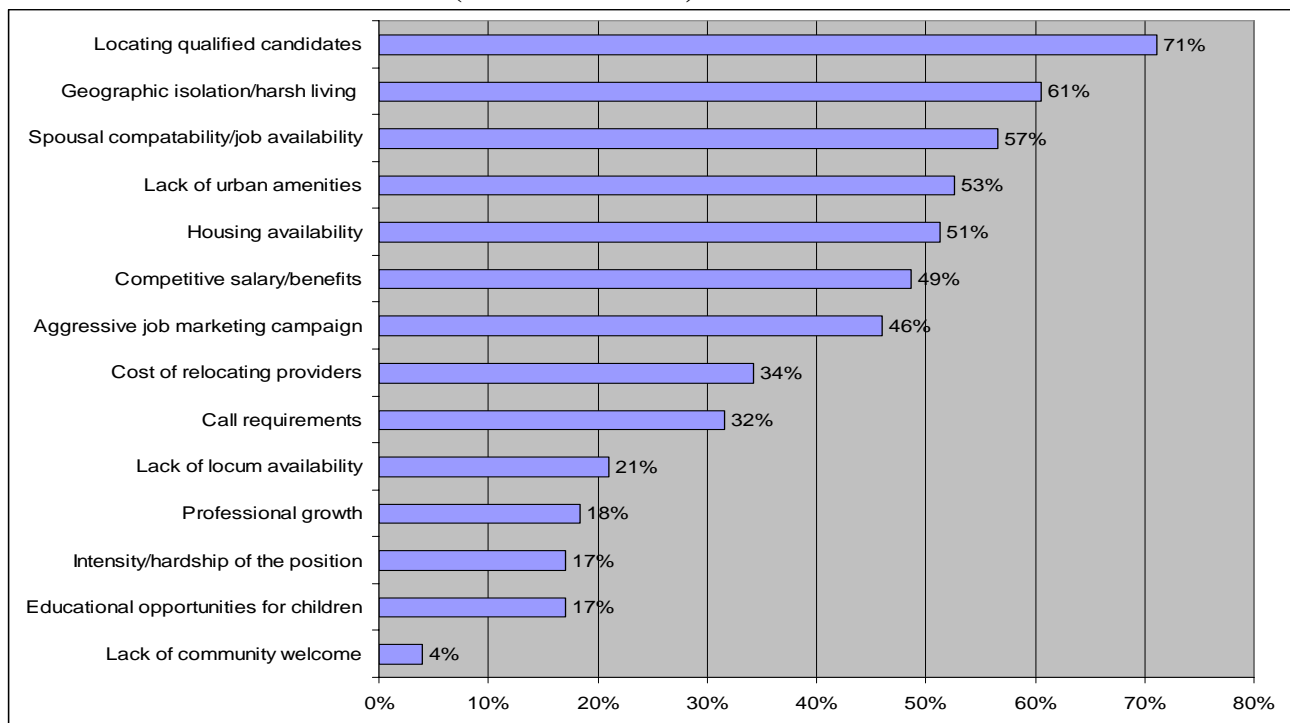
Strategy	SORRAS I		SORRAS II	
	% of Agencies Reporting Use	Rank	% of Agencies Reporting Use	Rank
	Newspaper ads	32%	1	18%
Websites	16%	2	14%	2
Journals	13%	3	9%	3
Professional Recruiting Firm	7%	4	4%	6
Recruiting “Outside”	4%	5	NA	NA
Financial/benefit incentives	3%	6	8%	4
Local recruitment	3%	7	6%	5
Emphasizing location	3%	8	NA	NA
Onsite visits	3%	9	1%	8
Recruiting is not a problem	3%	10	NA	NA
Direct mail	NA	NA	3%	7
Other	5%	11	9%	9

As table 20 above indicates, a number of the recruitment strategies considered most effective were also considered least effective, particularly newspaper ads, websites, financial/benefit incentives, and onsite visits. According to the report, those who found advertising in the

newspaper and use of websites ineffective emphasized the importance of clearly targeting your intended audience. In terms of strategies used by particular organizations, the report stated that regional tribal health organizations, non-tribal rural hospitals, and hospitals nearly all used newspapers in their recruitment, despite this strategy being commonly referred to as the least effective recruitment method for these facilities.

Understanding the relative effectiveness of recruitment strategies requires knowledge of barriers that agencies or organizations run into when recruiting providers. Data from the SORRAS I indicates at least 14 different barriers to recruitment. Five of these barriers were reported by over 50% of respondents. Starting with the barrier indicated by the highest percent of respondents, these five include: locating qualified candidates (71%), geographic isolation/harsh living (61%), spousal compatibility/job availability (57%), lack of urban amenities (53%), and housing availability (51%). It should be noted that all organizations participating in the SORRAS I were rural. The four biggest barriers to recruitment in the SORRAS II are identical to those reported in the SORRAS I study. The chart below lists the other barriers reported by respondents from SORRAS I.

