Iowa Psychological Association

A Survey of Psychologist Demographic Characteristics and Factors that Influence the Practice of Psychology in Iowa

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Introduction

The healthcare landscape has changed significantly in the past several years and, more recently, with the COVID-19 pandemic. Providing high quality mental or behavioral health care to all Iowans has been quite challenging given the shortage of psychologists in Iowa, lack of demographic information regarding the psychologist workforce, and the unique challenges that psychologists face in providing psychological services. There is a significant need to better understand factors that may influence or impact how psychological services are delivered in Iowa.

The Iowa Psychological Association (IPA) and Iowa Department of Public Health (IDPH) have teamed up to design and implement a survey to examine psychologist demographic characteristics, issues related to the business of psychology (e.g., billing/reimbursement), factors that influence the practice of psychology (e.g., delivering psychological services and access to care concerns), and how psychologists uniquely contribute to the well-being and public health of Iowans. Data gathered from the survey will help IDPH better understand the psychologist workforce as well as how psychologists address factors that impact the public health of Iowans. Additionally, information collected from the survey will be used to help IPA revise its strategic plan and provide direction for strategic initiatives for years to come.

In the fall of 2020, an e-mail was sent from the Iowa Department of Public Health to all licensed psychologists in Iowa requesting participation in the survey. Survey completion time was approximately 15 minutes. At the conclusion of the survey, respondents were entered into a drawing to win a $25 Amazon gift card, purchased by IPA. This report presents the data collected from the survey, additional information from the IDPH database, and data from the National Registrar of Health Service Providers.

Demographics

Participants and Response Rate

Original data collection had 310 respondents; however, five of them were not licensed in Iowa, therefore they were excluded from any data analysis, resulting in 305 final participants. According to the Iowa Department of Public Health (IDPH, 2020), there were 800 psychologists licensed in Iowa by October 5, 2020 (the date the survey closed), therefore the survey represents 38% of the psychologists licensed in Iowa. In order to measure the representativeness of the sample, residential status, age, and gender of the survey respondents were compared to all active Iowa license holders. As displayed in Figures 1 and 2, survey participants appeared to be a representative sample of IA licensure holders based on the demographic factors compared.

Figure 1: IA active licensure compared to survey sample

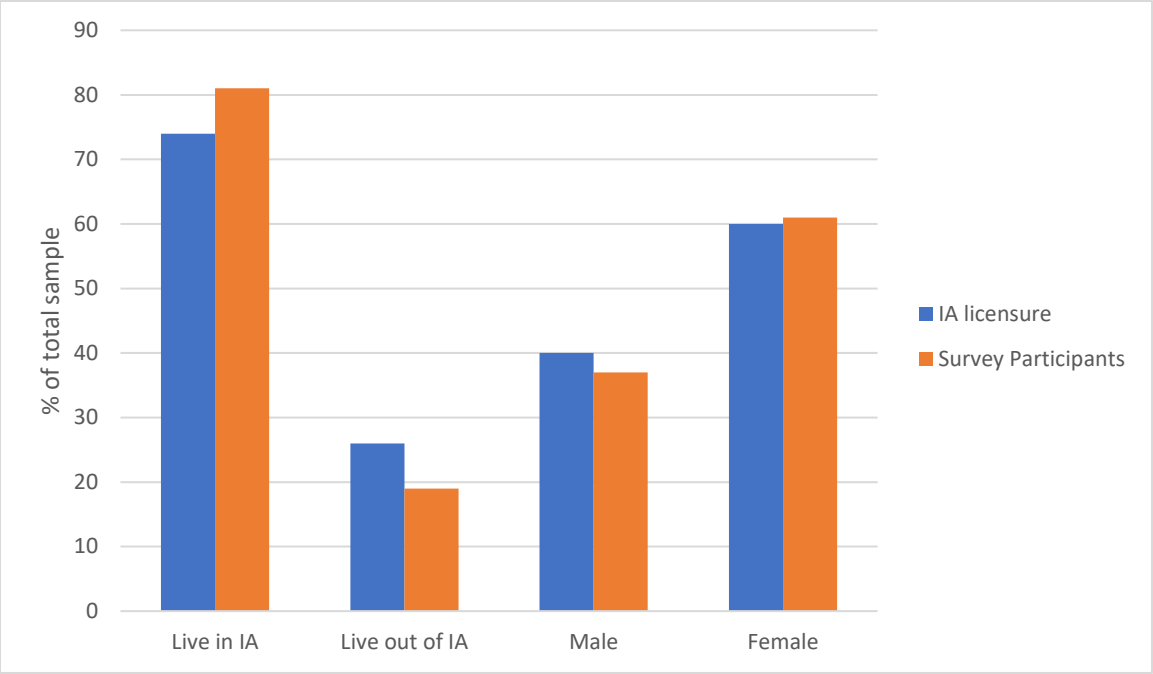
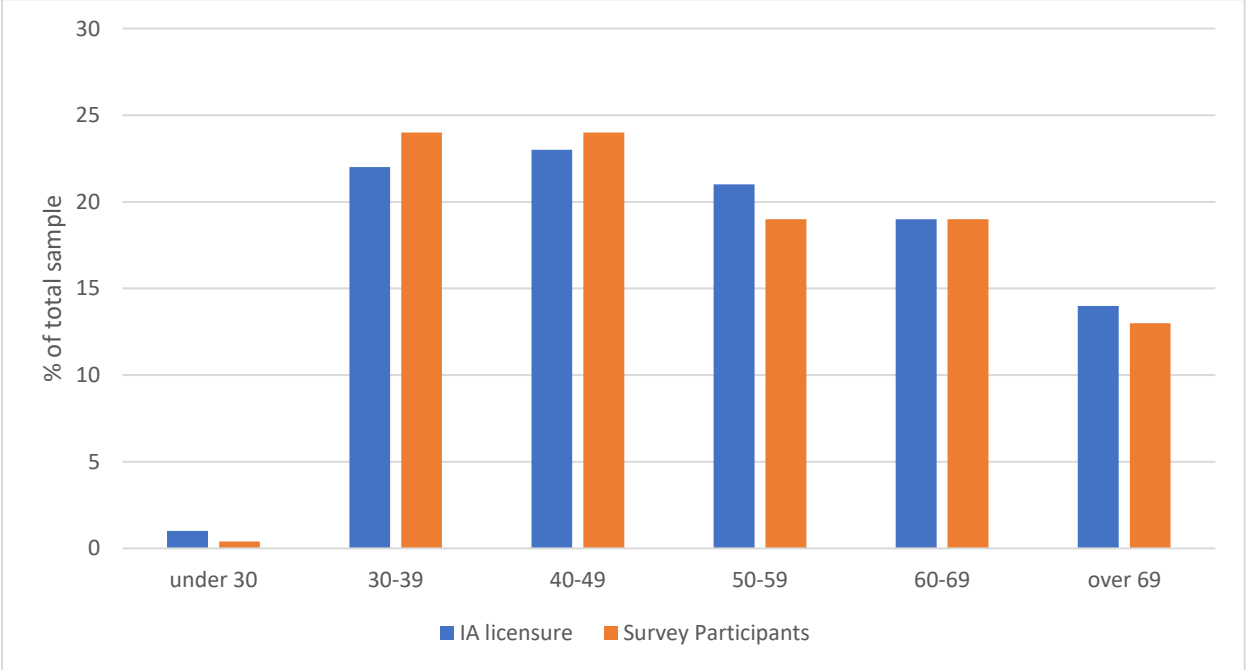


