UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
RESEARCH CENTER

What PRISM Data Tell Us About Behavioral Health Clinicians in Integrated Health Settings: Practice Trends, Clinician Satisfaction, and Retention

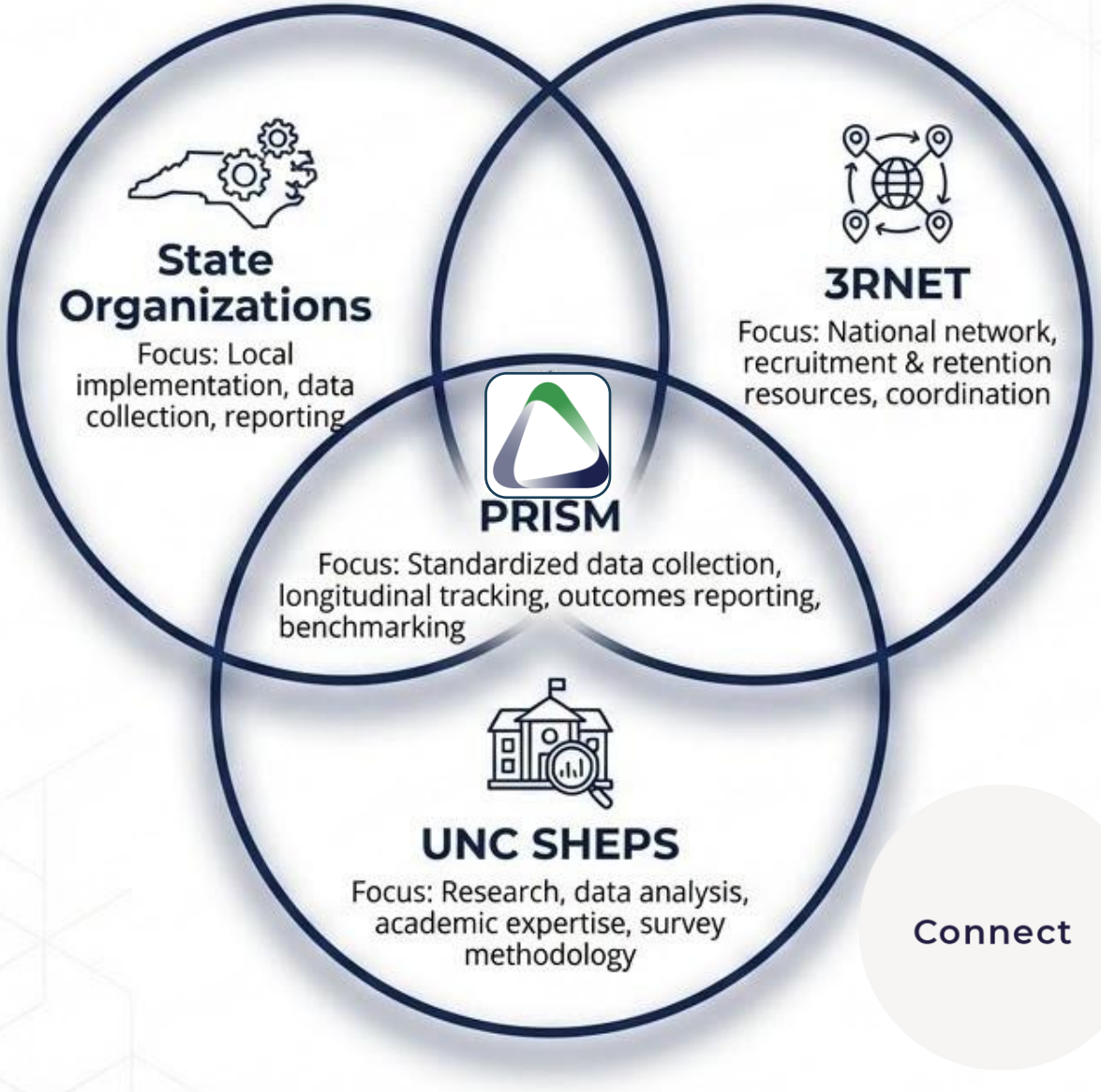
The University
of North Carolina
at Chapel Hill

Brianna Lombardi, PhD, MSW
Director, Behavioral Health Workforce Research Center
Associate Professor, Department of Family Medicine
University of North Carolina at Chapel Hill

Natalie Uy
Prism Analyst
3RNET

Don Pathman, MD MPH
Professor, Department of Family Medicine
Director, Program on Primary Care Research
Cecil G. Sheps Health Services Research Center
University of North Carolina at Chapel Hill

PRISM: A Partnership for Healthcare Workforce Data



Connect

Learn

Strengthen

Program Reach & Impact

~65%

Response Rate

100,655

Completed Questionnaires

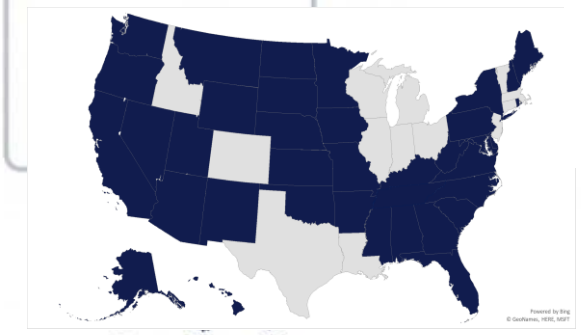
~90% of these are from NHSC programs

33

State Loan Repayment Programs

34

State-funded Programs



37

Participating States

Timing and Content of Questionnaires

Program Structure

Program on Health Workforce Research and Policy

Funding & Acknowledgements

This project is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U81HP46529 Cooperative Agreement for a Regional Center for Health Workforce Studies.

This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by SAMHSA, HRSA, HHS or the U.S. Government.

Find us at Bhworkforce.unc.edu

Increasing Recognition of the Behavioral Health Need

NATIONAL

CNN / KAISER FAMILY FOUNDATION | Oct 2022

90% of US adults say mental health is a crisis in the United States

Half of young adults and 1 in 3 all adults report feeling anxious always or often in the past year

NBC NEWS | May 2023

Social media is driving teen mental health crisis, surgeon general warns

Murthy calls youth mental health "the defining public health issue of our time"

NBC MEET THE PRESS SPECIAL | May 25, 2025

Lost & Lonely: America's Mental Health Crisis

Surgeon General Vivek Murthy, Rep. Patrick J. Kennedy join special edition on the national mental health emergency

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH | Aug 2025

Mental Health Crisis Hits Nearly 1 in 10 U.S. Adults

Young adults ages 18-29 report the highest crisis prevalence at 15.1%

WORLD HEALTH ORGANIZATION | Sep 2025

Over a billion people living with mental health conditions: services require urgent scale-up

ACROSS THE STATES

NEVADA · LAS VEGAS SUN | Jan 2026

Mental health funding mess leaves Nevada providers on edge

A federal grant freeze that was reversed within a day still rattled recovery and treatment programs statewide

ARIZONA · THE ARIZONA REPUBLIC | Oct 2025

Arizona ranks near the bottom in the 2025 mental health report

The state posted some of the weakest scores in the nation for adult access to mental health treatment

GEORGIA · KFF HEALTH NEWS | Jan 2026

When suicidal calls come in, who answers? Georgia crisis line response rates reveal gaps

A high share of 988 callers hang up or get rerouted out of state before reaching a local counselor

TEXAS · DALLAS EXPRESS | Mar 2026

Texas leads the nation with 393 mental health professional shortage areas

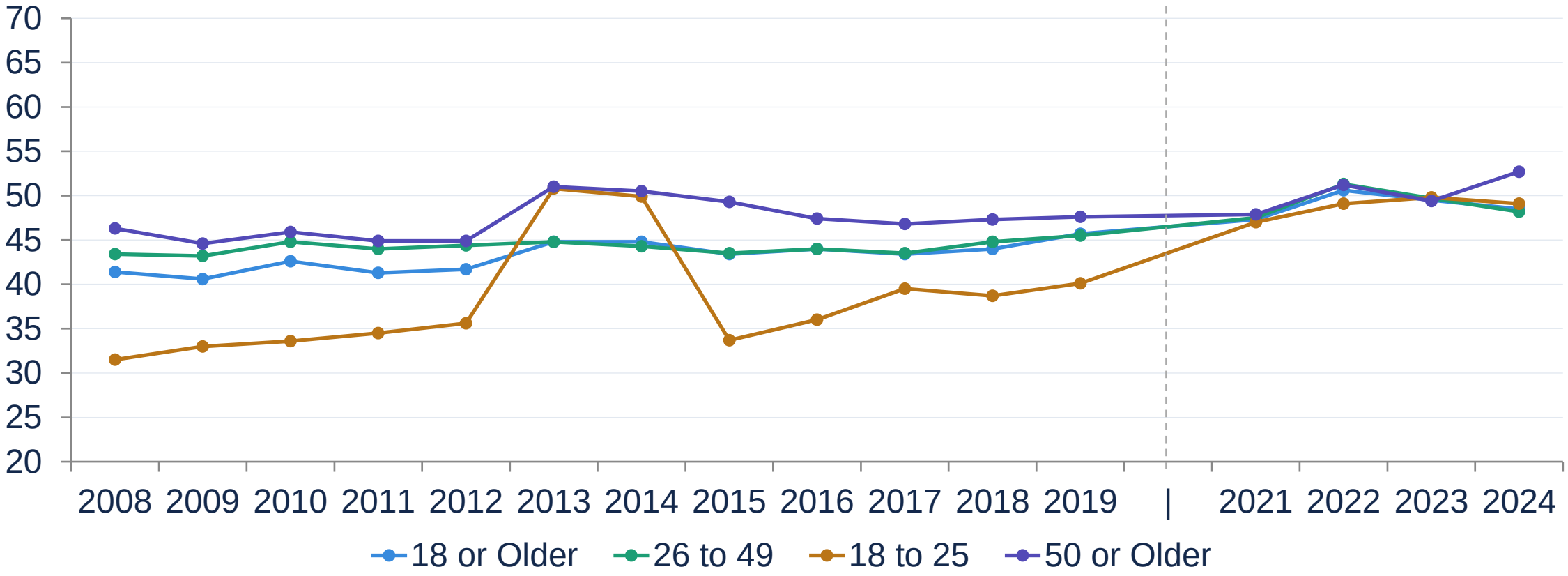
More than 13.4 million residents live in areas meeting only about 32% of the state's mental health workforce need

NORTH CAROLINA · CBS 17 (WNCN) | Apr 2026

N.C.'s mental health crisis: too many people, not enough providers

One in five North Carolinians will experience a mental illness in their lifetime, but providers remain in short supply

Percent of Adults with Any Mental Illness Receiving Mental Health Services



Source: SAMHSA, National Survey on Drug Use and Health (NSDUH), 2008–2019 (Behavioral Health Barometers, Vols. 5–6); NSDUH 2021–2024 national estimates. Adults aged 18 or older with any mental illness (AMI) in the past year. Pre- and post-2020 estimates are not directly comparable due to 2020–2021 survey redesign (multimode data collection and updated treatment questions).

UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
RESEARCH CENTER

Behavioral Health Workforce Shortages

New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society

April 25, 2023

Mental health care is hard to find, especially for people with Medicare or Medicaid

APRIL 3, 2024 · 12:02 AM ET

AAMCNEWS

A growing psychiatrist shortage and an enormous demand for mental health services

November 21, 2022

Association of Youth Suicides and County-Level Mental Health Professional Shortage Areas in the US

Jennifer A. Hoffmann, MD, MS[1]; Megan M. Attridge, MD[1]; Michael S. Carroll, PhD[2]; et al

Clinician Shortage Exacerbates Pandemic-Fueled "Mental Health Crisis"

Bridget M. Kuehn, MSJ

Workforce crisis has left mental health staff at "breaking point" as demand rises

Maryland needs another 30,000 behavioral health workers to meet growing demand

Recent report shows that Maryland's 'significant' shortage will worsen unless the state can boost the workforce

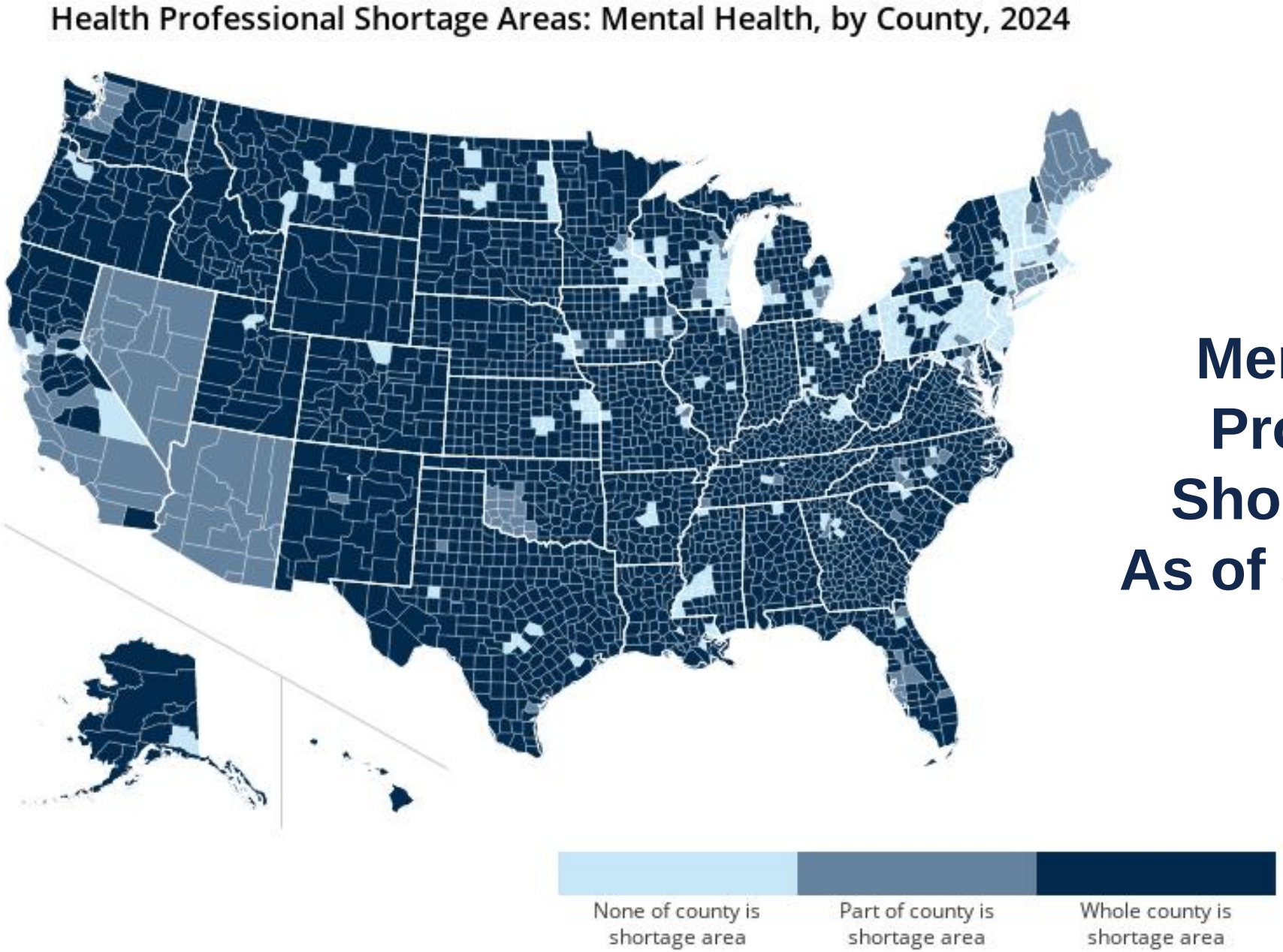
Texas' shortage of mental health care professionals is getting worse

> The COVID-19 pandemic exacerbated an already short supply of therapists, psychologists, psychiatrists and social workers.

Distance, workforce shortages complicate mental health access in rural Nevada communities

> As of 2023, nearly 86.9 percent of the state's population lives in a federally designated mental health professional shortage area.

UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
RESEARCH CENTER



Mental Health Professional Shortage Areas As of January 2024

Source: data.HRSA.gov, January 2024.

RHI hub
Rural Health Information Hub

UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
RESEARCH CENTER

Maldistribution of Behavioral Health Workforce in Rural Areas

	RURAL COUNTIES	URBAN COUNTIES	
Psychiatrists per 100,000 *Andrilla et al., WWAMI RHRC, 2022 (1995-2019 data)*	3.5	13.0	*Rural = ¼ of urban supply*
Counties with NO psychiatrist *Andrilla et al., WWAMI RHRC, 2022 (2019 data)*	70.2%	27.1%	*No improvement since 1995 (was 71.6% rural)*
Counties with NO psychologist *Andrilla et al., WWAMI RHRC, 2022 (2021 data)*	45.3%	15.7%	*Rural counties 3× more likely to lack a psychologist*
Psychologists per 100,000 *Andrilla et al., WWAMI RHRC, 2022 (2021 data)*	15.8	39.5	*Rural = 40% of urban supply*

All rural/urban comparisons: Andrilla CHA, Woolcock SC, Garberson LA, Patterson DG. "Changes in the Supply and Rural-Urban Distribution of [Psychiatrists/Psychologists/Social Workers/Counselors/Psychiatric NPs] in the U.S." Data Brief series. WWAMI Rural Health Research Center, University of Washington. October 2022.

UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
RESEARCH CENTER

Why Integrate Behavioral Health Clinicians into Primary Care

1 Access to Care

- Eight in ten people with a behavioral health condition already see a primary care provider every year, even if they never see a mental health specialist
- Most never make it to a separate provider: two-thirds of primary care doctors say they can't get their patients in for outside behavioral health care
- Having a behavioral health clinician in the same office closes that gap and makes getting help feel like a normal part of a regular visit, not a separate, harder step

2 Mind and Body Are Connected

- Common physical illnesses like diabetes and heart disease very often come along with depression or anxiety, and each one tends to make the other harder to manage
- When primary care teams treat mood and physical health together, patients see bigger improvements, and those improvements last for months to years, not just weeks
- The benefit is largest for people already managing an ongoing illness, such as diabetes, alongside depression, showing that whole-person care pays off most where it's needed most

Sources: Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012;10:CD006525. • Kathol RG, deGruy F, Rollman BL. Integrating mental health and substance abuse care into primary care. Ann Intern Med. 2015;163(3):232-233. • Panagioti M, Bower P, Kontopantelis E, et al. Association between chronic physical conditions and effectiveness of collaborative care for depression: an individual participant data meta-analysis. JAMA Psychiatry. 2016;73(9):978-989. • Primary Care Collaborative. Benefits of Integration of Behavioral Health.

How do you define integrated health care?

Integration is a continuum, not a yes or no. SAMHSA-HRSA defines six levels across three tiers.

COORDINATED Levels 1-2

Separate sites, separate systems. Providers communicate by referral, sporadically and about specific patients.

CO-LOCATED Levels 3-4

Same facility, still largely separate systems. Regular communication and some shared workflow.

INTEGRATED Levels 5-6

One team, one care plan, shared records and operations. Behavioral health is part of routine care.

1. Shared practice team

Behavioral and medical clinicians hold joint responsibility for the same patients, rather than exchanging cases as referral partners.

2. Shared space and workflow

Co-location, warm handoffs and joint scheduling, so a behavioral health contact is a normal part of a medical visit.

3. One care plan, shared records

A single treatment plan per patient, documented in a record that both disciplines write to and read.

4. Defined population, measured to target

Systematic case finding rather than referral alone, with treatment adjusted against tracked outcomes until the patient improves.

5. Linkage to the wider system

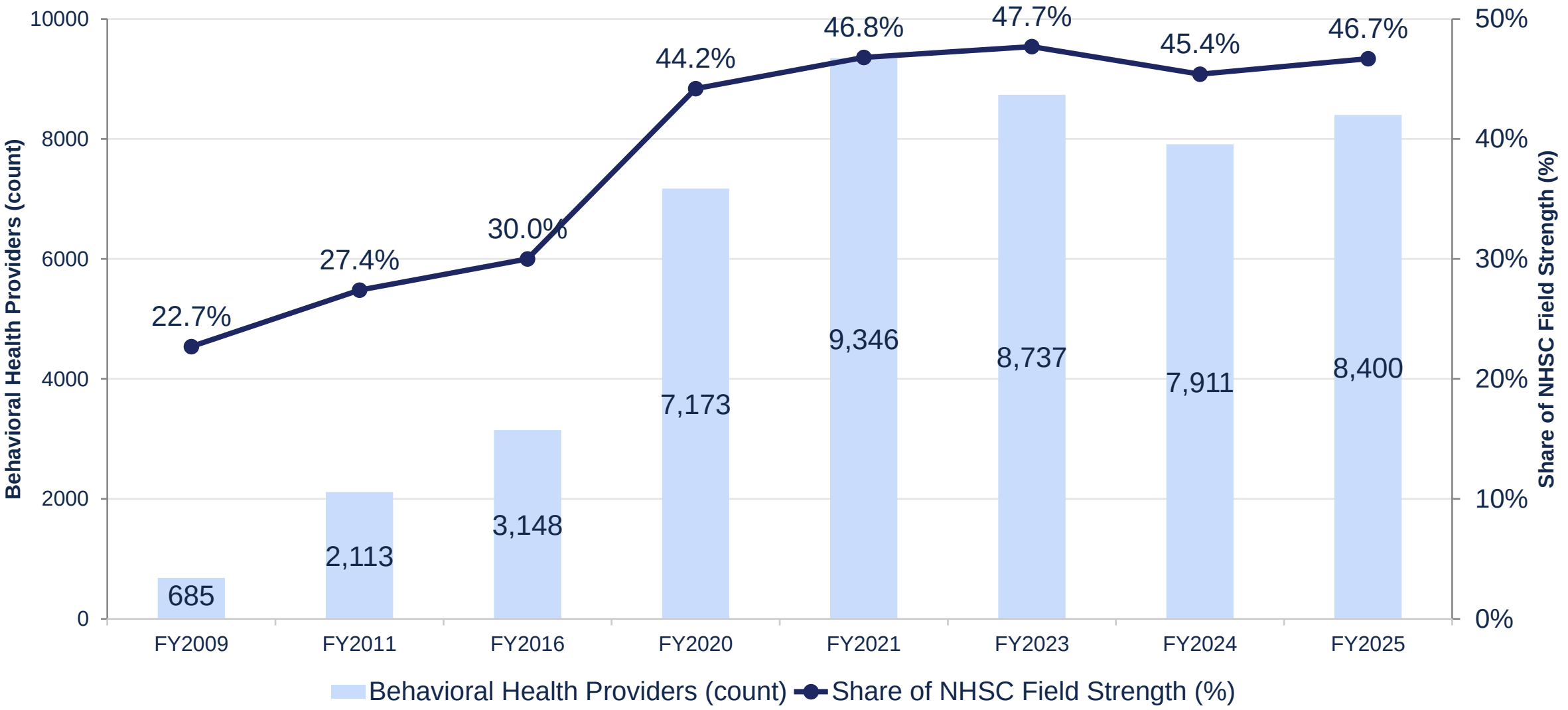
Working connections beyond the practice walls to specialty mental health, substance use, dental and social services.

6. Organizational and financial supports

Leadership commitment, stable staffing, and a payment model that covers behavioral health time.