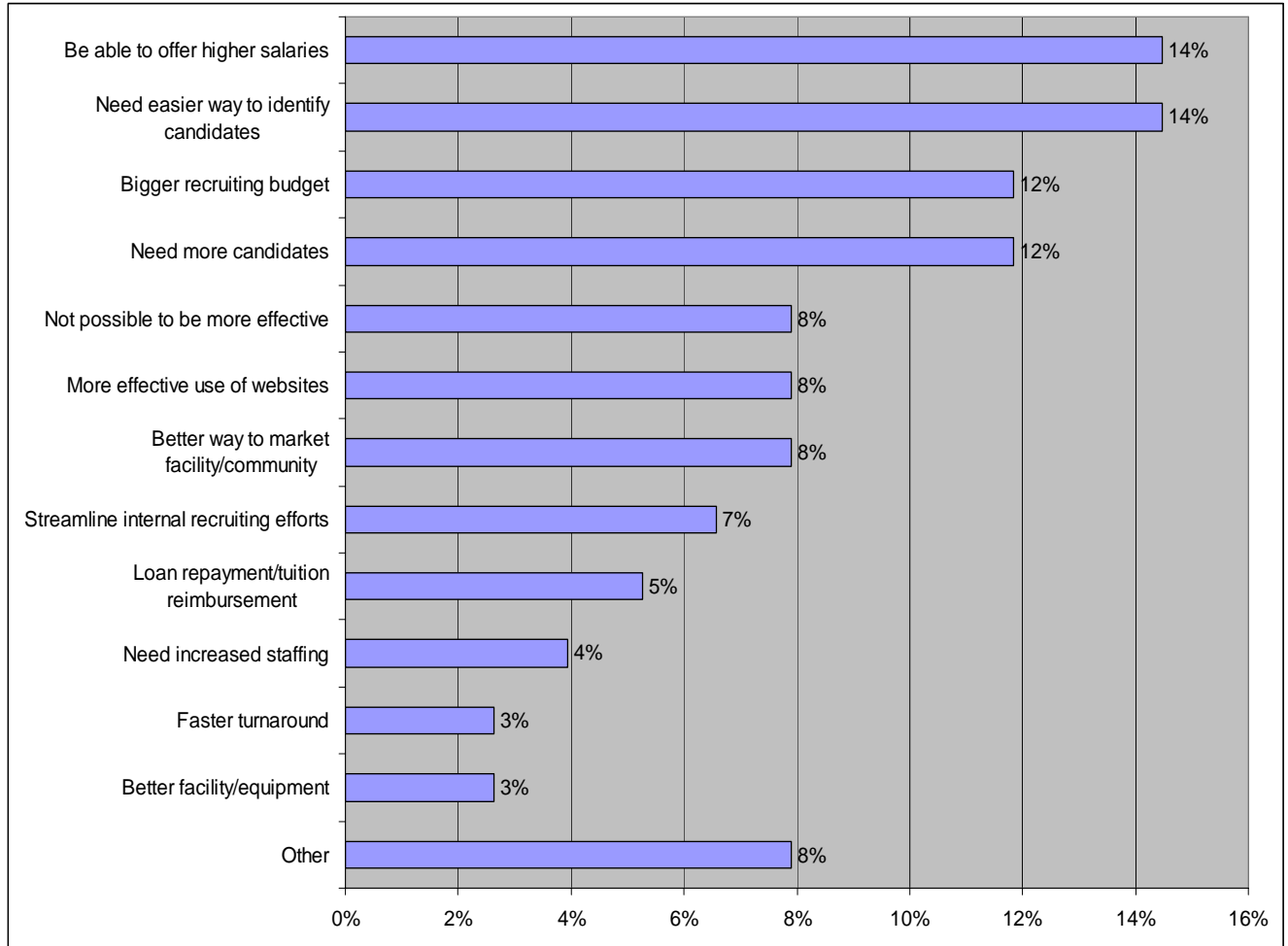
**Barriers to Recruitment Overall (SORRAS I Data)**



The SORRAS studies also collected data on factors that would make recruitment more effective. Data from the SORRAS I is presented in the chart below (again bear in mind that these are only rural sites). As can be seen, there were four primary factors identified: being able to offer higher salaries, easier ways to identify candidates, bigger recruiting budgets, and needing more candidates. The report indicated that many respondents reported that their recruitment efforts could be improved if there was a centralized pool of candidates available. However, they did not necessarily know if this is feasible or how it would work. The chart below presents other factors identified as improving recruitment efforts, including more effective use of websites, better

marketing of the facility or community, streamlining internal recruiting efforts, and loan repayment. Interestingly, 8% of respondents indicated that it was not possible to be more effective in their recruitment strategies.

**Factors That Would Make Recruitment Efforts More Effective (SORRAS I)**



*\*Categories above were created from verbatim responses to the open-ended question, “What would make your recruitment efforts more effective?”*

SORRAS II data is quite similar to SORRAS I and indicates that the following five factors would make recruitment efforts more effective: 1) higher salaries/benefit package; 2) bigger recruitment budget; 3) improvements to internal processes; 4) need for increased staffing; and 5) need more candidates/grow our own.

**Section III: Higher Education Data and Trends**

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Educators in the behavioral health programs across the UA system understand their important role in training tomorrow’s workforce. As part of creating a workforce development plan, an analysis of enrolled majors in and degree recipients of behavioral health programs was undertaken. However, tracking this data is somewhat complex, due to distance education

students, “pre-majors” who are taking required coursework in a given program but not necessarily officially entered, and trying to ensure unduplicated numbers. The data presented below represents the best estimates with the caveat that they may not be exact.

Data in Table 21 indicates the number of persons enrolled or receiving a degree in Behavioral Health (BH) disciplines at UAA, UAF, and the UA system as a whole for the period of Fall, 2001 to Fall, 2005.

Enrollment in BH programs for UA as a whole has increased 18.6% since 2001 and degrees awarded increased by 23.8%. By way of contrast, a previous WICHE report on this data for the period 1998 to 2003 indicated that enrollment had increased 8.2% while degrees awarded had actually decreased by 16.1% during that period. However, that report noted that enrollments have been rising since 2001 (although degree production during that time was more variable). Thus, it appears that the trend toward rising enrollment has continued and degree production, overall, has progressively increased from 2001 to 2005.

Of note is that trends in overall enrollments and degrees awarded in behavioral health programs leveled off in 2005. However, both saw spikes in the Fall 2003, with enrollments up 14.6% from the previous year (18.6% from 2001) and degrees up 8.9% from the previous year (21.9% from 2001). Undoubtedly, this positive trend relates to the University's President, Mark Hamilton, who has pushed to reverse the "brain drain" the state has experienced. In the fall of 2002, for the first time in the history of the state or territory, the majority of Alaska's college-bound students stayed home to pursue their educational goals. In the fall of 2003, 55% of Alaska's college bound students enrolled at UA campuses of UA, compared to 40% five years prior.