Figure 2: Age of Iowa active licensure compared to survey sample



Additionally, 50 respondents who identified as not being an "active" Iowa psychologist were removed from the sample. Specifically, eight participants were retired, 20 participants did not practice in Iowa despite holding a license in the state, 15 participants' primary roles were non-

clinical, and 7 worked at VA hospitals outside of Iowa. The remaining data analysis is based on the final sample of 255 participants who were considered "active" psychologists in Iowa at the time of survey completion

Geographic Region

Within our sample, 91% of participants resided in Iowa and 29% held licensure in additional states. In total, 24 different states other than Iowa were identified. The most common states were those that shared boarders with Iowa (Illinois = 18%, Nebraska = 15%, Wisconsin = 10%, Minnesota = 10%), as well as California (n = 13%).

Table 1 presents the counties psychologists serve. Survey results indicated psychologists primarily provide services in the center of the state, around the capital of Des Moines (Polk, Story, Dallas), and in the southeastern region of the state (Linn, Scott, Johnson), leaving much of the state with a potential shortage of providers. In fact, only 22% of respondents report that more than 50% of their clientele live in rural areas (see Figure 3), and only 27% report that the majority of their clientele travel 30 minutes or more for an appointment (see Figure 4). As of 2018, 35.7% of the Iowa population lived in rural areas (US Census Bureau, 2018). As such, the data suggest that psychologists who responded to our survey are providing services to rural individuals at a rate below the proportion of Iowans living in rural areas.

Table 1: Counties respondents serve

County	Rank in population	% of respondents (number in parentheses)
Polk	1	25% (n = 64)
Linn	2	7% (n = 17)
Scott	3	2% (n = 5)
Johnson	4	22% (n = 57)
Black Hawk	5	2% (n = 5)
Woodbury	6	4% (n = 9)
Dubuque	7	5% (n = 14)
Story	8	8% (n = 21)
Dallas	9	7% (n = 17)
Pottawattamie	10	1% (n = 3)

Figure 3: Percent of clients that are defined as "rural"