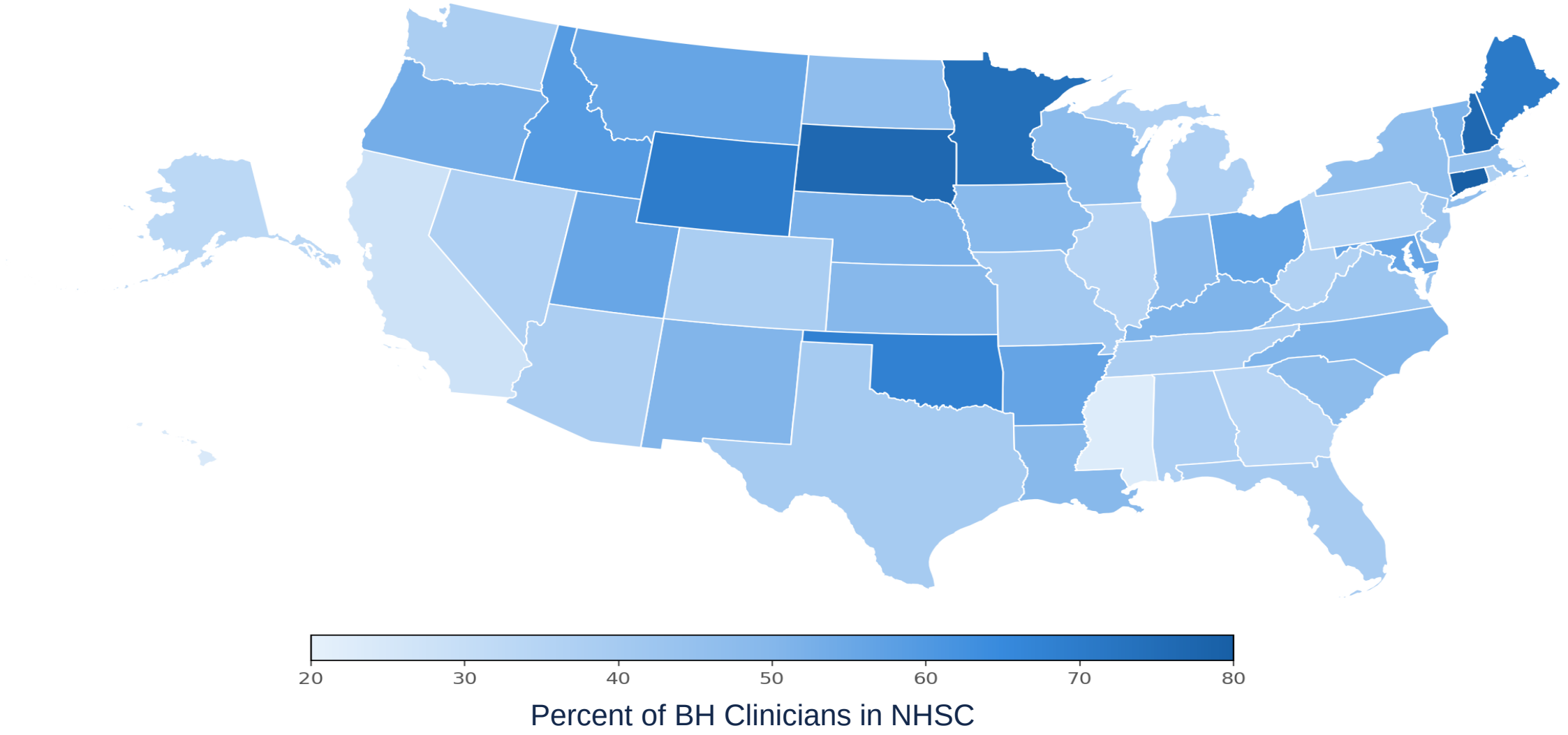
Source: Heath B, Wise Romero P, Reynolds K. A Standard Framework for Levels of Integrated Healthcare. SAMHSA-HRSA Center for Integrated Health Solutions, April 2013. Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration. AHRQ Publication No. 13-IP001-EF, 2013. Implication for this analysis: PRISM measures the clinician-experience side of integration and not the structural side, so practice setting is a proxy for where someone works rather than a measure of how integrated that practice is.

Size and Scale of Behavioral Health Clinicians in the National Health Service Corp



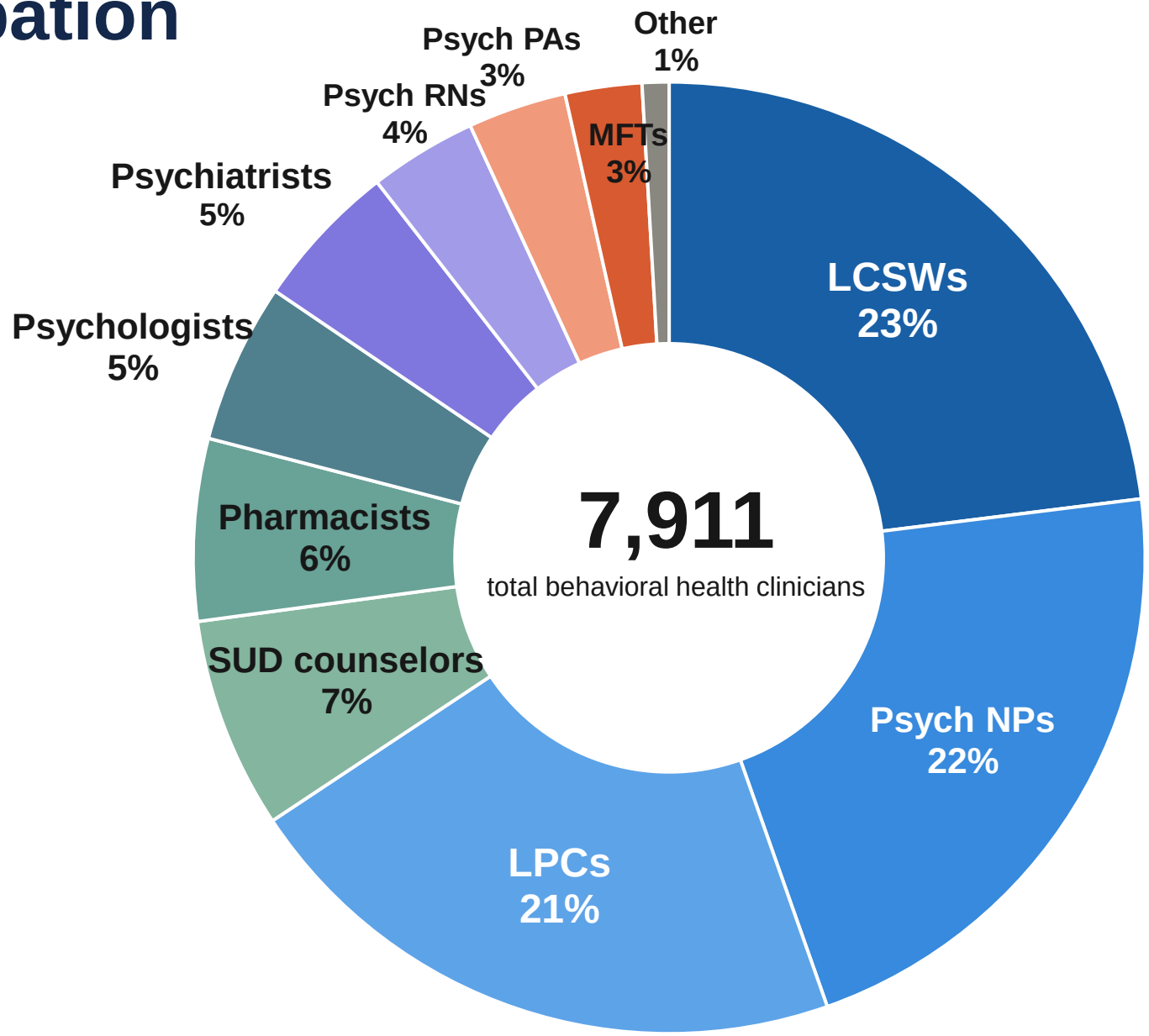
Note: FY2009/FY2011 counts derived from Proser et al., Am Board Fam Med (2012), which reports NHSC field strength grew from 3,017 to 7,713 clinicians during the ARRA expansion. FY2016 total field strength (10,493) from CRS R44970. FY2020–FY2024 counts are exact figures from HRSA NHSC Reports to Congress, Appendix A field strength tables. FY2025 figures are rounded from the NHSC FY2025 Field Strength Infographic.

Proportion of Behavioral Health Clinicians in the NHSC by State, 2024



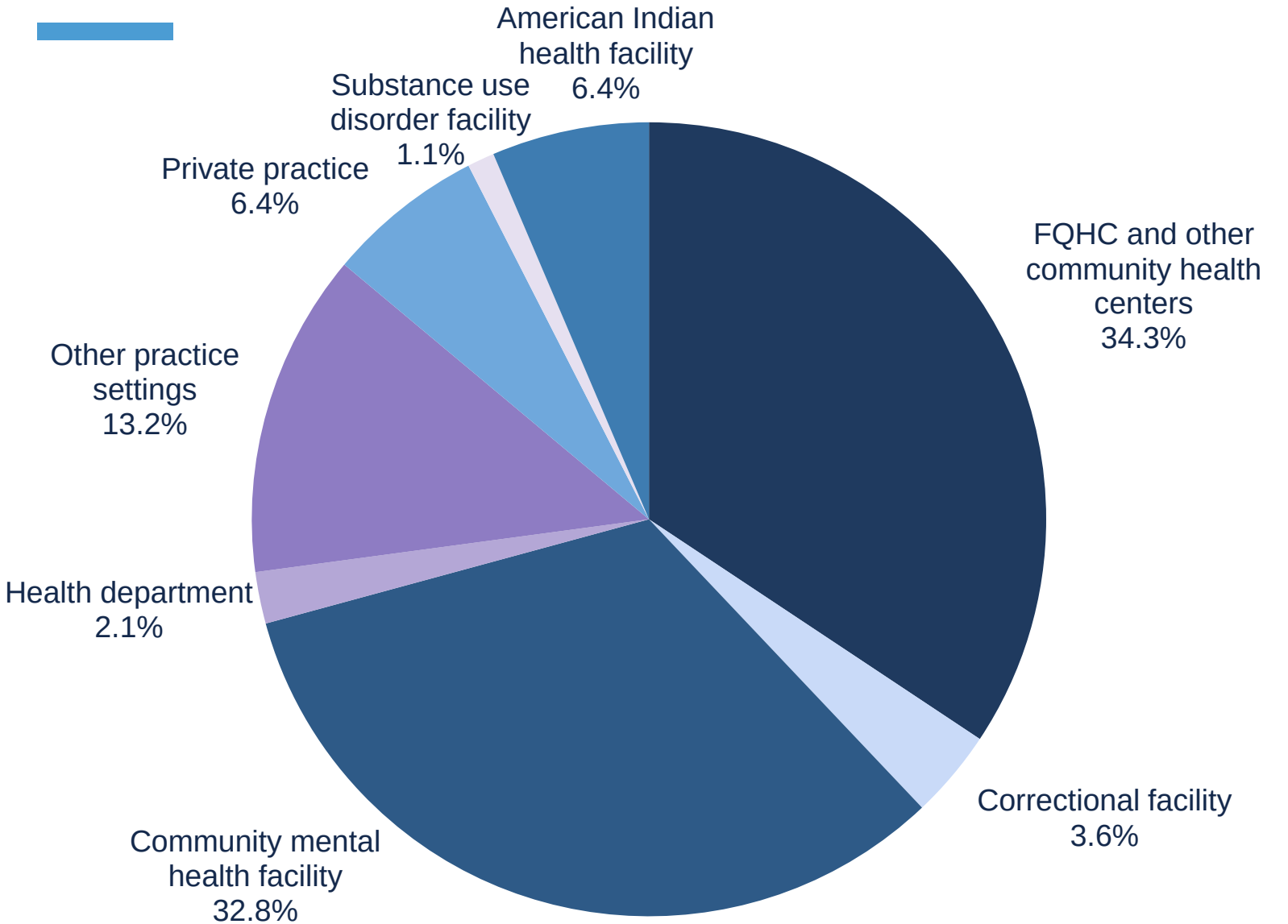
Source: HRSA National Health Service Corps Report to Congress, FY2024, Appendix A (Overall and Behavioral Health Field Strength by state). State boundaries: U.S. Census Bureau, 2018 Cartographic Boundary Files (cb_2018_us_state_20m).