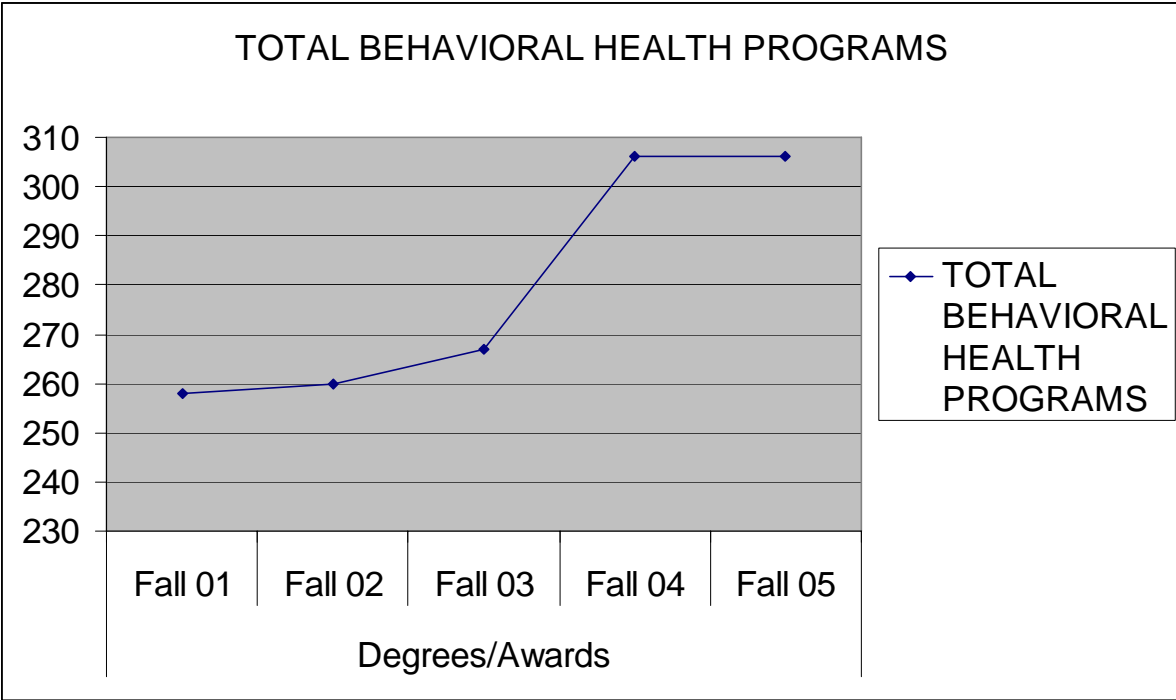
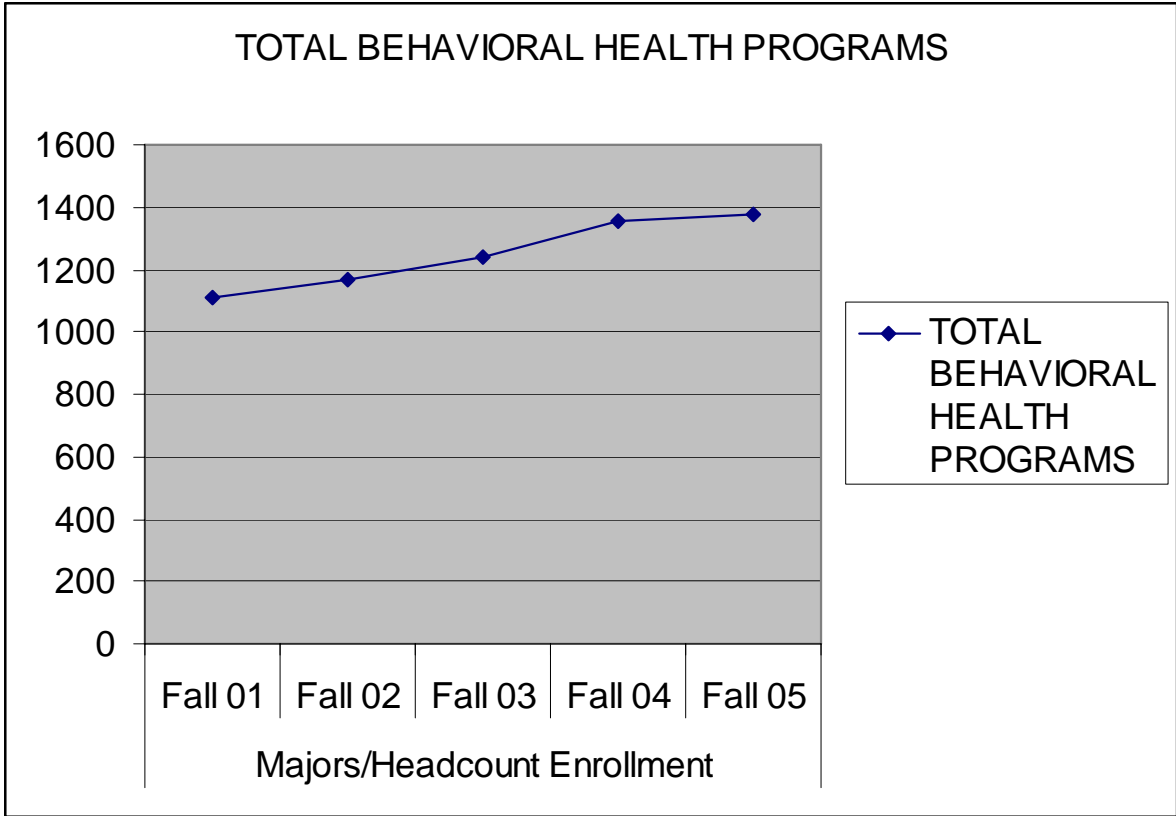
The data indicate that a significant number of those students entered the behavioral health field and many have already graduated. If trends hold, there should be another spike of graduates within the period of the Spring, 2006 and Spring, 2009 (depending on whether graduates are in 2-year or 4+ year programs). However, it will be important to continue increasing enrollments or the years shortly after the projected period could see significant declines in graduates.