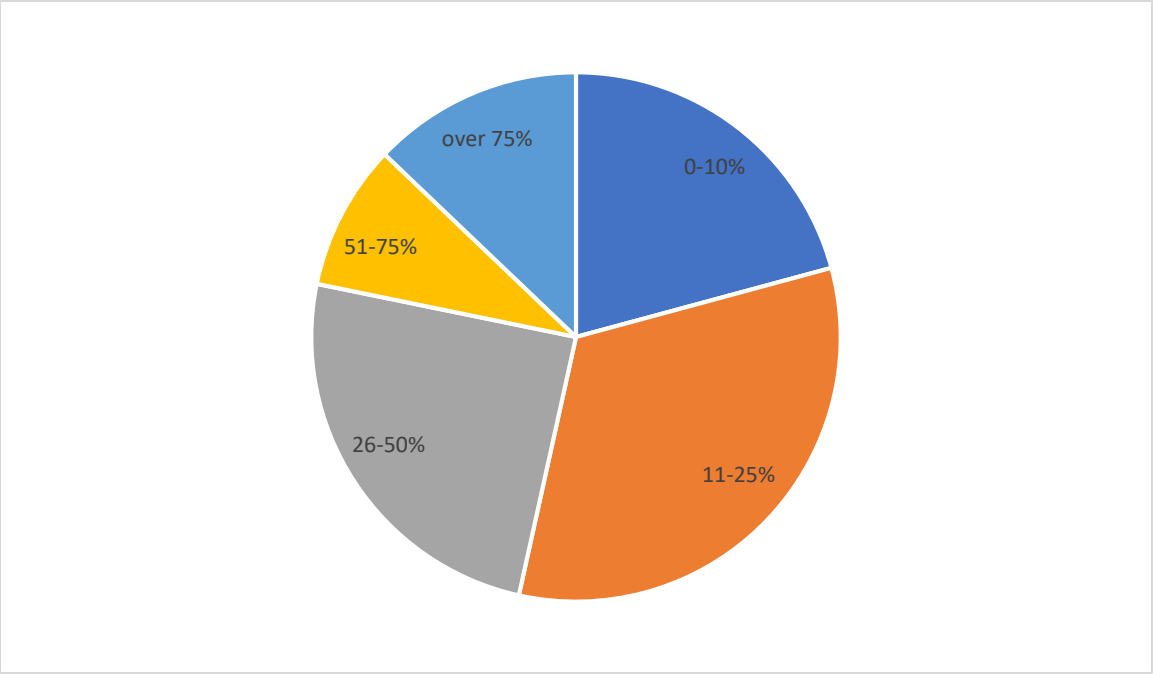
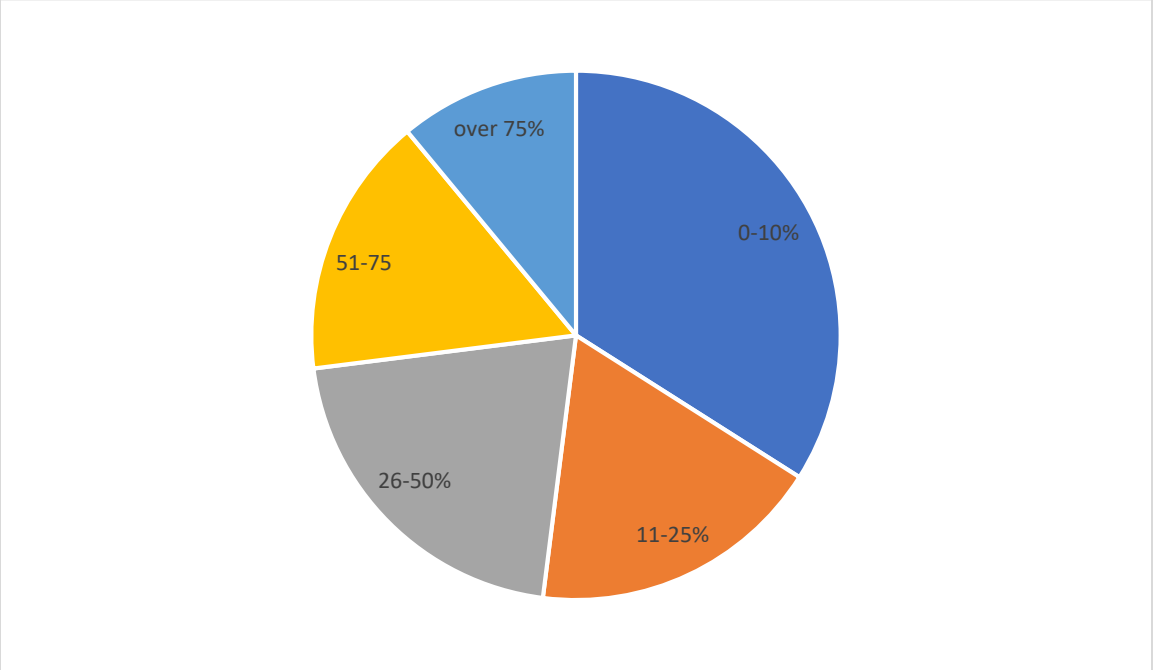


Figure 4: Percent of clients that travel more than 30 minutes for services



Age

The majority of psychologists in our sample were under 60 years of age (70%, se Figure 5) and indicated they do not plan to retire for at least 15 years (53%, see Figure 6). The previous