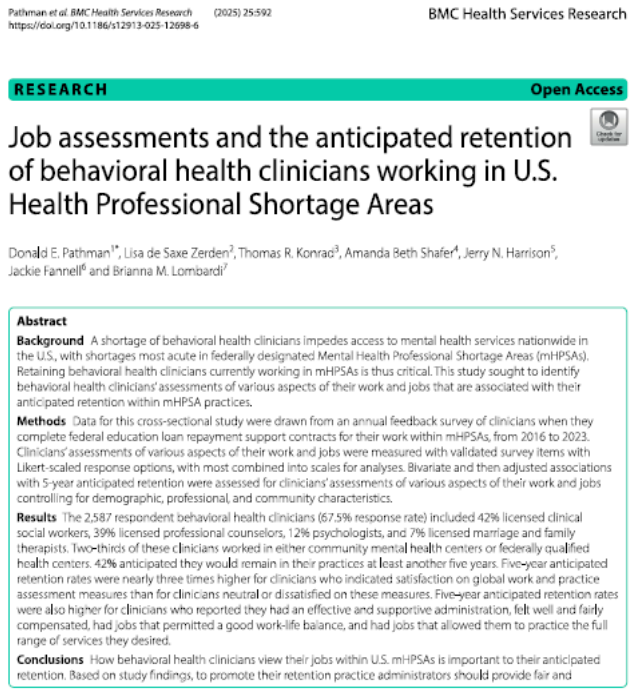
FY2024 NHSC Behavioral Health Workforce, by Occupation



Source: HRSA National Health Service Corps Report to Congress, FY2024, Appendix A (Mental and Behavioral Health Field Strength table). Total behavioral health field strength: 7,911. "Other" combines psychiatric nurse specialists (0.6%), certified nurse midwives (0.2%), and certified registered nurse anesthetists (0.1%).

Previous PRISM Project Told Us About NHSC Behavioral Health Clinicians





Pathman et al. BMC Health Services Research (2025) 25:592
https://doi.org/10.1186/s12913-025-12698-6

BMC Health Services Research

RESEARCH Open Access

Job assessments and the anticipated retention of behavioral health clinicians working in U.S. Health Professional Shortage Areas

Donald E. Pathman[1*], Lisa de Saxe Zerden[2], Thomas R. Konrad[3], Amanda Beth Shafer[4], Jerry N. Harrison[5], Jackie Fannell[6] and Brianna M. Lombardi[7]

Abstract

Background A shortage of behavioral health clinicians impedes access to mental health services nationwide in the U.S., with shortages most acute in federally designated Mental Health Professional Shortage Areas (mHPSAs). Retaining behavioral health clinicians currently working in mHPSAs is thus critical. This study sought to identify behavioral health clinicians' assessments of various aspects of their work and jobs that are associated with their anticipated retention within mHPSA practices.

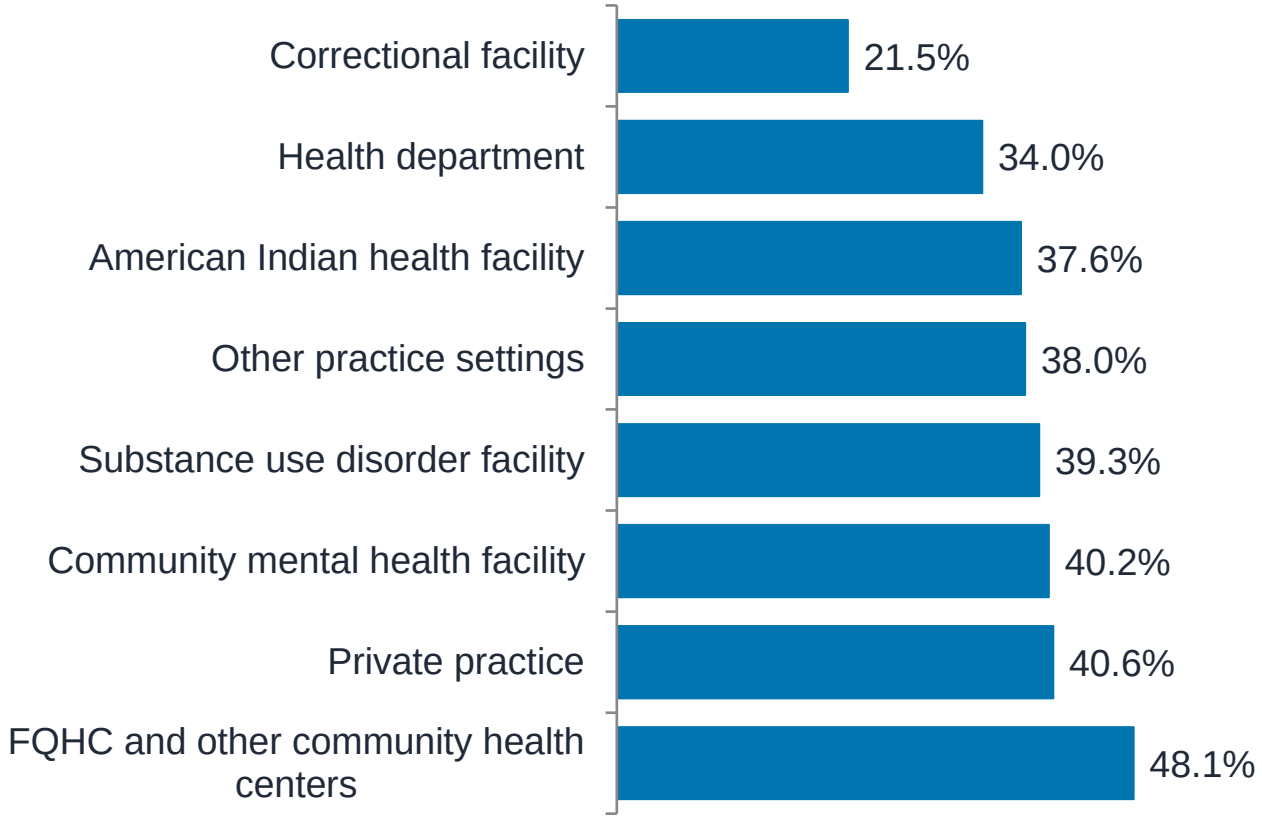
Methods Data for this cross-sectional study were drawn from an annual feedback survey of clinicians when they complete federal education loan repayment support contracts for their work within mHPSAs, from 2016 to 2023. Clinicians' assessments of various aspects of their work and jobs were measured with validated survey items with Likert-scaled response options, with most combined into scales for analyses. Bivariate and then adjusted associations with 5-year anticipated retention were assessed for clinicians' assessments of various aspects of their work and jobs controlling for demographic, professional, and community characteristics.

Results The 2,587 respondent behavioral health clinicians (67.5% response rate) included 42% licensed clinical social workers, 39% licensed professional counselors, 12% psychologists, and 7% licensed marriage and family therapists. Two-thirds of these clinicians worked in either community mental health centers or federally qualified health centers. 42% anticipated they would remain in their practices at least another five years. Five-year anticipated retention rates were nearly three times higher for clinicians who indicated satisfaction on global work and practice assessment measures than for clinicians neutral or dissatisfied on these measures. Five-year anticipated retention rates were also higher for clinicians who reported they had an effective and supportive administration, felt well and fairly compensated, had jobs that permitted a good work-life balance, and had jobs that allowed them to practice the full range of services they desired.

Conclusions How behavioral health clinicians view their jobs within U.S. mHPSAs is important to their anticipated retention. Based on study findings, to promote their retention practice administrators should provide fair and

Previous PRISM Project Told Us About Behavioral Health Clinicians Working in HPSAs

Behavioral Health Clinicians Intending to Leave Within 5 Years, by Setting



Pathman et al. BMC Health Services Research (2025) 25:592
https://doi.org/10.1186/s12913-025-12698-6

BMC Health Services Research

RESEARCH Open Access

Job assessments and the anticipated retention of behavioral health clinicians working in U.S. Health Professional Shortage Areas

Donald E. Pathman[1*], Lisa de Saxe Zerden[2], Thomas R. Konrad[3], Amanda Beth Shafer[4], Jerry N. Harrison[5], Jackie Fannell[6] and Brianna M. Lombardi[7]

Abstract

Background A shortage of behavioral health clinicians impedes access to mental health services nationwide in the U.S., with shortages most acute in federally designated Mental Health Professional Shortage Areas (mHPSAs). Retaining behavioral health clinicians currently working in mHPSAs is thus critical. This study sought to identify behavioral health clinicians' assessments of various aspects of their work and jobs that are associated with their anticipated retention within mHPSA practices.

Methods Data for this cross-sectional study were drawn from an annual feedback survey of clinicians when they complete federal education loan repayment support contracts for their work within mHPSAs, from 2016 to 2023. Clinicians' assessments of various aspects of their work and jobs were measured with validated survey items with Likert-scaled response options, with most combined into scales for analyses. Bivariate and then adjusted associations with 5-year anticipated retention were assessed for clinicians' assessments of various aspects of their work and jobs controlling for demographic, professional, and community characteristics.

Results The 2,587 respondent behavioral health clinicians (67.5% response rate) included 42% licensed clinical social workers, 39% licensed professional counselors, 12% psychologists, and 7% licensed marriage and family therapists. Two-thirds of these clinicians worked in either community mental health centers or federally qualified health centers. 42% anticipated they would remain in their practices at least another five years. Five-year anticipated retention rates were nearly three times higher for clinicians who indicated satisfaction on global work and practice assessment measures than for clinicians neutral or dissatisfied on these measures. Five-year anticipated retention rates were also higher for clinicians who reported they had an effective and supportive administration, felt well and fairly compensated, had jobs that permitted a good work-life balance, and had jobs that allowed them to practice the full range of services they desired.