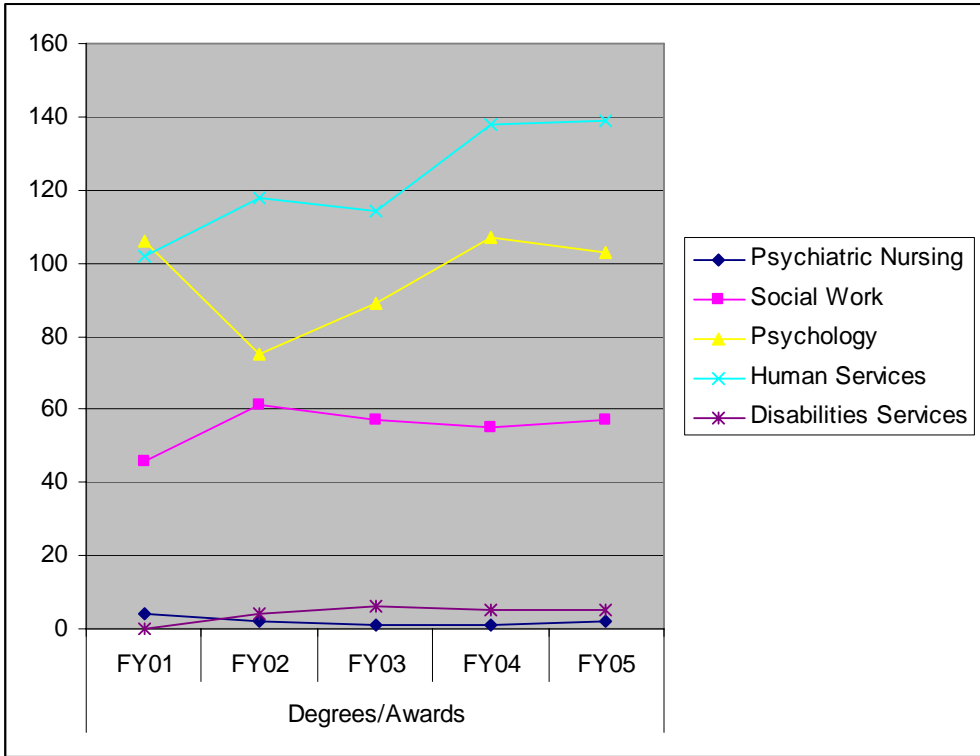
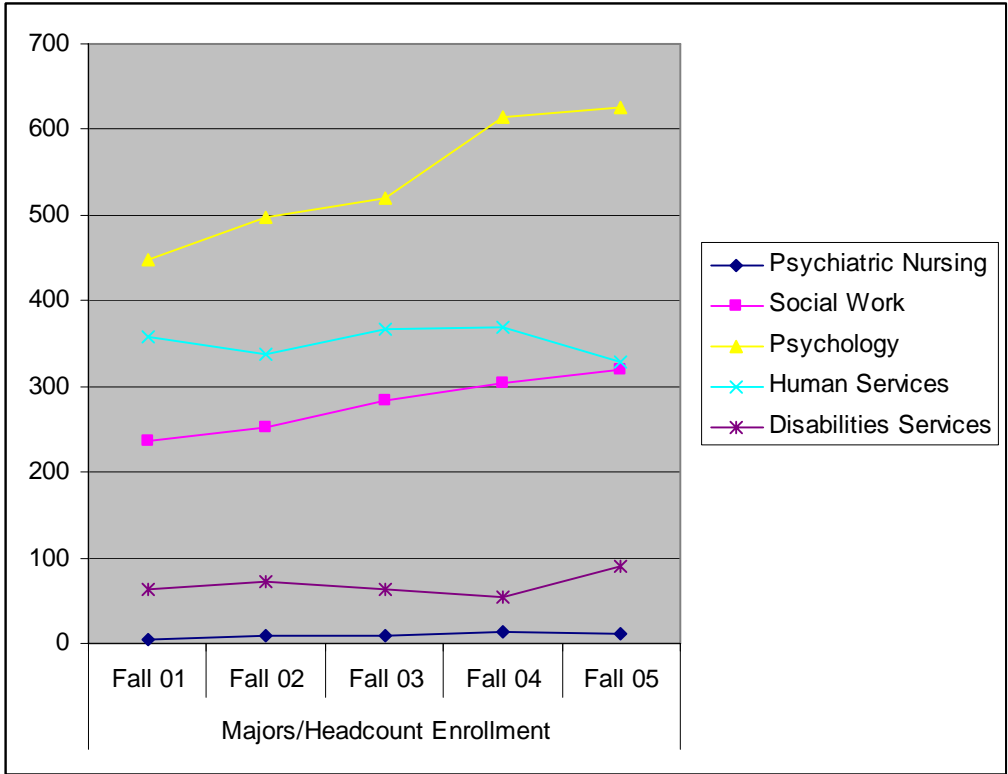
The graphs below show trends for the five behavioral health programs indicated in Table 21 (Psychiatric Nursing, Social Work, Psychology, Human Services, and Disability Services). In terms of enrollment, all programs but Human Services have net increases during the period from 2001 to 2005. Psychiatric Nursing and Disability Services have had the highest percents of increases in enrollment, but are the two smallest programs, which can lead to wild swings of percentage because of the low numbers involved. Psychology and Social Work have both had steady increases in enrollment, with the former up 39.7% and the latter up 35% since 2001. The Human Services program had a spike in enrollment in Fall, 2003 but then a drop of in Fall, 2005.

Three of the five programs had increased percentages of degrees awarded from 2001 to 2003. These were Human Services (36.3%), Disability Services (25%), and Social Work (23.9%). Psychology and Psychiatric Nursing had decreases, but the low number of students in the latter program makes suggests caution when interpreting this data. Graphs of each program are provided in Appendix B.

Table 21

University of Alaska Behavioral Health Programs Students - Majors and Degrees/Awards													
Program	UAA	UAF	UAS	Majors/Headcount Enrollment					Degrees/Awards				
				Fall 01	Fall 02	Fall 03	Fall 04	Fall 05	FY01	FY02	FY03	FY04	FY05
<b>Behavioral Health Programs</b>													
<b>Psychiatric Nursing</b>													
Psychiatric Nurse Practitioner (MS)	X			5	9	8	14	11	4	2	1	1	2
<b>Social Work</b>													
Pre-Major Social Work BA/BS	X	X		99	105	114	123	125	NA	NA	NA	NA	NA
Social Work (BSW)	X			23	30	25	20	24	23	20	24	22	18
Social Work (BA)		X		76	75	87	96	97	7	26	16	19	17
Social Work (MSW)	X			39	41	58	64	74	16	15	17	14	22
<b>TOTAL SOCIAL WORK</b>				<b>237</b>	<b>251</b>	<b>284</b>	<b>303</b>	<b>320</b>	<b>46</b>	<b>61</b>	<b>57</b>	<b>55</b>	<b>57</b>
<b>Psychology</b>													
Clinical Psychology (MS)	X			20	23	19	24	29	11	3	5	12	6
Community Psychology (MA)		X		24	23	22	21	12	2	0	8	9	3
Community Mental Health Services (Certificate) - In Development	X												
Pre-Major Psychology BA/BS	X	X		0	0	4	9	11	NA	NA	NA	NA	NA
Psychology (BA/BS)													
Psychology (BA)	X			320	366	369	430	455	73	67	62	76	79
Psychology (BS)		X		84	85	107	130	119	20	5	14	10	15
Total Psychology (BA/BS)				404	451	476	560	574	93	72	76	86	94
<b>TOTAL PSYCHOLOGY</b>				<b>448</b>	<b>497</b>	<b>521</b>	<b>614</b>	<b>626</b>	<b>106</b>	<b>75</b>	<b>89</b>	<b>107</b>	<b>103</b>
<b>Human Services</b>													
BHS	X			47	49	48	44	40	21	33	31	31	31
AAS	X			209	205	180	236	204	61	42	61	52	66
AAS		X		73	67	68	54	51	15	20	17	12	12
Rural Human Services (Certificate)		X		29	17	70	35	33	5	23	5	43	30
<b>TOTAL HUMAN SERVICES</b>				<b>358</b>	<b>338</b>	<b>366</b>	<b>369</b>	<b>328</b>	<b>102</b>	<b>118</b>	<b>114</b>	<b>138</b>	<b>139</b>
<b>Disabilities Services</b>													
Disabilities Services - Learn as you Earn (Certificate/AAS)	X			35	41	30	19	23	0	4	6	5	5
Project Success (Courses)	X			27	31	33	34	66					
<b>TOTAL DISABILITIES SERVICES</b>				<b>62</b>	<b>72</b>	<b>63</b>	<b>53</b>	<b>89</b>	<b>0</b>	<b>4</b>	<b>6</b>	<b>5</b>	<b>5</b>
<b>TOTAL BEHAVIORAL HEALTH PROGRAMS</b>				<b>1110</b>	<b>1167</b>	<b>1242</b>	<b>1353</b>	<b>1374</b>	<b>258</b>	<b>260</b>	<b>267</b>	<b>306</b>	<b>306</b>





## **Section IV: Strategic Planning Document**

The following strategic planning document was developed by stakeholder participants and the Alaska Trust Workforce Development Steering Committee over the course of several meetings and conference calls. The information provided in this section outlines the goals and strategies for each of focus areas: 1) Recruitment, 2) Retention, and 3) Education and Training. This document was submitted to the Alaska Mental Health Trust Board of Trustees on September 5, 2006.