survey suggested a "greying" of psychologists in the state (Kelly, 2006). Given that the current sample included only 38% of the licensed psychologists in Iowa, the results did not offer clarity regarding whether this trend continues.

Figure 5: Age and Gender of sample

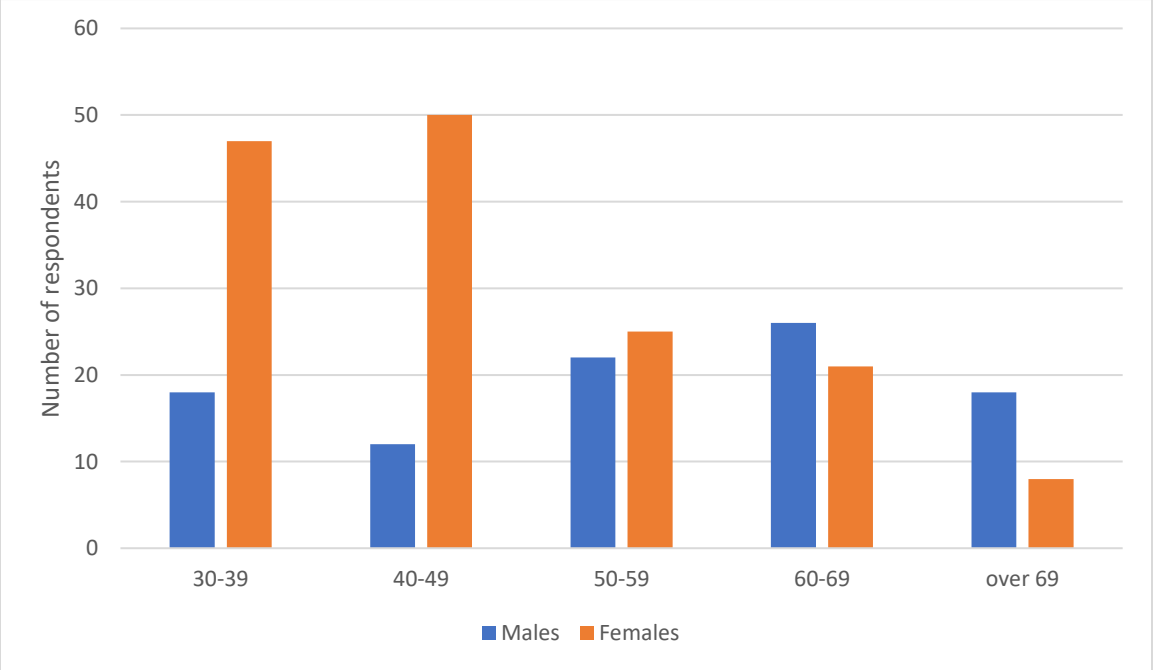
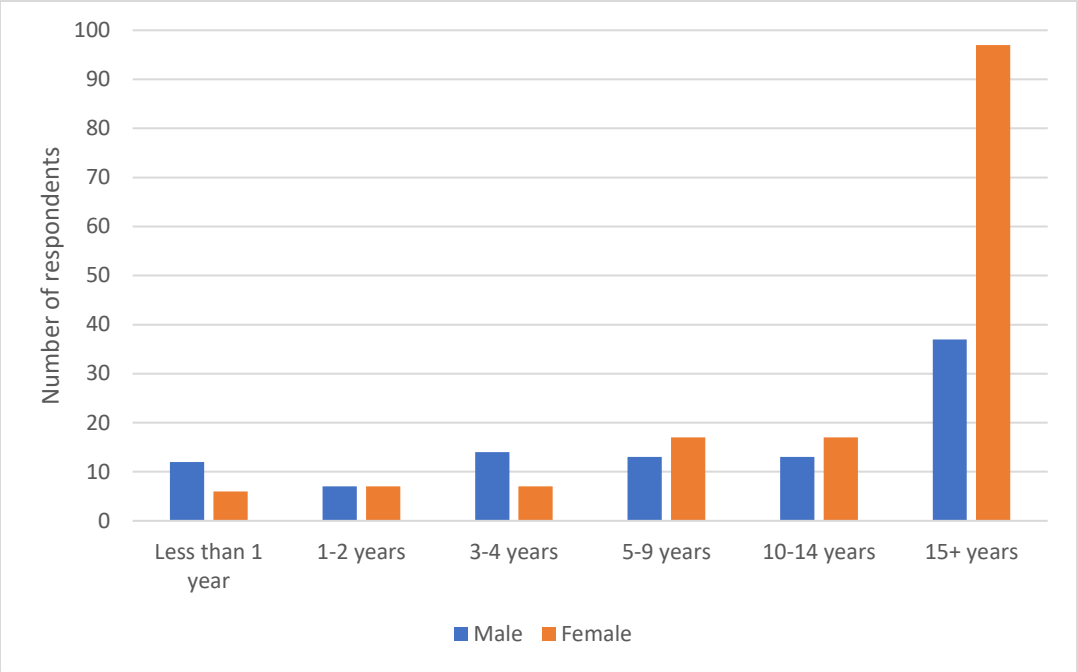