Conclusions How behavioral health clinicians view their jobs within U.S. mHPSAs is important to their anticipated retention. Based on study findings, to promote their retention practice administrators should provide fair and

What PRISM Data Tell Us About Behavioral Health Clinicians in Integrated Health Settings: Practice Trends, Clinician Satisfaction, and Retention

Understanding the data

Likert values 1 - 5

1 is dissatisfied and 5 is satisfied

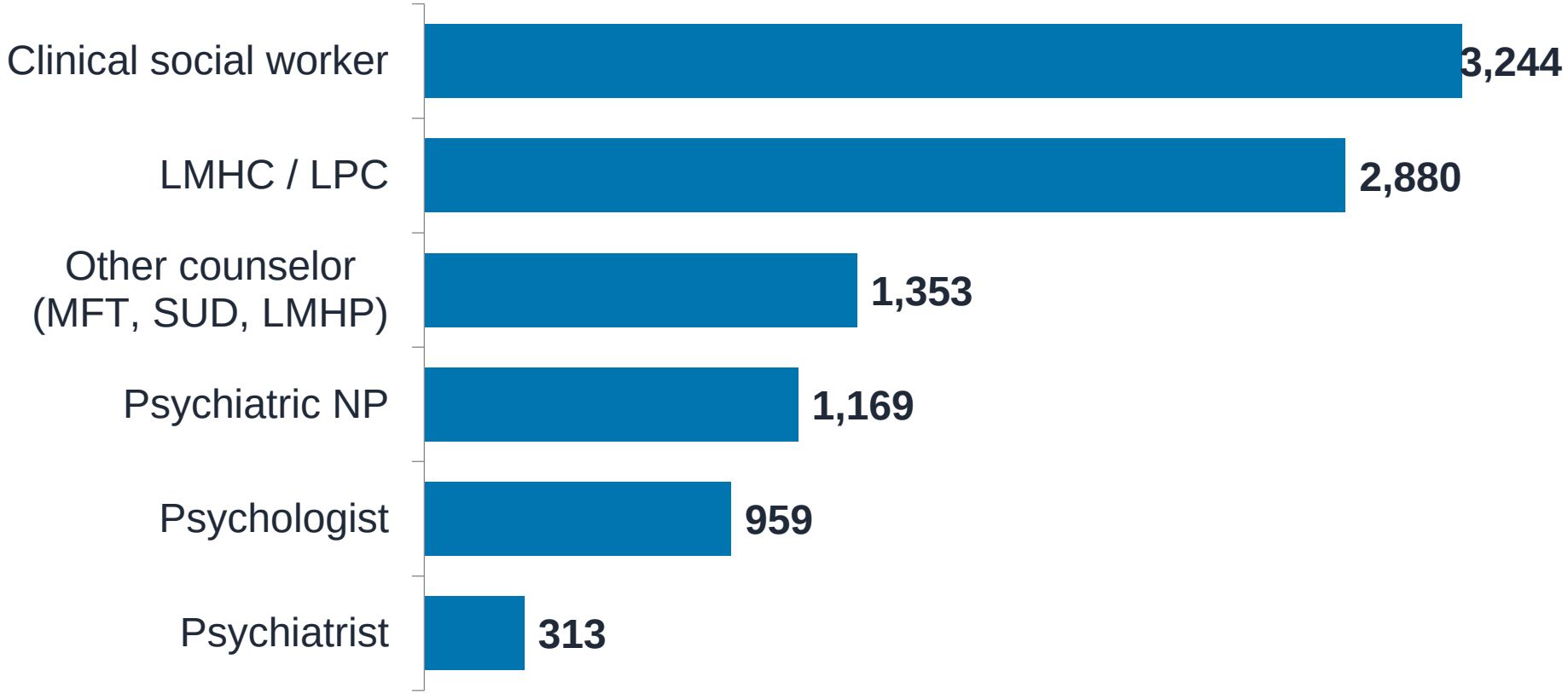
+0.36 = positive/satisfied

-0.05 = negative/dissatisfied

Findings are descriptive

Mental Health Clinicians in PRISM, by Occupation

9,918 unique clinicians across six occupational groups



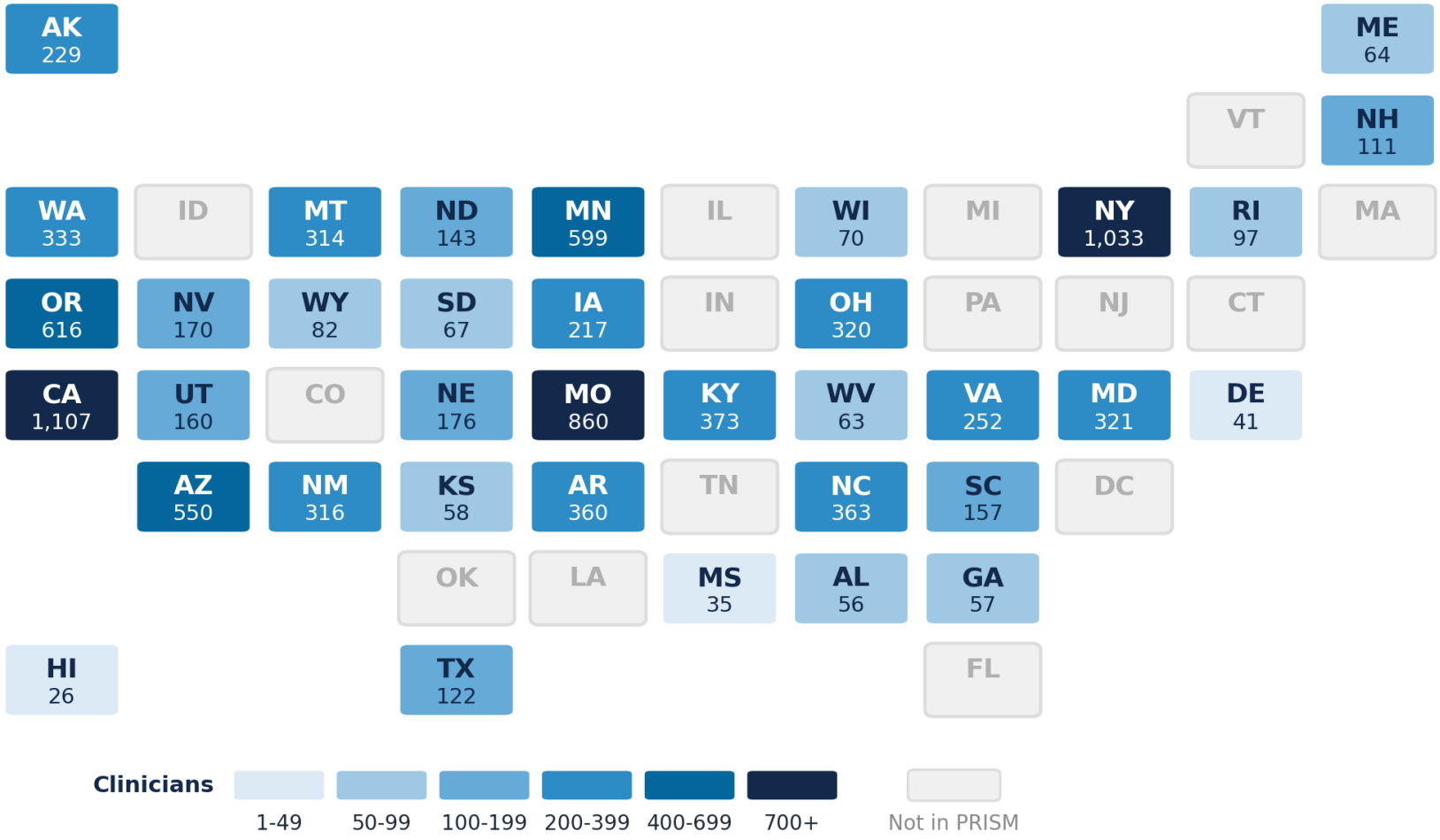
9,918

mental health clinicians

Source: PRISM survey data through May 8, 2024. Mental health clinicians are the eight disciplines in the PRISM Mental Health discipline category, plus psychiatric nurse practitioners (nurse practitioners with a psychiatric specialty, and psychiatric nurse therapists) and psychiatrists (physicians with a psychiatry or child and adolescent psychiatry specialty).

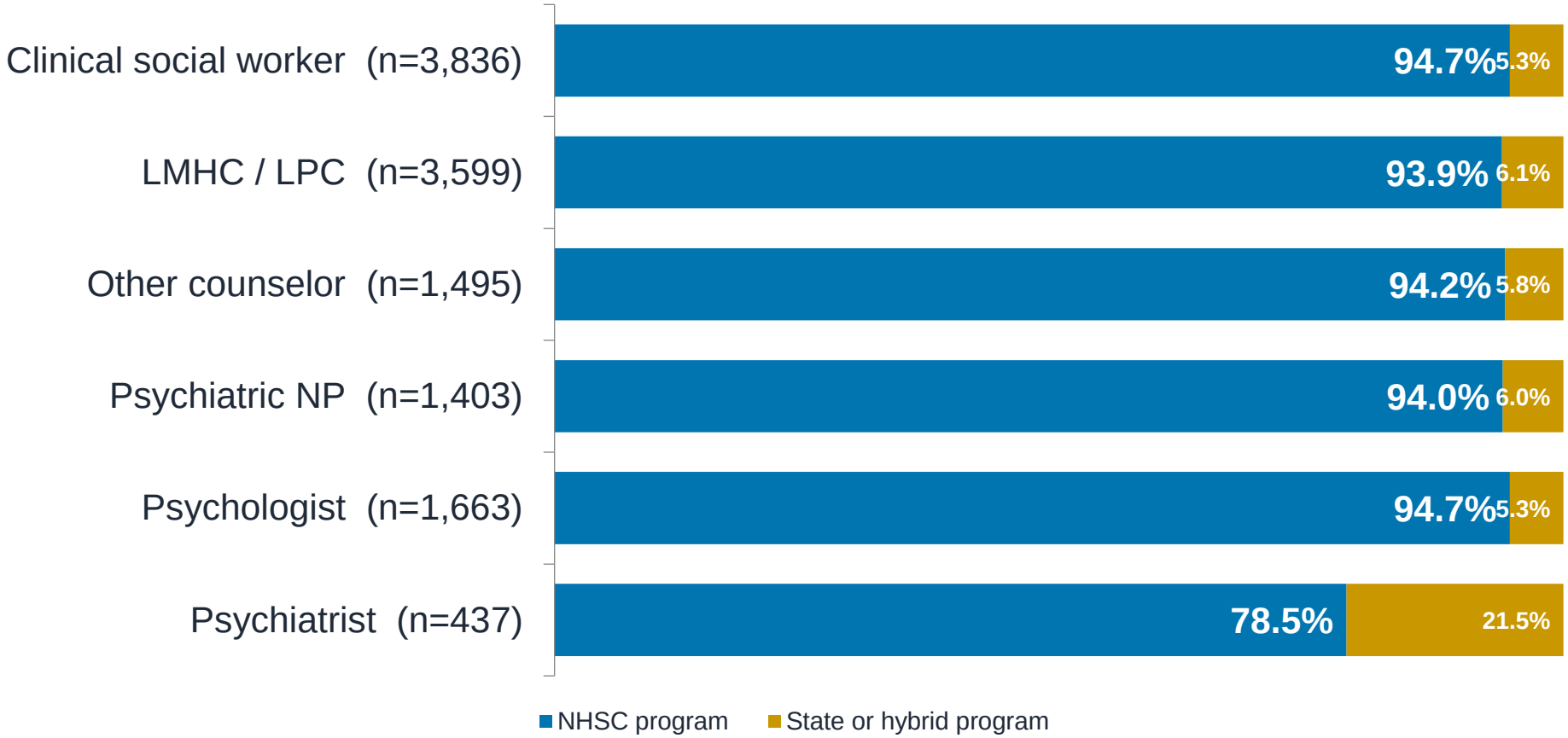
Mental Health Clinicians in PRISM by State

9,918 clinicians across the 36 states that contributed data



Source: PRISM survey data through May 8, 2024. Unique clinicians; those holding more than one loan repayment contract are counted once, and assigned to the state of their practice. Grid cartogram: each state is one equal-sized tile, so the map shows counts rather than land area. Grey tiles are states whose programs did not participate in PRISM.