### **Problem Statement**

Access to health services for Trust Beneficiaries, in Alaska, is seriously challenged by shortages across the professional and paraprofessional workforce. Alaska shares this problem with other rural and frontier States, but the challenges are magnified by the diversity of populations and their wide dispersion across the vast landmass of Alaska. Beneficiaries of The Alaska Mental Health Trust (referred to as “The Trust” for the remainder of this document) are directly and indirectly affected by these workforce shortages.

The Trust and its partners responded to the need and decided to develop a comprehensive workforce plan, serving all Trust beneficiary areas, to articulate an agreed upon set of action steps to facilitate the preparation and continuing education of a qualified health workforce. The Beneficiaries include Alaskans who experience mental illness; developmental disabilities; chronic alcoholism; or Alzheimer's disease and related dementia. While the individuals in these beneficiary areas often experience unique issues and require different approaches to treatment, workforce concerns span all areas.

The purpose of this project is to increase communication between systems and initiatives to foster a more coordinated strategy that maximizes resources and decreases duplication and expands current workforce efforts.

### **Influential Factors**

Influential factors are contextual issues that provide some information related to the project and either act as a guide to the goals or provide potential challenges to meeting the goals.

1. There is limited capacity and workforce with skills to meet the needs of Trust beneficiaries.
2. The Department of Health and Social Services has continued work toward integration of the mental health and substance abuse treatment systems. The Division of Behavioral Health received a federal grant for \$1.1 million annually for three years, beginning 2003, to improve integration of services for persons experiencing co-occurring disorders.
3. Although the legislature recently funded an increment to remove people from the DD waitlist and a process is underway to better manage the waitlist, having a workforce to fully support



individuals selected for services is a major issue, particularly in rural and remote areas of the state.

4. There are several ongoing workforce development initiatives including Bring/Keep the Kids Home and the Alaska Alliance for Direct Service Workers (AADSC). These initiatives have made progress toward various workforce development goals and could be partners in the Trust's current initiative to avoid duplication of efforts and resources. The University of Alaska also has implemented the Behavioral Health Aide program and the Behavioral health initiative between Trust, University, and the Division of Behavioral Health.
5. Some states will have more citizens entering than leaving the workforce, while others will have more leaving than entering. For instance, California is projected to have a net increase of 1,473,050 in workforce by 2025. Alaska, on the other hand, is projected to have a net decrease in their workforce of 10,384 by 2025.
6. The Census Bureau produced a report on population projections for Alaska for the period 1995 to 2025. In general, Alaska is projected to be the 45th most populous state with 885 thousand people (up from 48th). Its rate of population change, at 46.6%, ranks as the 8th largest. Alaska's "dependency ratio," (i.e., the number of youth under age 20 and elderly ages 65 and over for every 100 people of working ages 20 to 64) could rise from 65.1 in 1995 to 80.6 in 2025.
7. In terms of the health service sector overall, the Department of Labor in Alaska reported that the health services industry is the fastest growing, and one of the larger sectors of Alaska's economy.
8. Between 2002 and 2012, Alaska is projected to have an increase of 5,454 professionals across 30 occupations that serve Beneficiaries. This equates to a 28% increase.
9. The State of Alaska lacks a long-term fiscal plan to meet the workforce needs and demands for Trust beneficiaries.
10. State government fiscal policies and program actions in the last two fiscal years have focused on reduction and control of State spending, service reductions necessitated by spending reductions, and increased reliance on Medicaid financing and medical models of service delivery. These policies seem likely to continue for the foreseeable future.
11. The State fiscal situation and Executive fiscal policies have had significant impacts on Alaska's community mental health, substance abuse treatment systems. Significant reductions in resources have decreased the overall service capacity and services available to Trust beneficiaries.
12. Increase reliance on Medicaid financing and billings as the foundation of behavioral health care and other services for Trust beneficiaries limits and constrains services provided to Trust beneficiaries and places basic services at risk to changes in the Medicaid policies and program at the national and State levels.
13. A likely reduction in the Federal Medical Assistance Participation (FMAP) rate – the rate of federal to state match will potentially cause substantial reductions in service or require substantial additional GF appropriation to maintain existing Medicaid-funded services – resulting in a further reduction in service capacity, more narrowly focused services and eligibility.
14. State revenue-sharing to municipal governments has been reduced decreasing the capacity of communities to maintain or initiate services affecting Trust beneficiaries.

## **Goals & Strategies**

Overarching Workforce Development Vision: By 2015, Beneficiaries of the Alaska Mental Health Trust shall have access to a capable, culturally competent workforce to support their communities and families across the life span.

### **AREA 1: Recruitment of qualified employees.**

**PROBLEM STATEMENT:** There is a need for the recruitment of new employees into fields that support the beneficiary groups. Current recruitment efforts in all areas are costly and vacancies and turnover rates are still high. There is also a lack of awareness and education regarding the current workforce and training opportunities available.

**GOAL:** Alaska will have 1000 new qualified employees that work with Trust beneficiaries by 2010.

### **STRATEGIES:**

1. By January 2007, a Credentialing and Quality Standards Steering Committee will be formed. This committee will support the development and coordination of competencies, credentialing, and standardizations processes for certificate level programs to increase consistency and decrease duplication across programs.
2. By June 30, 2007, develop a comprehensive “grow your own” recruitment strategy for youth specific to: 1) Career options, 2) Rural/urban needs, 3) Cultural background and values.
3. By June 30, 2007, develop comprehensive marketing strategies in and out of Alaska for beneficiary area service careers.
  - a. Assess and build on existing promotional workforce campaigns or efforts.
  - b. Identify potential audiences.
  - c. Identify funding and personnel for the campaign and tailor the message/method to the audiences.
  - d. Highlight economic benefit to the community.
  - e. Disseminate information about training available.
  - f. Encourage rural service/employment.
  - g. Highlight career advancement opportunities.
  - h. Demonstrate the value of the work to improve worker status.
  - i. Include non-traditional diverse images in media campaign.
4. By January 2007, develop a partnership (e.g., quarterly meetings) with the Department of Labor & Workforce Development to enhance the collaborative process of recruiting a workforce to support Trust beneficiaries.

5. Recruit broader populations including Alaska Natives and other minority and non-traditional populations such as seniors and persons with disability.
  - a. Collaborate with community leaders, and appropriate state and federal agencies to develop a community-based system to identify, inform, and motivate the non-traditional population, especially Alaskan Native males, seniors, and people with disabilities to become providers.
  - b. Through volunteer (supervised) practicum placement in an agency, allow candidate to experience the beneficiary population and self-evaluate for what they feel is their “best fit.”
6. Develop and implement strategies to increase wages and benefits of the workforce serving Trust beneficiaries.
  - a. Develop and conduct a legislative advocacy campaign that ties wages increases to the credentialing of staff, thereby providing legislators with a tangible return on their investment.
  - b. Develop partnerships with businesses (i.e. banks, mortgage companies) and state agencies to offer discounts or special programs (e.g., student loan forgiveness) and make more effective use of existing benefits.