Figure 6: Time to retirement by gender



Gender, Race, Income

The majority of participants identified as female (60%) and White/Caucasian (93%). More than half of the participants reported making over $100,000 per year (56%). When income was broken down via race and gender, 58% of responders who identified as White/Caucasian and 50% of responders who identified as non-White (categories were collapsed together due to low numbers, n = 10) reported making over $100,000. In addition 52% of females reported making over $100,000 compared to 64% of males (see Figures 9 and 10).

Figure 7: Gender

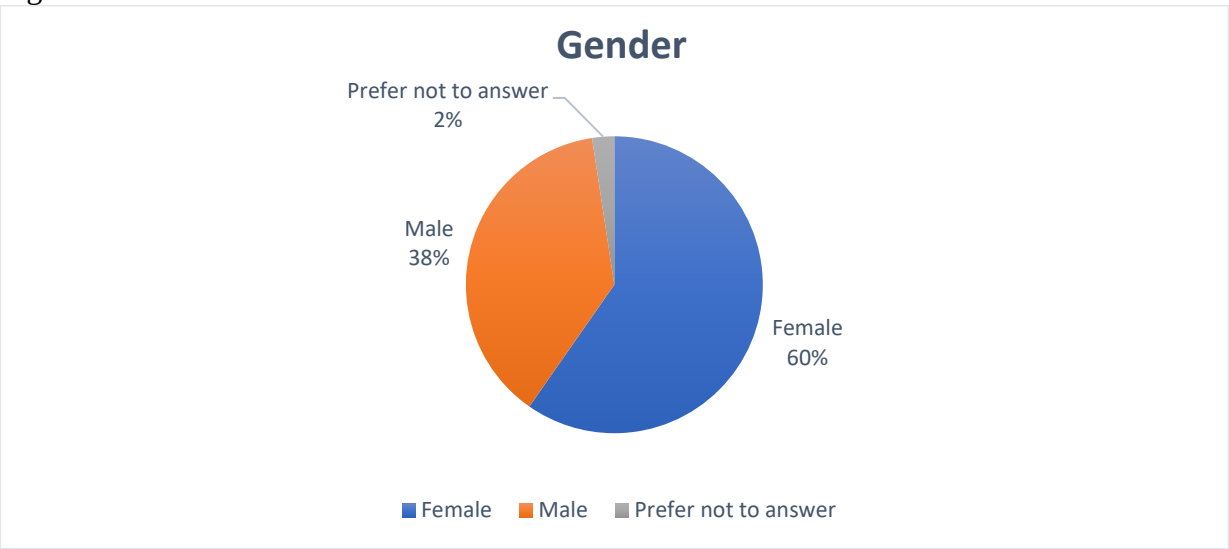


Figure 8: Race

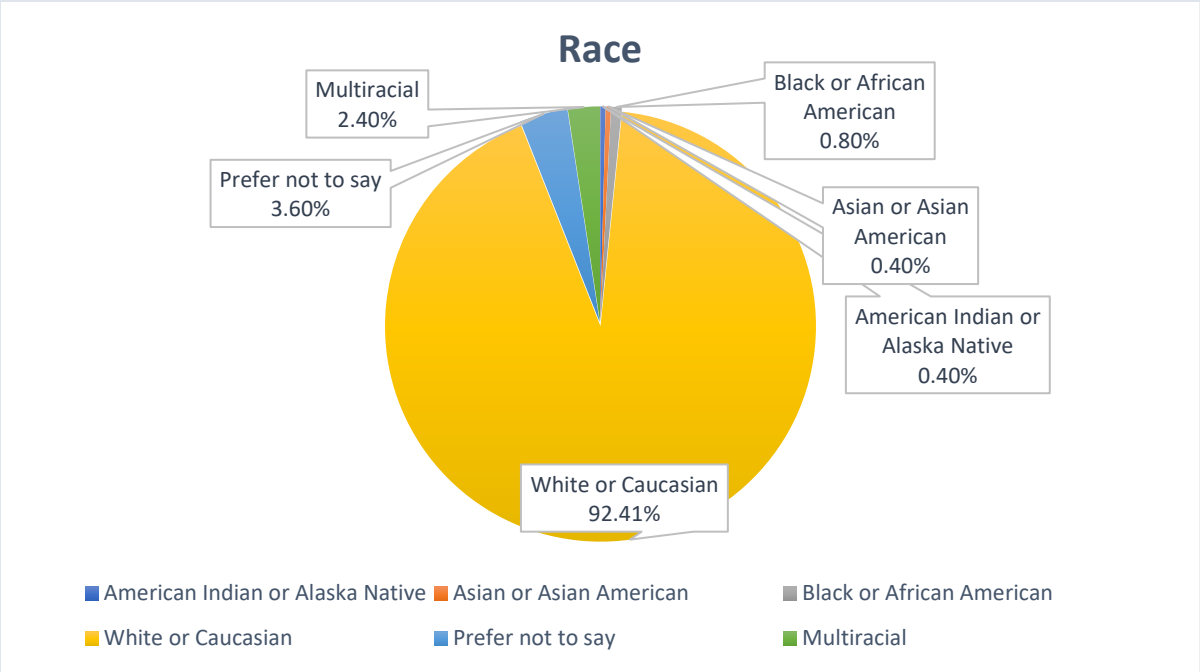


Figure 9: Income by Race

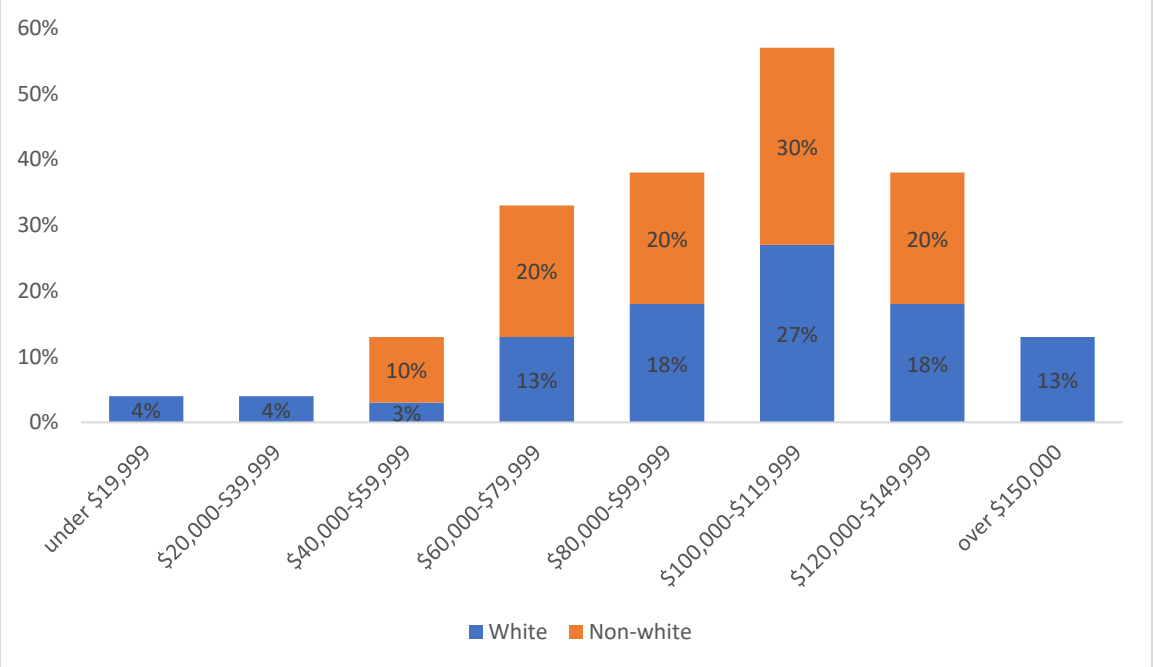
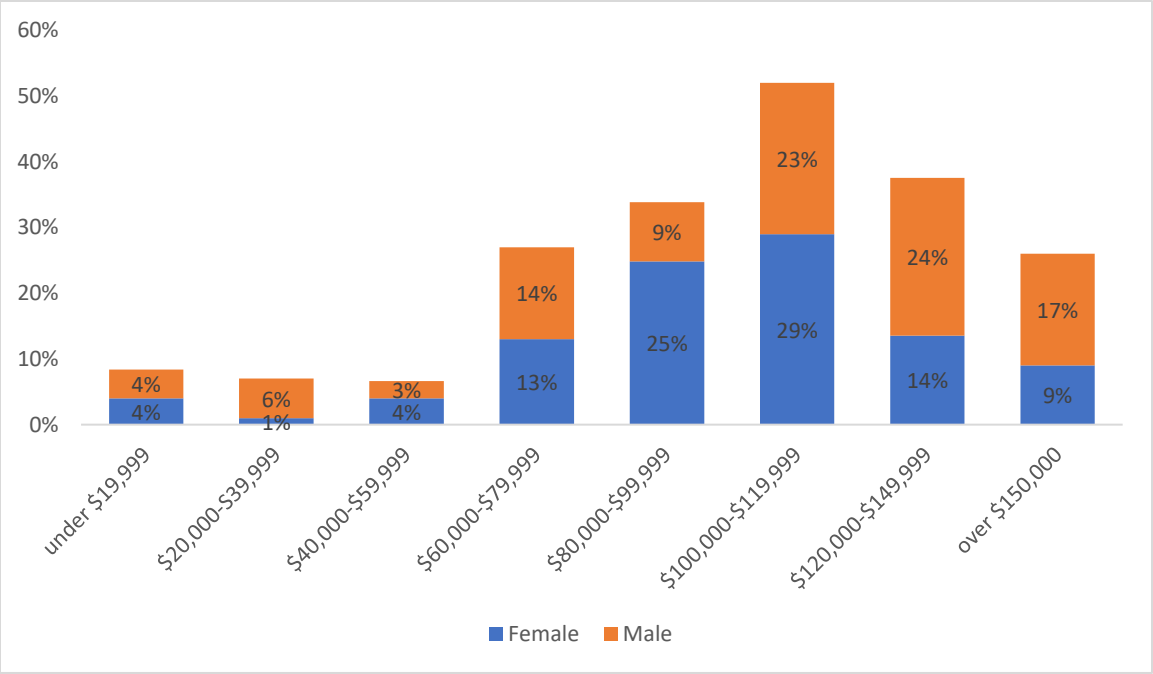