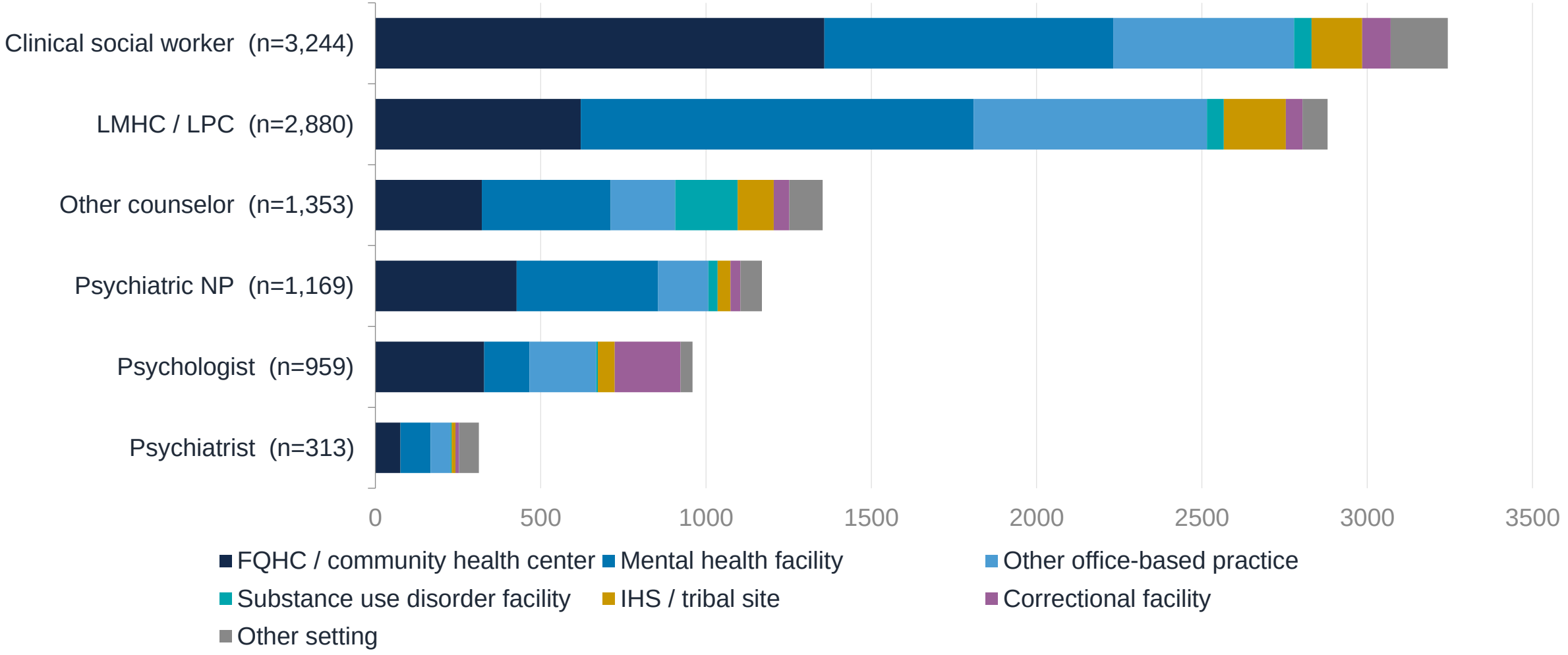
PRISM Mental Health Clinicians in NHSC vs State Loan Repayment Programs



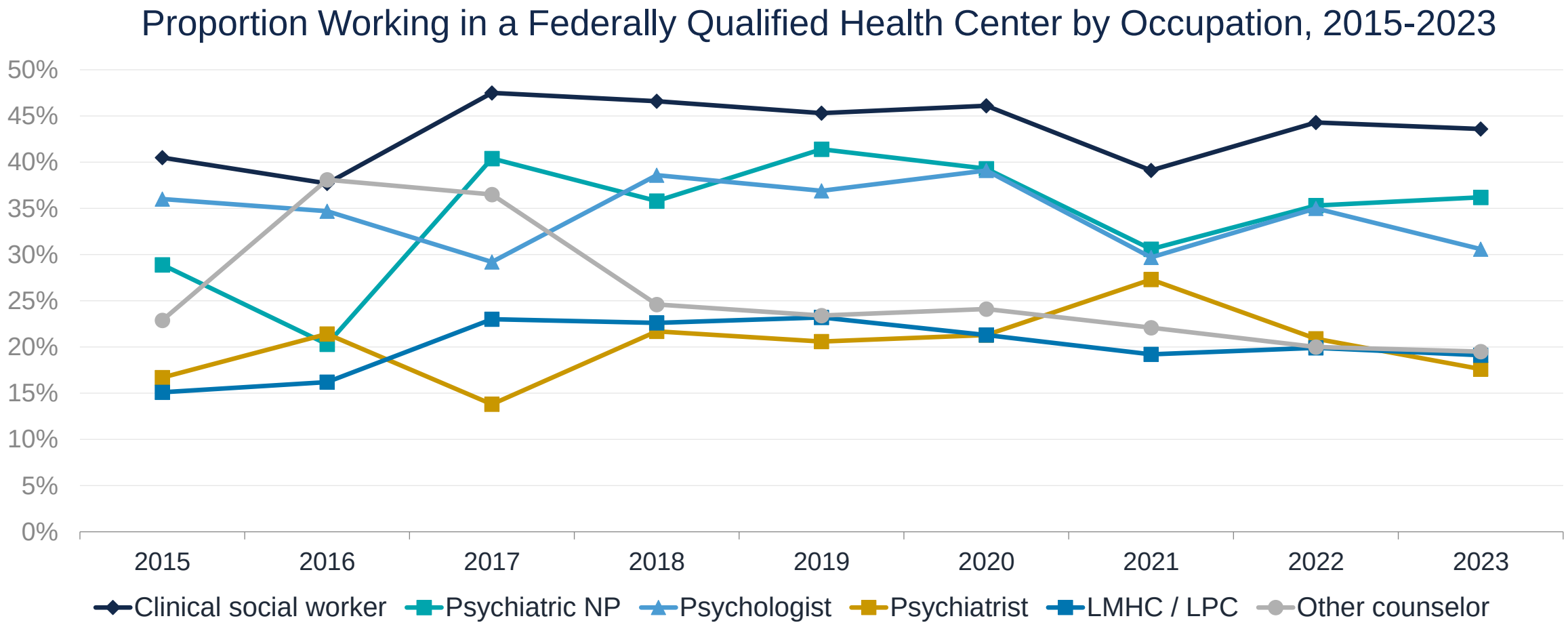
Nearly 94% of the 12,433 mental health contracts run through NHSC rather than a state program

Source: PRISM survey data through May 8, 2024; 12,433 mental health contracts. NHSC combines the core Loan Repayment Program (9,360), the Substance Use Disorder Workforce LRP (1,506) and the Rural Community LRP (790). State or hybrid combines 43 programs (777 contracts), including NHSC Nebraska SLRP, which is state-administered despite its name.

Practice Trends of PRISM Mental Health Clinicians in Integrated Health Settings

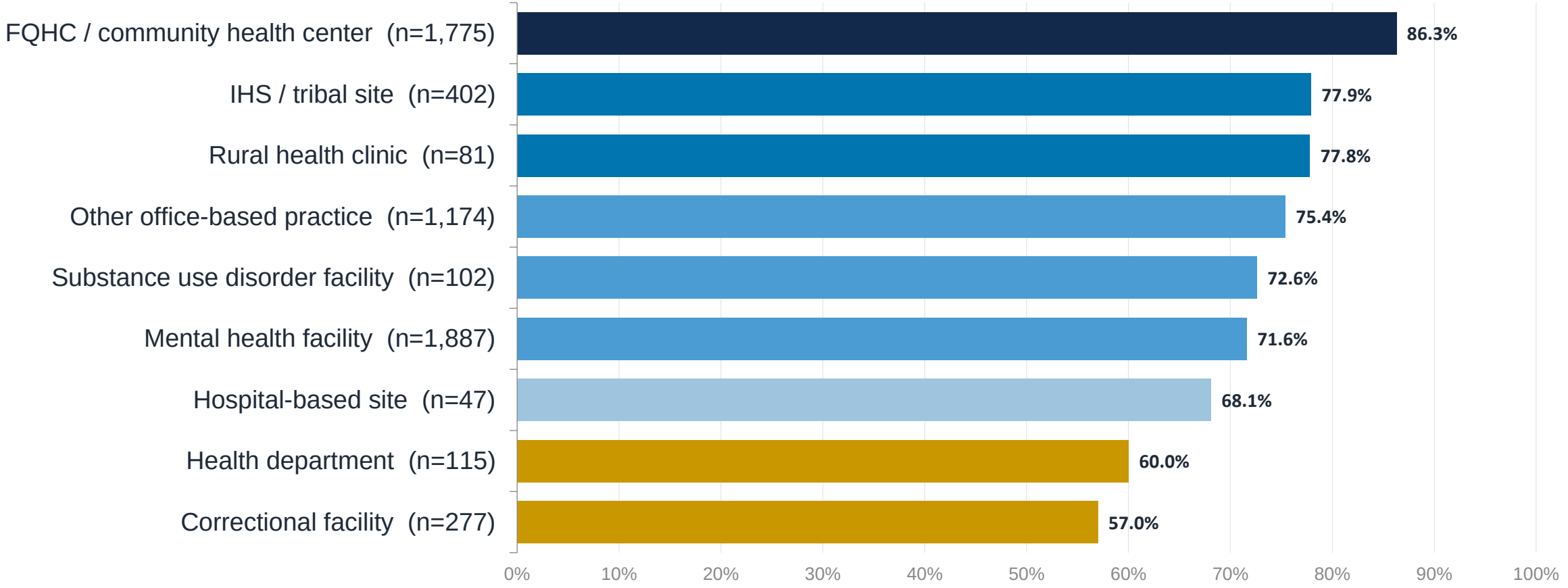


Practice Trends in Integrated Health Settings



Feeling Connected to the Wider Health System

"My practice is well linked with the broader medical, mental, and dental health care system"



Source: PRISM End of Contract surveys through May 8, 2024; 5,888 mental health contracts with this item. Bars show the percent agreeing or strongly agreeing on a 1-5 scale. Setting differences are large overall (F=30.7, p<.001). Compared with FQHCs, every setting is lower and all are significant at p<.05 except rural health clinics (n=81). Hospital-based sites (n=47) and rural health clinics rest on small samples. An "other" category of 28 contracts is omitted.

No differences in mental health clinician reports of feeling connected by occupation type

Mean agreement (1-5) in the three settings that hold most mental health clinicians

Occupation	FQHC / community health center	Mental health facility	Other office-based practice	FQHC difference
Clinical social worker	**4.27** (n=764)	3.78 (n=532)	3.91 (n=311)	**+0.36**
LMHC / LPC	**4.28** (n=361)	3.97 (n=768)	3.98 (n=448)	**+0.30**
Other counselor	**4.25** (n=139)	3.91 (n=162)	3.84 (n=70)	**+0.34**
Psychiatric NP	**4.07** (n=177)	3.76 (n=205)	3.73 (n=78)	**+0.31**
Psychologist	**4.40** (n=288)	3.93 (n=157)	4.23 (n=230)	**+0.17**
Psychiatrist	**4.13** (n=46)	3.68 (n=63)	3.81 (n=37)	**+0.32**

Source: PRISM End of Contract surveys through May 8, 2024. FQHCs score highest for all six occupations, and the gap is smallest for psychologists in other office-based practice. The item correlates only moderately with overall practice satisfaction (r=0.38), so it is measuring something distinct from general contentment.

Clinician Satisfaction in Integrated Health Settings

Factors Higher in Federally Qualified Health Centers

Item	In FQHC	Not FQHC	Difference
Practice is well linked with the broader health care system	4.27	3.91	**+0.36*** **
I feel a strong personal connection with my patients	4.40	4.32	**+0.08*** **
Work rarely encroaches on my personal time	3.11	3.02	**+0.08** **
I fully value the mission of my practice	4.56	4.52	**+0.05***
I feel that I am doing important work	4.67	4.65	+0.02
Well compensated given my training	3.08	3.06	+0.01

Source: PRISM End of Contract surveys through May 8, 2024; 5,870 mental health contracts. Means on a 1-5 agreement scale. Effect size is Cohen's d. * p<.05, ** p<.01, *** p<.001, unadjusted. The integration item is the largest effect in the whole 22-item battery, roughly four times the next largest. The bottom two rows are not significant and are shown for completeness.