**AREA 2: Retention of qualified employees including incentives for the development of a qualified and compassionate workforce.**

**PROBLEM STATEMENT:** There exists a lack of incentives for the workforce serving Trust beneficiaries and a lack of resources to support the workforce once they are hired.

**GOAL:** To decrease staff turnover in the workforce serving Trust beneficiaries by 20%.

**STRATEGIES:**

1. Provide loan forgiveness, scholarships and other incentives for recruitment, training, and education.
  - a. Research current loan, scholarships and other incentive programs for workers.
  - b. Determine ways to disseminate information.
  - c. Determine if programs should be changed, expanded, etc. or if new programs are needed.
  - d. Advocate for identified system changes (federal, state, private sector, foundations, etc.) that will provide incentives for student recruitment and staff retention.
2. Provide technical assistance resources to help provider agencies develop work environments, supervisory support, wages, and benefits that recruit, support, and retain their staff.
  - a. Develop a process to assist agencies with organizational change (i.e., research, staff surveys, assessment and planning tools) that will increase retention of employees.
  - b. Provide technical assistance to help agencies implement their organizational change plan.
  - c. Work with agencies that provide program reviews (i.e., technical assistance/quality assurance teams) to enhance the strategies for recruitment and retention.
3. Support direct service personnel through improved supervision practices.

- a. Improve supervisor/coaching skills through the Frontline Supervisor Leadership Institute, in-house training, participation in national leadership projects and Train-the-Trainer training.
  - b. Provide technical assistance and support to help agencies implement management and supervisory practices that feature relationship building with direct service professionals.
  - c. Establish employee assistance programs.
4. Elevate the value and support direct service professionals feel about their jobs.
- a. Increase the membership of the Alaska Alliance for Direct Service careers.
  - b. Provide training and technical assistance for families and consumers to work better with direct service professionals.
  - c. Encourage professionalism (e.g. paying for them to go to conferences such as the annual Full Lives Conference).

**AREA 3: Education and training of current and future workforce.**

**PROBLEM STATEMENT:** There is a lack of education and training particularly in rural areas and/or small agencies for and by leaders, other professionals, direct service workers, paraprofessionals, family members and consumers in the workforce serving Trust beneficiaries.

**GOAL 1:** By July 2008, establish 3 regional training cooperatives (i.e., providers, universities, post-secondary, state agencies, family members, and consumers) that provide and coordinate training and career development when and where the need arises.

**STRATEGIES:**

1. Provide resources for infrastructure (e.g., project coordinator, 3 regional coordinators).
2. Identify mutually agreed upon training standards.
3. Develop MOA's and how each cooperative will function.
4. Develop collaborative agreements among the training cooperatives.
5. Facilitate career ladders through the articulation of training received through the regional cooperatives to university degree programs.
6. Provide leadership and supervisor training and coaching.
7. Provide or arrange technical assistance and consultation.
8. Provide and/or arrange the use of technology to provide training.
9. Develop an evaluation process to monitor the progress of the training cooperatives.

**GOAL 2:** Support and build upon existing education and training programs.

## **STRATEGIES:**

1. Maintain and expand funding for existing education and training programs.
2. Support appropriate, effective, and adequate professional development.

## **Desired Outcome Indicators**

1. Increase the workforce serving Trust beneficiaries by 20% by FY10.
2. Increase access to training and education for Trust beneficiaries including professionals, families, and consumers by establishing regional training cooperatives.
3. Increase standardization of certificate training programs for the workforce serving Trust beneficiaries.
4. Reduce turnover in agencies serving Trust beneficiaries by 20% by FY08.
5. Decrease vacancy rates for Village Counselors, Psychologists, Psychiatric Nurse Practitioners, and other positions serving Trust beneficiaries.
6. Increase number of people working in healthcare occupations that serve Trust beneficiaries (i.e., current workforce is 19,325 and need in 2010 will be 24,779) by 2010.
7. Increase amount of money spent on the most effective recruitment strategies (i.e., websites, word of mouth/networking, newspaper ads).
8. Increase wages and benefits for the workforce serving Trust beneficiaries by 25% by 2010.
9. Increase enrollment in programs at the University of Alaska (e.g., health services, disability services, behavioral health and gerontology) by 30% by 2010.
10. Increase number of people/workforce with gerontology specialty training by 30% by 2010.

## **Partners**

The Alaska Mental Health Trust Authority, Department of Health and Social Services (DHSS), Division of Behavioral Health (DHSS), Division of Senior and Disabilities Services (DHSS), University of Alaska, Alaska Native Tribal Health Consortium, Governor's Council on Disabilities & Special Education, Alaska Commission on Aging, Alaska Mental Health Board and Advisory Board on Alcoholism & Drug Abuse, Alaska Alliance For Direct Service Careers, Alaska Association on Developmental Disabilities, Department of Corrections, Alzheimer's Disease Resource Agency of Alaska, Alaska Brain Injury Network, Faith-based Community, Community providers, Adult Protective Services, Office of Public Advocacy, Long-term Care Ombudsman, Developmental Disabilities and Senior Care Coordinators, Department of Labor and Workforce Development, Social Security Administration, Rural CAP Homeward Bound, Municipal governments.

## **Sustainability Strategy**

The Trust cannot be the sole provider of sustainable funding, however, The Trust can provide seed money as a springboard for long-term programming. By May 2007, The Trust will convene public and private funders (e.g., Commission, DOL, ANTHC, DHHS, Rasmuson, Gates, RWJ, Federal – SAMSHA), to develop a coordinated sustainable leverage plan. It will be important to

maintain and expand funding for all existing certificate, degree, and training programs by placing general fund/mental funding in the mental health budget bill.

Part of developing a sustainability strategy is to ensure that there is reliable data and a continuous quality improvement process. Good data collection and procedures will increase the ability to evaluate the progress of this project and to revise goals and strategies if necessary. This data collection and management mechanism should be implemented concurrent with the project timeline.