Figure 10: Income by Gender



Treatment

Survey respondents reported working in a variety of settings and with a variety of populations. Most respondents reported they are self-employed (49%), and/or salaried employees (45%), and the most popular primary work setting was an independent practice (49%, see Figure 11). The majority of respondents hold a health service provider certificate (84%) and reported that their common responsibilities include providing individual psychotherapy (85%), general assessment (53%), and consultation (40%, see Figure 12). The most common assessment practices reported were ADHD (46%), general diagnostic (44%), intellectual disability (40%), and personality (37%, see Figure 13). Popular primary practice areas reported by our survey respondents include depression (80%), anxiety/phobias (78%), mood disorders (73%), PTSD/trauma (59%), ADHD (46%), bereavement/grief (45%), and anger (40%). Although adults were the most common population served by the respondents (95%), 64% of the respondents reported serving adolescents, and 43% served children (see Figure 14). Additionally, other common populations served by survey respondents included people with disabilities (59%), people with medical conditions (50%), individuals who are at or above 65 years of age (50%), people who identify as LGBQ (49%), people who identify as transgender (40%), and Veterans (35%).

Less common populations served by respondents (less than 20%) included people with hearing/vision impairments (18%), indigent populations (14%), and the homeless (13%). Less common practice areas reported by respondents included pediatric psychology (20%), neuropsychology (20%), psychosis/serious mental illness (18%), divorce/co-parenting (18%), religious/spiritual concerns (18%), alcohol/drug abuse (16%), eating disorders (16%), forensic psychology (13%), gifted/twice exceptional (11%), perinatal mental health (8%), end of life care (7%), sexual abuse (offender, 7%), and rehabilitation psychology (5%).

When practice area and work setting were divided based on how close a respondent was to retirement, there was no setting or issue that included a large percentage of respondents planning to retire soon. In other words, based on the current sample, no practice setting, or specific presenting issue seemed to be facing a disproportionate loss of psychologists in the near future (i.e., 15 years). Results indicated the areas of practice that early career psychologists in our survey (i.e., those that have worked 5 or less years) are practicing mirrored the top practice areas of all psychologists in our survey (see Figure 13).