Clinician Satisfaction in Integrated Health Settings

Factors Lower in Federally Qualified Health Centers

Item	In FQHC	Not FQHC	Difference
I have real input into administrative decisions	2.95	3.21	**-0.26*** **
I have the needed flexibility in my work hours	3.39	3.65	**-0.26*** **
The staffing of my practice is stable	2.78	3.02	**-0.24*** **
The administrator of my practice is effective	3.55	3.78	**-0.23*** **
I have a good relationship with the administrator	3.77	3.98	**-0.21*** **
Staff are a major source of personal support	3.71	3.87	**-0.16*** **
I have good backup from partners or supervisors	3.92	4.07	**-0.15*** **
I can provide the full range of services I trained for	4.06	4.20	**-0.14*** **
I feel a sense of belonging to the community	3.86	3.99	**-0.13*** **
Overall, I am pleased with my work	4.05	4.15	**-0.10*** **
Staff support my professional judgment	4.29	4.38	**-0.09*** **
I am involved in community issues important to me	3.72	3.80	**-0.09** **
My practice/organization is financially stable	3.85	3.91	**-0.06* **

Source: PRISM End of Contract surveys through May 8, 2024; 5,870 mental health contracts. Means on a 1-5 agreement scale. Effect size is Cohen's d; every effect here is small (|d| < 0.25) even where the p-value is very small. Two further items show no difference at all and are omitted: compensation package is fair (-0.02, p=0.37) and enough time for personal life (-0.03, p=0.25).

Where FQHC Scores Run Higher, by Occupation

Item	Clinical social worker	LMHC / LPC	Other counselor	Psychiatric NP	Psychologist	Psychiatrist
Practice linked to broader system	**4.27** **+0.40*** **	**4.28** **+0.30*** **	**4.25** **+0.36*** **	**4.07** **+0.32** **	**4.40** **+0.41*** **	**4.13** **+0.46** **
Work rarely encroaches on time	**3.17** **+0.14** **	**3.17** **+0.16***	**3.09** -0.03	**3.05** -0.01	**2.92** +0.00	**3.02** -0.10
Value the mission of my practice	**4.56** +0.05	**4.53** -0.01	**4.54** +0.04	**4.56** +0.00	**4.63** **+0.15** **	**4.50** +0.11

Source: PRISM End of Contract surveys through May 8, 2024. Large number is the FQHC mean on a 1-5 scale; small number is the FQHC mean minus the non-FQHC mean. Red lower in FQHCs, green higher. * p<.05, ** p<.01, *** p<.001, unadjusted. Psychiatrists are n=46 in FQHCs; that column is descriptive only.

Where FQHC Scores Run Lower, by Occupation

Item	Clinical social worker	LMHC / LPC	Other counselor	Psychiatric NP	Psychologist	Psychiatrist
Flexibility in work hours	**3.32** **-0.32*****	**3.54** -0.12	**3.29** **-0.31****	**3.26** **-0.38*****	**3.49** **-0.17***	**3.45** -0.18
Real input into admin decisions	**2.86** **-0.22*****	**2.87** **-0.31*****	**2.89** **-0.32****	**2.94** **-0.28***	**3.23** **-0.20***	**3.66** +0.19
Staffing is stable	**2.76** **-0.20*****	**2.84** **-0.25*****	**2.70** -0.20	**2.63** **-0.43*****	**2.89** **-0.18***	**2.95** -0.02
Administrator is effective	**3.51** **-0.21*****	**3.59** **-0.23*****	**3.49** **-0.26***	**3.49** **-0.36*****	**3.65** -0.13	**3.70** +0.00
Full range of services trained for	**4.03** **-0.17*****	**4.12** **-0.11***	**4.06** -0.15	**4.08** -0.17	**4.00** -0.08	**4.20** +0.09
Overall satisfied in practice	**3.76** **-0.14****	**3.68** **-0.24*****	**3.78** -0.09	**3.74** **-0.27****	**3.91** -0.10	**4.00** +0.05

Source: PRISM End of Contract surveys through May 8, 2024. Large number is the FQHC mean on a 1-5 scale; small number is the FQHC mean minus the non-FQHC mean. Red lower in FQHCs, green higher. * p<.05, ** p<.01, *** p<.001, unadjusted. Psychiatrists are n=46 in FQHCs; that column is descriptive only.

Where the FQHC Effect Differs by Occupation

Item	Clinical social worker	LMHC / LPC	Other counselor	Psychiatric NP	Psychologist	Psychiatrist	Differs across occ.
Personal connection with patients	**4.35** +0.03	**4.41** +0.05	**4.46** +0.09	**4.41** +0.07	**4.51** **+0.30*** **	**4.20** -0.03	**p = 0.0005**
Sense of belonging to the community	**3.80** **-0.20*** **	**3.81** **-0.21*** **	**3.95** -0.04	**3.83** -0.12	**4.04** +0.09	**4.02** +0.08	**p = 0.002**
Involved in community issues	**3.67** **-0.10***	**3.68** **-0.17****	**3.79** -0.03	**3.62** -0.16	**3.87** +0.11	**3.88** +0.17	**p = 0.005**
Good relationship w/ administrator	**3.74** **-0.20*** **	**3.73** **-0.25*** **	**3.61** **-0.39*** **	**3.79** **-0.22***	**3.91** **-0.14***	**4.23** +0.25	**p = 0.019**
Doing important work	**4.66** +0.02	**4.64** -0.02	**4.74** +0.06	**4.65** -0.05	**4.74** **+0.13*** **	**4.61** +0.06	**p = 0.045**

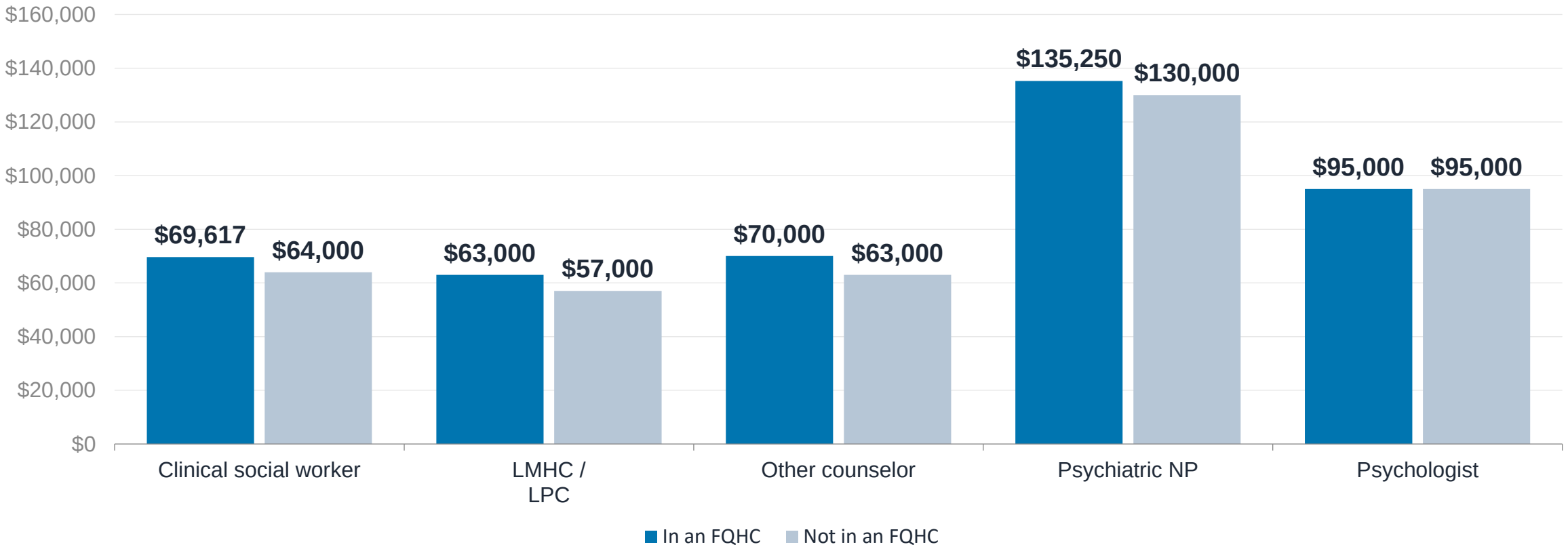
Source: PRISM End of Contract surveys through May 8, 2024. Final column is the p-value for the occupation-by-setting interaction; a small value means the FQHC gap is genuinely different across occupations rather than one common effect. Large number is the FQHC mean on a 1-5 scale; small number is the FQHC mean minus the non-FQHC mean. Red lower in FQHCs, green higher. * p<.05, ** p<.01, *** p<.001, unadjusted. Psychiatrists are n=46 in FQHCs; that column is descriptive only.

Satisfaction with Compensation and Comparison of Median Salary

	Says compensation package is fair		Median salary, full time		
Occupation	**In FQHC**	**Not FQHC**	**In FQHC**	**Not FQHC**	**Difference**
Clinical social worker	56%	53%	$69,617	$64,000	**+$5,617*** **
LMHC / LPC	54%	55%	$63,000	$57,000	**+$6,000*** **
Other counselor	58%	53%	$70,000	$63,000	**+$7,000** **
Psychiatric NP	51%	58%	$135,250	$130,000	**+$5,250***
Psychologist	62%	68%	$95,000	$95,000	no difference
Psychiatrist	59%	63%	$250,000	$250,000	no difference

Source: PRISM End of Contract surveys through May 8, 2024. Fairness is the percent agreeing or strongly agreeing that their total compensation package including benefits is fair; no occupation shows a significant FQHC difference on this item (all p>0.17). Salary is self-reported, trimmed to $20,000-$400,000, restricted to 35-80 reported hours per week; n ranges from 33 (psychiatrists in FQHCs) to 1,178 (LMHC/LPCs outside FQHCs). * p<.05, ** p<.01, *** p<.001. Psychologist and psychiatrist medians are identical across settings.

Median Salary by Setting

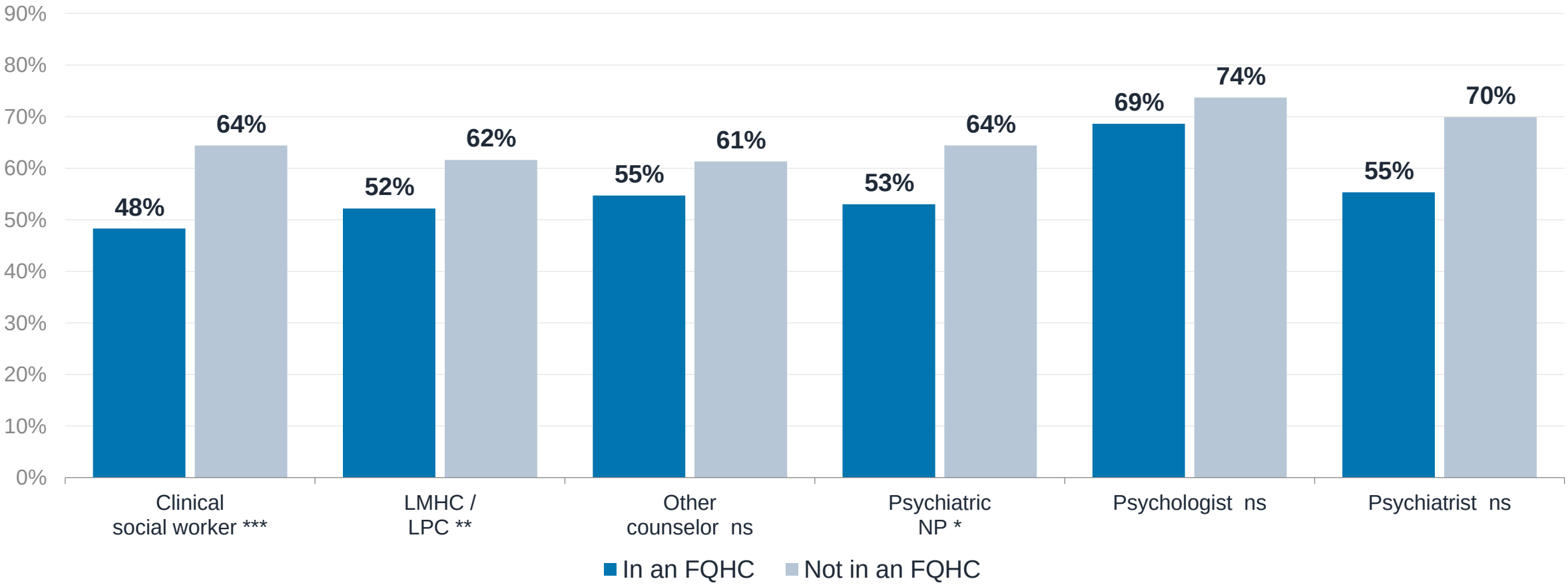


Source: PRISM End of Contract surveys through May 8, 2024. Self-reported salary trimmed to $20,000-$400,000, restricted to 35-80 reported hours per week. Psychiatrists are omitted from the chart because their median of $250,000 in both settings compresses the rest; they show no FQHC difference on n=33 versus 133.