## Section V: Workforce Initiative Budget

Workforce Development Focus Area	Dept/RDU	FY08 MHTAAR	FY08 Authority Grant	FY08 GF/MH	FY08 Other	FY08 Total	Dept RDU	FY09 MHTAAR	FY09 Authority Grant	FY09 GF/MH	FY09 Other	FY09 Total
<b>Goal #1 Alaska will have 1000 new qualified employees that work with Trust beneficiaries by 2010.</b>												
Development of a Credentialing and Quality Standards Steering Committee to support the development and coordination of competencies, credentialing, and standardizations processes for certificate level programs to increase consistency and decrease duplication across programs.												
Develop a comprehensive "grow your own" recruitment strategy for youth specific to: 1) Career options, 2) Rural/urban needs, 3) Cultural background and values.	DHSS/GCDSE	\$175,000				\$175,000	DHSS/GCDSE	\$175,000				\$175,000
Develop comprehensive marketing strategies in and out of Alaska for beneficiary area service careers.	DHSS/GCDSE	\$175,000				\$175,000	DHSS/GCDSE	\$175,000				\$175,000
Develop a partnership (e.g., quarterly meetings) with the Department of Labor & Workforce Development to enhance the collaborative process of recruiting a workforce to support Trust beneficiaries.												
Recruit broader populations including Alaska Natives and other minority and non-traditional populations such as seniors and persons with disability.												
<b>Goal #2: Retention of qualified employees including incentives for the development of a qualified and compassionate workforce.</b>												
Provide loan forgiveness, scholarships and other incentives for recruitment, training, and education.		\$200,000				\$200,000		\$200,000				\$200,000
Provide technical assistance resources to help provider agencies develop work environments, supervisory support, wages, and benefits that recruit, support, and retain their staff.	Tied to lines 6 & 7											
<b>Goal # 3: Education &amp; Training of current and future workforce.</b>												
Establish 3 regional training cooperatives (i.e., providers, universities, post-secondary, state agencies, family members, and consumers) that provide and coordinate training and career development when and where the need arises.	UAA/CHD	\$325,000		\$325,000		\$650,000	UAA-CHD	\$450,000				\$450,000
Geriatric Education and Training Project	DHSS/DSDS	\$125,000				\$125,000		\$0				\$0
Support and enhance existing effective education and training programs.	University of Alaska	\$300,000				\$300,000	University of Alaska	\$300,000				\$300,000
<b>Workforce Development Administration Costs</b>			\$50,000			\$50,000			\$50,000			\$50,000
		MHTAAR	Authority Grant	GF/MH	Other	Total Budget all Sources		MHTAAR	Authority Grant	GF/MH	Other	Total Budget all Sources
		\$1,300,000	\$50,000	\$325,000	\$0	\$1,675,000		\$1,300,000	\$50,000	\$0	\$0	\$1,350,000

## **Section VI: Trustee Meeting & Next Steps**

The Board of Trustees approved the proposed budget for the workforce initiative on September 5, 2006. The next step will be to reconvene the Steering Committee and determine who will be the lead person on each of the three main goal areas. The Steering Committee will be divided into three planning groups who will be responsible for creating the action plan and timeline for each strategy or strategies. It is anticipated that each planning committee will meet once a month for several months until a plan is created. The progress on this initiative will be monitored and evaluated in order to provide the Trustees with a detailed report on progress toward project goals.



## APPENDIX A

### **Alaska Mental Health Trust Workforce Steering Committee**

Frank Appel, Chair, Alaska Commission on Aging,  
Laura Brooks, Department of Corrections  
Rick Calcote, Division of Behavioral Health  
Kathy Craft, Executive Director, Advisory Board on Alcohol & Drug Abuse/Alaska Mental Health Board  
Delisa Culpepper, Chief Operating Officer, Alaska Mental Health Trust  
Dr. William Doolittle, Vice Chair, Alaska Mental Health Trust  
Cheryl Easley, Dean, College of Health & Social Welfare, University of Alaska Anchorage  
Paula Easley, Trustee, Alaska Mental Health Trust  
Linda Gohl, Executive Director, Alaska Commission on Aging  
Pat Hefley, Director, SEARHC  
Bill Herman, Program Officer, Alaska Mental Health Trust  
Jill Hodges, Executive Director, Alaska Brain Injury Network  
Steve Horn, Executive Director, Alaska Behavioral Health Association  
Jim Hughes, Team Leader, Division of Senior & Disabilities Services  
Catherine Koverola, Chair UAF Dept of Psychology  
Gwen Lee, President, Alaska Association on Developmental Disabilities  
Jerry Mohatt, Principal Investigator & Director, Center for Alaska Native Health Research, University of Alaska Fairbanks  
Dulce Nobre, Executive Director, Alzheimer's Disease Resource Agency of Alaska,  
Karen Perdue, Associate Vice President, University of Alaska  
Scot Prinz, Director, Behavioral Health & Rural Services, Alaska Native Health Tribal Consortium  
John Pugh, Chancellor, University of Alaska Southeast  
Millie Ryan, Executive Director, Governors Council on Disabilities and Special Education  
Cyndee Sugar, HCB Associate Coordinator, Division of Senior & Disabilities Services  
Beverly Tallman, Associate Director, Center for Human Development, UAA  
MaryAnn VandeCastle, Planner, Alaska Commission on Aging  
Karen Ward, Director, Center for Human Development, UAA  
Theresa Warfield, Department of Corrections  
Cristy Willer, Director, Division of Behavioral Health  
Steve Williams, Program Officer, Alaska Mental Health Trust

## **APPENDIX B**

Based on a December 17<sup>th</sup>, 2003 meeting regarding behavioral health workforce development in Alaska, educators in University of Alaska behavioral health programs recommend the following actions in the areas of collaboration, education, financing, and evaluation and research:

### **Collaboration**

1. Convene the first ever University of Alaska/Behavioral Health stakeholder discussion on workforce development. The workshop will be held in the spring of 2004, co-hosted by the State of Alaska Behavioral Health Division and the University of Alaska Associate Vice President for Health. It will include provider groups, policy boards, the Alaska Mental Health Trust, and urban and rural providers. The workshop will develop a behavioral health workforce vision and action plan.
2. Create collaborations to develop more rural-specific training and continuing education opportunities at all levels of competency.
3. Educate practitioners for changing roles; provide multidisciplinary training.
4. Explore how UA should respond to the integration of mental health and substance abuse disciplines.

### **Education**

1. Support innovative approaches using distance education to expand access to continuing education that enables rural persons to obtain professional training.
2. Improve access to higher education for underrepresented students.
3. Support the development of an articulated career pathway from paraprofessional through post-graduate training.

### **Financing**

1. Provide adequate funding to expand behavioral health professional training.
2. Offer financial incentives for graduates to return to or remain in Alaska to practice in rural and underserved areas.

### **Evaluation and Research**

1. Collect and analyze more data regarding articulation of coursework and training among UA behavioral health programs, as well as workforce needs.
2. Analyze factors that increase enrollments and declared majors, as well as factors that promote retention and degree completion.