Figure 11: Primary employment of respondents

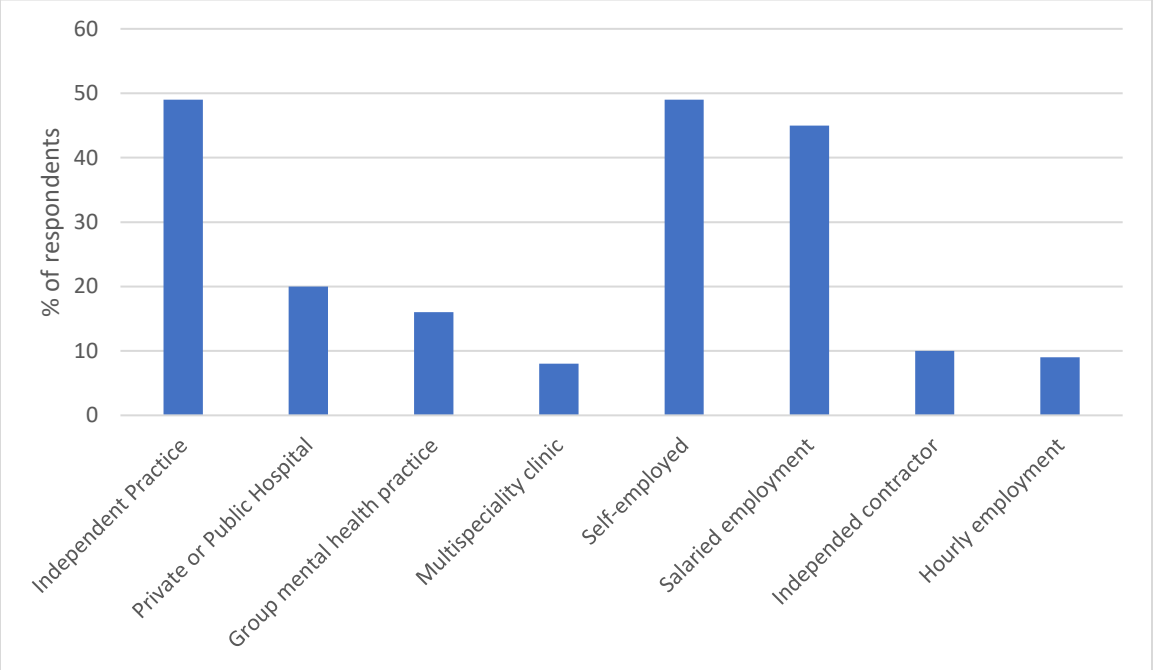


Figure 12: Primary responsibilities

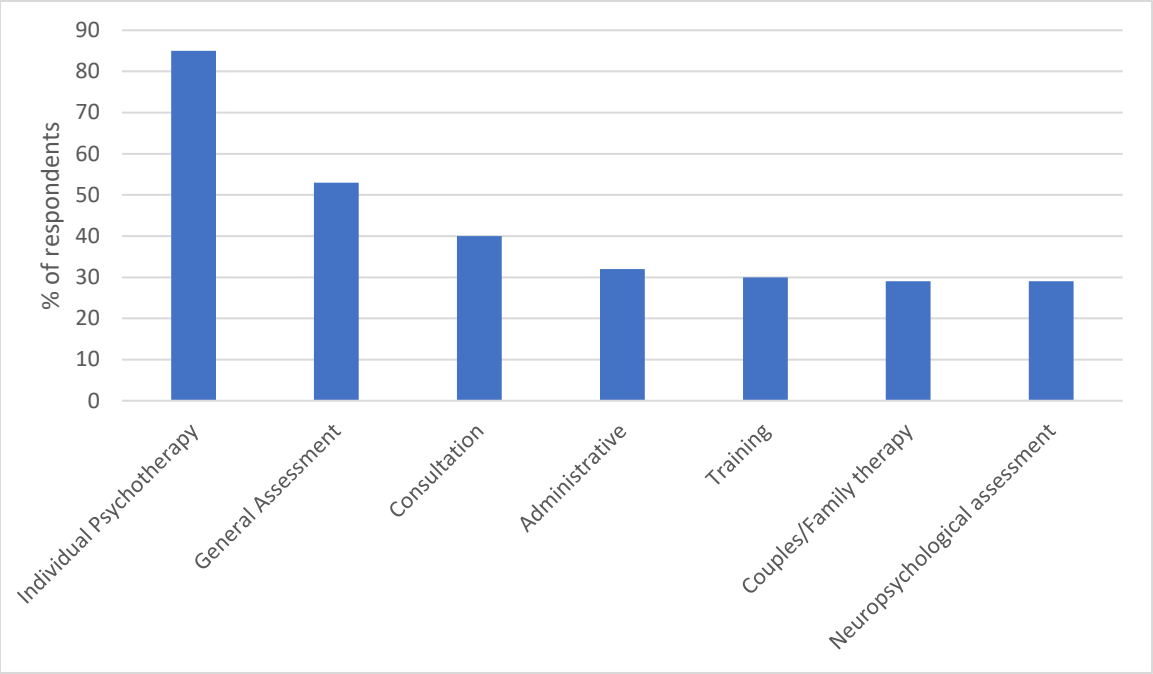


Figure 13: Primary Practice and Assessment Areas

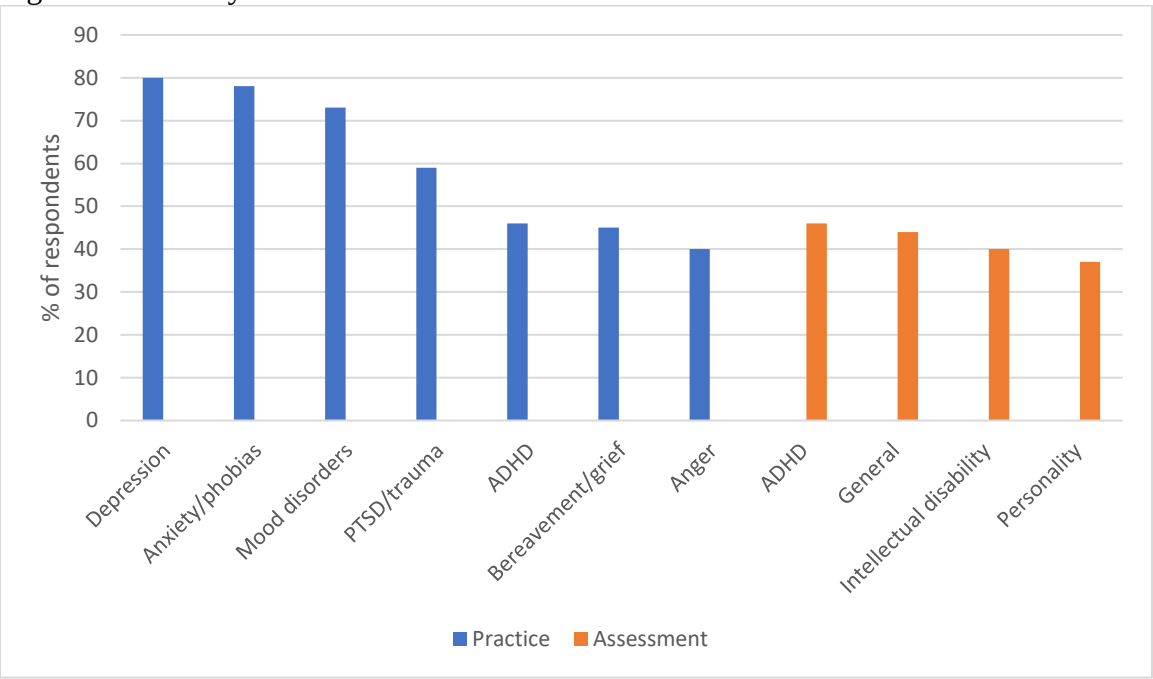


Figure 14: Primary populations served

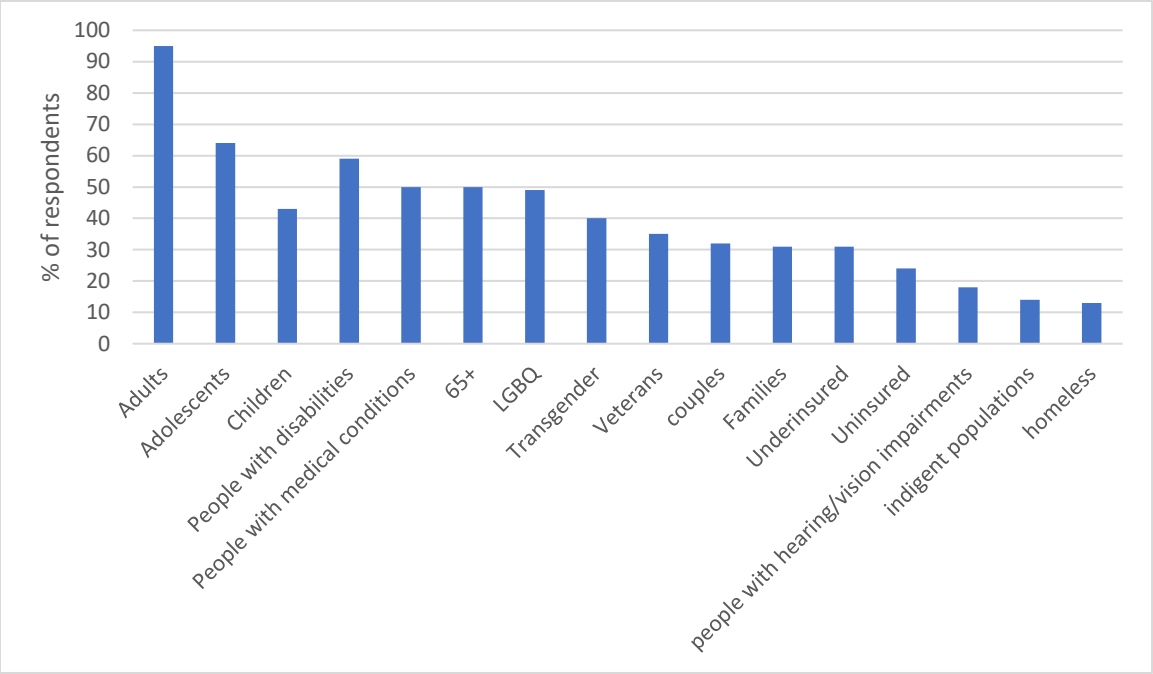


Table 2: Respondents treating medical conditions based on setting

Setting	number
Independent practice	45
community mental health	5
hospital	33
VA	11
Rehabilitation center	11
primary care clinic	3
school	2
community college	1
4 year college	2
state university	5
college counseling center	2
multispecialty clinic	14
group mental health	16

Billing

Participants reported an average of 22.3 (SD = 10.6) face-to-face client hours per week with a range from 0 to 55 hours. This data should be interpreted cautiously, however, as some respondents may have underreported client hours by not including telehealth appointments which were frequent due to the COVID-19 pandemic. The most common CPT codes billed were 90834, 45-minute psychotherapy (67%), 90837, 60-minute psychotherapy (66%), 90791, psychiatric diagnostic evaluation (56%), 90832, 30-minute psychotherapy (51%), 96130/96131, psychological testing (50%), and 96136/96137 psychological and neuropsychological testing (44%), mirroring the most common practices of psychologists (see Figure 15).

Interestingly, despite the finding that 48% of respondents reported working with persons with medical conditions and 24% reported health psychology as one of their primary practice areas, only 5% of respondents reported using the billing code for health and behavioral assessment and intervention. The most reported factor for selecting CPT codes was the description of the services (64%), followed by client diagnosis (36%), type of insurance (25%), reimbursement rates (20%), and the policies of the agency (12%).

Regarding reimbursement, over half of the respondents (64%) who bill insurance reported that they have concerns about reimbursement from both Medicaid and commercial insurance companies (see Figure 16). An additional 12% indicated they were only concerned with Medicaid reimbursement and 12% of respondents were only concerned about commercial insurance companies. Twelve percent responded that they have no concerns about reimbursement. Specifically, for the year 2020, 8% of respondents reported having problems with reimbursement from only Medicaid, another 10% from only commercial insurance companies, and 15% reported having problems from both (see Figure 17). Respondents indicated they were most commonly in-network with the following insurance carriers: Blue Cross/Blue Shield (70%), United Behavioral Health/Optum (49%), Medicare (46%), United Health Care (45%), Cigna (42%), and Medicaid: Amerigroup (40%).