Anticipated Retention in the Current Practice

Percent expecting to stay 5 or more years: 54% in FQHCs vs 65% elsewhere

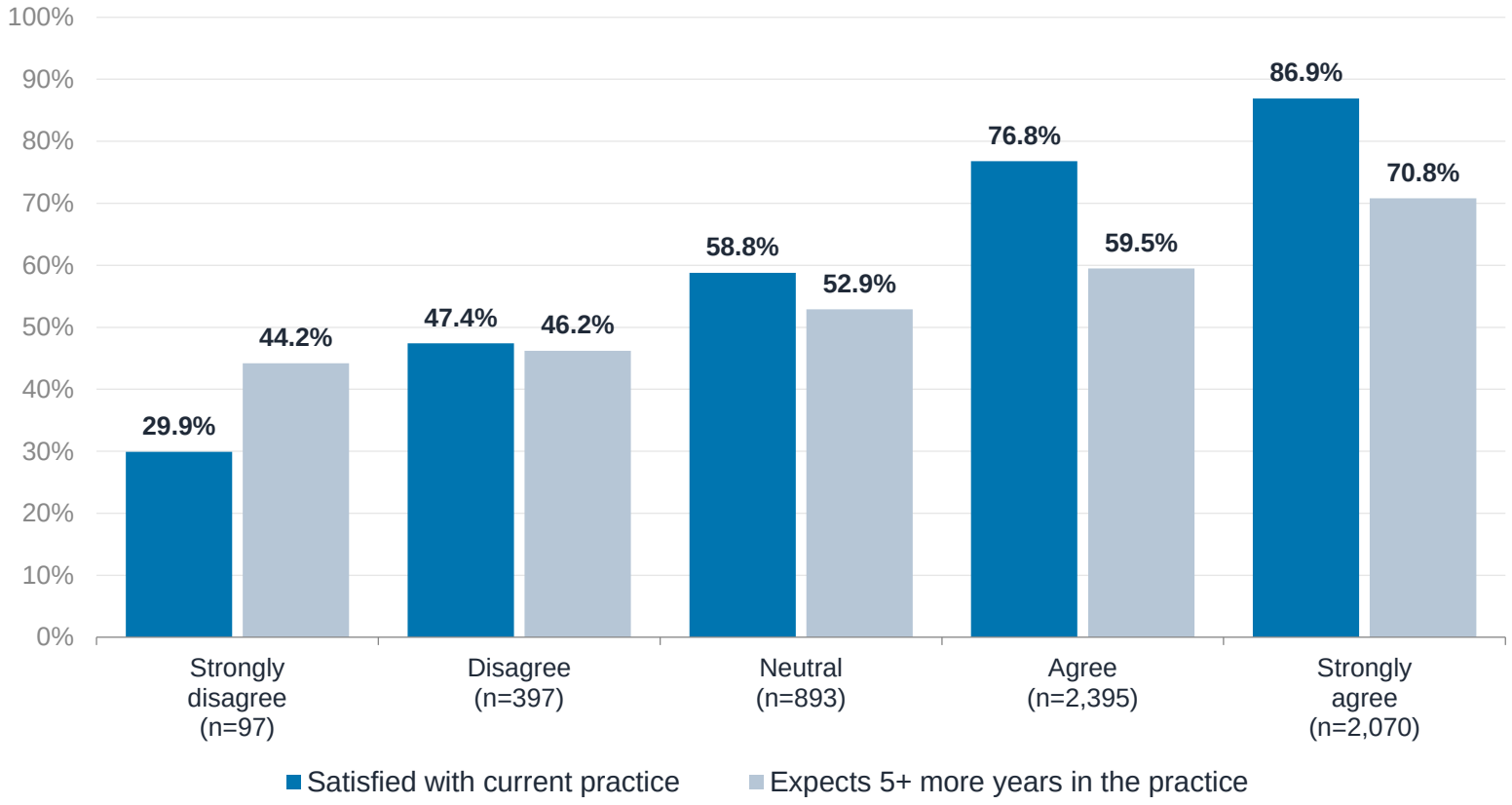
Significant for clinical social workers, LMHC/LPCs and psychiatric NPs. ns = not significant. *** p<.001 ** p<.01 * p<.05



Source: PRISM End of Contract surveys through May 8, 2024. "Looking ahead from now, about how many years do you anticipate remaining in the current practice." Responses trimmed to 0-40 years. Differences significant for clinical social workers (p<.001), LMHC/LPCs (p=.002) and psychiatric NPs (p=.018); not significant for the three smaller groups. Psychiatrists are n=47 in FQHCs.

Connectedness Tracks Satisfaction and Retention

By level of agreement that "my practice is well linked with the broader health care system"



2.20

odds of being overall satisfied in my current practice, per point on the connectedness item (95% CI 2.06-2.36), adjusting for occupation, setting, state and contract year

No difference by setting

No difference across settings (interaction p = 0.34). FQHC 2.40 vs mental health facility 2.12, p = 0.16.

Source: PRISM End of Contract surveys through May 8, 2024; 5,852 mental health contracts with both items, of 12,433 total. Satisfied means agrees or strongly agrees that they are satisfied in their current practice. Retention is anticipating 5 or more further years in the practice, trimmed to 0-40 years. Both measures come from the same survey at the same moment, so direction cannot be established and shared response tendency may inflate the association.

Takeaways

- Things that impact satisfaction within integrated health settings
  - Administrator relationship
  - Staffing stability
  - Lack of flexibility
  - Not working full scope
- Strengths of integrated health settings
  - Strong pay and adequate compensation
  - Integrated health center may be a strong recruiting factor

Find us, Follow Us, Sign up For our Newsletter

Sheps Program on Health Workforce Research and Policy

go.unc.edu/Workforce

SHEPS HEALTH WORKFORCE NC

nchealthworkforce.unc.edu

UNIVERSITY OF NORTH CAROLINA BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER

bhworkforce.unc.edu

Sign up for our newsletter directly at go.unc.edu/WorkforceNewsletter

Contact information

Brianna Lombardi

Co-Director

Program on Health Workforce Research and Policy

Director

UNC Behavioral Health Workforce Research Center

brianna_lombardi@med.unc.edu

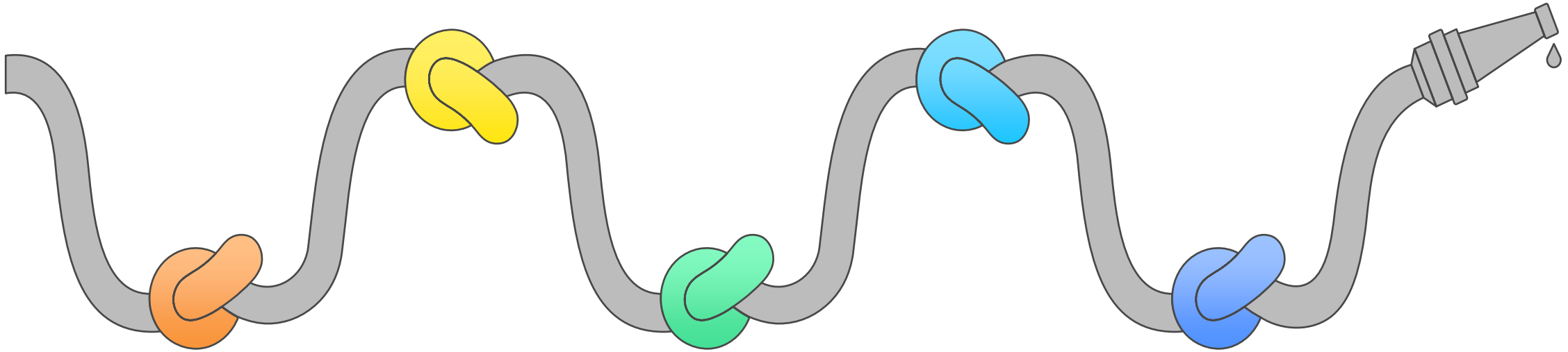
Natalie Uy

Prism Analyst

uy@3rnet.org

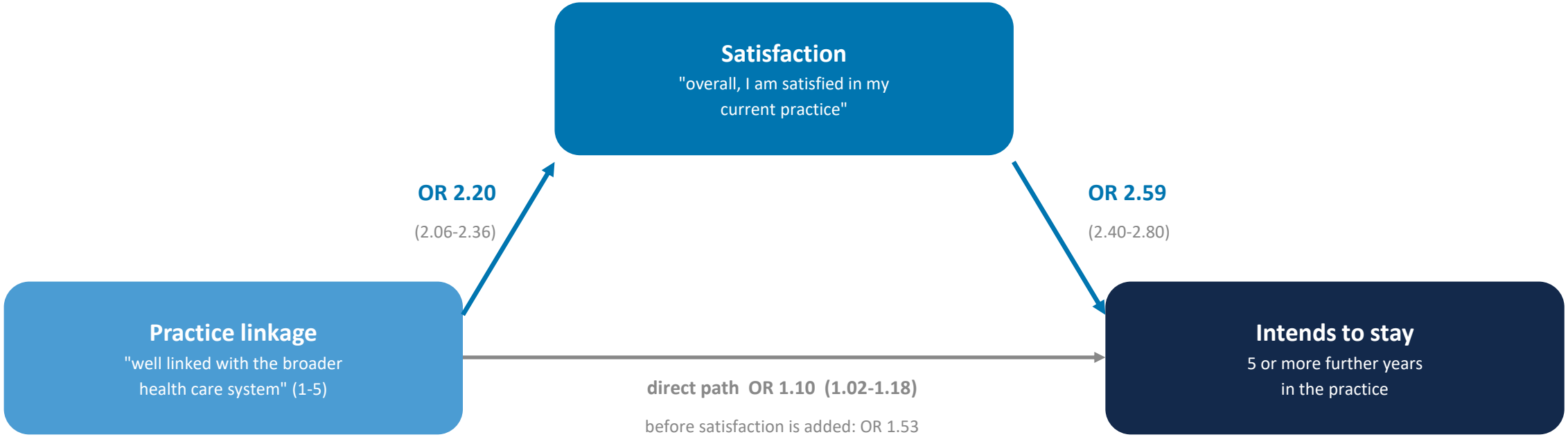
Designing Interventions that focus on careers

Undergraduate Degree → Master's Degree → Supervised Practice → Independent Practice



How Practice Linkage Reaches Retention

The association with intending to stay runs through satisfaction rather than around it



Adding satisfaction to the model shrinks the linkage effect on retention by about 78%. Practice linkage is a lever on satisfaction, and satisfaction is the lever on retention. If linkage improves but clinicians are no more satisfied, retention should not be expected to move.

Source: PRISM End of Contract surveys through May 8, 2024; 5,601 mental health contracts with all three measures. Odds ratios from logistic regression adjusting for occupation, practice setting, state and contract start year. IMPORTANT: all three measures come from the same survey at one moment, so this ordering is an interpretation, not a demonstrated causal sequence. Satisfaction could equally colour how a clinician rates their practice's linkage. The residual direct path remains significant (p=0.012) but small.