**APPENDIX C**

<b>Health Care Occupations Working in All Industries By Numeric Change</b>						
<b>Occupation</b>	<b>Employment</b>	<b>Projected</b>	<b>Numeric</b>	<b>Growth</b>	<b>Nonresident</b>	<b>Non-Resident</b>
	<b>Total</b>	<b>Employment</b>				
	<b>(2002)</b>	<b>Total</b>				<b>%<sup>13</sup></b>
		<b>(2012)<sup>7</sup></b>				
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Nursing Aides, Orderlies, and Attendants	1,704	2,148	444	26.1	144	7.0
Social and Human Service Assistants	1,123	1,501	378	33.7	80	11.4
Mental Health and Substance Abuse Social Workers	469	648	179	38.2	34	6.9
Pharmacists	364	541	177	48.6	262	25.8
Counselors, All Other	683	843	160	23.4	43	11.0
Healthcare Support Workers, All Other	470	614	144	30.6	142	6.8
Substance Abuse and Behavioral Disorder Counselors	513	645	132	25.7	38	10.3
Child, Family, and School Social Workers	764	894	130	17.0	51	8.1
Rehabilitation Counselors	346	460	114	32.9	29	7.0
Social and Community Service Managers	626	738	112	17.9	24	5.5
Mental Health Counselors	302	396	94	31.1	16	6.2
Licensed Practical and Licensed Vocational Nurses	521	609	88	16.9	72	13.7
Medical and Public Health Social Workers	253	340	87	34.4	7	4.0
Personal Care and Service Workers, All Other	266	344	78	29.3	115	11.3
Clinical, Counseling, and School Psychologists	315	384	69	21.9	11	13.1
Physician Assistants	185	251	66	35.7	79	23.9
Special Education Teachers, Preschool, Kindergarten, and Elementary School	604	664	60	9.9	66	9.3
Psychiatric Aides	379	411	32	8.4	4	3.3
Occupational Therapists	155	186	31	20.0	15	10.1
Special Education Teachers, Secondary School	327	354	27	8.3	23	7.5
Psychiatric Technicians	125	151	26	20.8	16	6.8
Special Education Teachers, Middle School	232	251	19	8.2	12	7.3
Marriage and Family Therapists	73	91	18	24.7	2	3.9
Psychiatrists	83	100	17	20.5	8	11.3
Social Scientists and Related Workers, All Other	238	253	15	6.3	3	9.4
Pediatricians, General	64	74	10	15.6	15	34.1
Educational, Vocational, and School Counselors	476	463	-13	-2.7	21	4.5
<b>Totals</b>	<b>19,325</b>	<b>24,779</b>	<b>5,454</b>	<b>28%</b>	<b>2,479</b>	

**Health Care Occupations Working in All Industries By Growth Rate**

<b>Occupation</b>	<b>Employment Total (2002)</b>	<b>Projected Employment Total (2012)<sup>7</sup></b>	<b>Numeric Change</b>	<b>Growth Rate %<sup>10</sup></b>	<b>Nonresident Workers</b>	<b>Non-Resident Workers %<sup>13</sup></b>
Pharmacists	364	541	177	48.6	262	25.8
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Mental Health and Substance Abuse Social Workers	469	648	179	38.2	34	6.9
Physician Assistants	185	251	66	35.7	79	23.9
Medical and Public Health Social Workers	253	340	87	34.4	7	4.0
Social and Human Service Assistants	1,123	1,501	378	33.7	80	11.4
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Rehabilitation Counselors	346	460	114	32.9	29	7.0
Mental Health Counselors	302	396	94	31.1	16	6.2
Healthcare Support Workers, All Other	470	614	144	30.6	142	6.8
Personal Care and Service Workers, All Other	266	344	78	29.3	115	11.3
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Pediatricians, General	64	74	10	15.6	15	34.1
Special Education Teachers, Preschool, Kindergarten, and Elementary School	604	664	60	9.9	66	9.3
Psychiatric Aides	379	411	32	8.4	4	3.3
Special Education Teachers, Secondary School	327	354	27	8.3	23	7.5
Special Education Teachers, Middle School	232	251	19	8.2	12	7.3
Social Scientists and Related Workers, All Other	238	253	15	6.3	3	9.4
Educational, Vocational, and School Counselors	476	463	-13	-2.7	21	4.5
<b>Totals</b>	<b>19,325</b>	<b>24,779</b>	<b>5,454</b>	<b>28%</b>	<b>2,479</b>	

**Health Care Occupations Working in All Industries By Nonresident Workers**

Occupation	Employment Total (2002)	Projected		Growth Rate % <sup>10</sup>	Nonresident Workers	Non- Resident Workers % <sup>13</sup>
		Employment Total (2012) <sup>7</sup>	Numeric Change			
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
Pharmacists	364	541	177	48.6	262	25.8
Home Health Aides	1,173	1,646	473	40.3	246	11.9
Personal and Home Care Aides	1,488	2,109	621	41.7	216	8.9
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Mental Health and Substance Abuse Social Workers	469	648	179	38.2	34	6.9
Rehabilitation Counselors	346	460	114	32.9	29	7.0
Social and Community Service Managers	626	738	112	17.9	24	5.5
Special Education Teachers, Secondary School	327	354	27	8.3	23	7.5
Educational, Vocational, and School Counselors	476	463	-13	-2.7	21	4.5
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Psychiatric Technicians	125	151	26	20.8	16	6.8
Occupational Therapists	155	186	31	20.0	15	10.1
Pediatricians, General	64	74	10	15.6	15	34.1
Special Education Teachers, Middle School	232	251	19	8.2	12	7.3
Clinical, Counseling, and School Psychologists	315	384	69	21.9	11	13.1
Psychiatrists	83	100	17	20.5	8	11.3
Medical and Public Health Social Workers	253	340	87	34.4	7	4.0
Marriage and Family Therapists	73	91	18	24.7	2	3.9
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Social Scientists and Related Workers, All Other	238	253	15	6.3	3	9.4
<b>Totals</b>	<b>19,325</b>	<b>24,779</b>	<b>5,454</b>	<b>28%</b>	<b>2,479</b>	

### Health Care Occupations Working in All Industries By % Nonresident Workers

Occupation	Employment	Projected	Numeric	Growth	Nonresident	Non-
	Total	Employment		Rate		Resident
	(2002)	Total	Change	% <sup>10</sup>	Workers	Workers
		(2012) <sup>7</sup>				% <sup>13</sup>
Pediatricians, General	64	74	10	15.6	15	34.1
Pharmacists	364	541	177	48.6	262	25.8
Physician Assistants	185	251	66	35.7	79	23.9
Registered Nurses (Only some in BH)	5,004	6,670	1,666	33.3	685	14.8
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Personal Care and Service Workers, All Other	266	344	78	29.3	115	11.3
Psychiatrists	83	100	17	20.5	8	11.3
Counselors, All Other	683	843	160	23.4	43	11.0
Substance Abuse and Behavioral Disorder Counselors	513	645	132	25.7	38	10.3
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Marriage and Family Therapists	73	91	18	24.7	2	3.9
Psychiatric Aides	379	411	32	8.4	4	3.3
<b>Totals</b>	<b>19,325</b>	<b>24,779</b>	<b>5,454</b>	<b>28%</b>	<b>2,479</b>	

## APPENDIX D