Only a small percentage of our sample was in-network with Medicaid: fee-for-service (24%), Medicaid: Iowa Total Care (38%), and Medicaid: Amerigroup (41%). Of those who accepted Medicaid, 29% said that they limited their number of Medicaid clients. For those who indicated they do not accept Medicaid, 44% reported it was due to inadequate reimbursement rates, 17% reported it was due to slow reimbursement, and 15% reported it was due to agency or practice decision (i.e., not within their control).

Although several respondents reported they recognize the need to serve the Medicaid population, almost all of the respondents who limit their Medicaid clientele did so due to slow and low reimbursement and/or cumbersome regulations. Many respondents reported having issues with broken contracts with Medicaid and indicated their practice could not survive on Medicaid reimbursement rates (recall that 49% of the sample reported being in private practice). Many respondents also reported limiting or refusing testing with Medicaid clients due to the limited number of hours authorized for testing and, when approved, the reimbursement is often too low (14% of the open-ended responses addressed this issue specifically).

As expected, the most common policy/legislative change that could increase services to Medicaid clients were increased reimbursement (53% of open-ended responses), easier paperwork and fewer pre-authorizations (17%), and more adequate testing reimbursement (13%). Respondents also mentioned the need for timely reimbursement (4%), payment for no shows/cancellations (4%, since this population tends to be a higher risk of this), and greater regulation of Medicaid to be more collaborative with providers and uphold contracts (4%).

Finally, respondents also mentioned the need for full reimbursement of telehealth appointments (3%) which is particularly concerning based on the increased need for telehealth due to Covid-19 risks. In fact, when asked about global policy changes for all insurance companies, the need for full and continued reimbursement for telehealth appointments was the primary concern (36%) suggesting that regardless of insurance, this has been an issue.

Through open-ended questions, respondents also identified reimbursement as a major issue regarding insurance companies. Overall, they reported that reimbursement in general was low and not keeping up with inflation (19%). In particular, reimbursement was not adequate for testing (particularly for educational testing; 13%), and group therapy (3%). Many respondents pointed out that there was a need for more parity with the medical profession (8%), and treatment would be more efficient with consistency of reimbursement and guidelines between companies (12%). Respondents also discussed how interference from insurance companies and lack of reimbursement for certain diagnoses (i.e., autism spectrum disorder) hurts treatment (12%) and there is a need for safeguards for practitioners from unethical practices of insurance companies (3%). Inefficient and time-consuming paperwork for pre-authorization and continued treatment was also reported as a problem (14%).

Figure 15: Primary CPT Codes

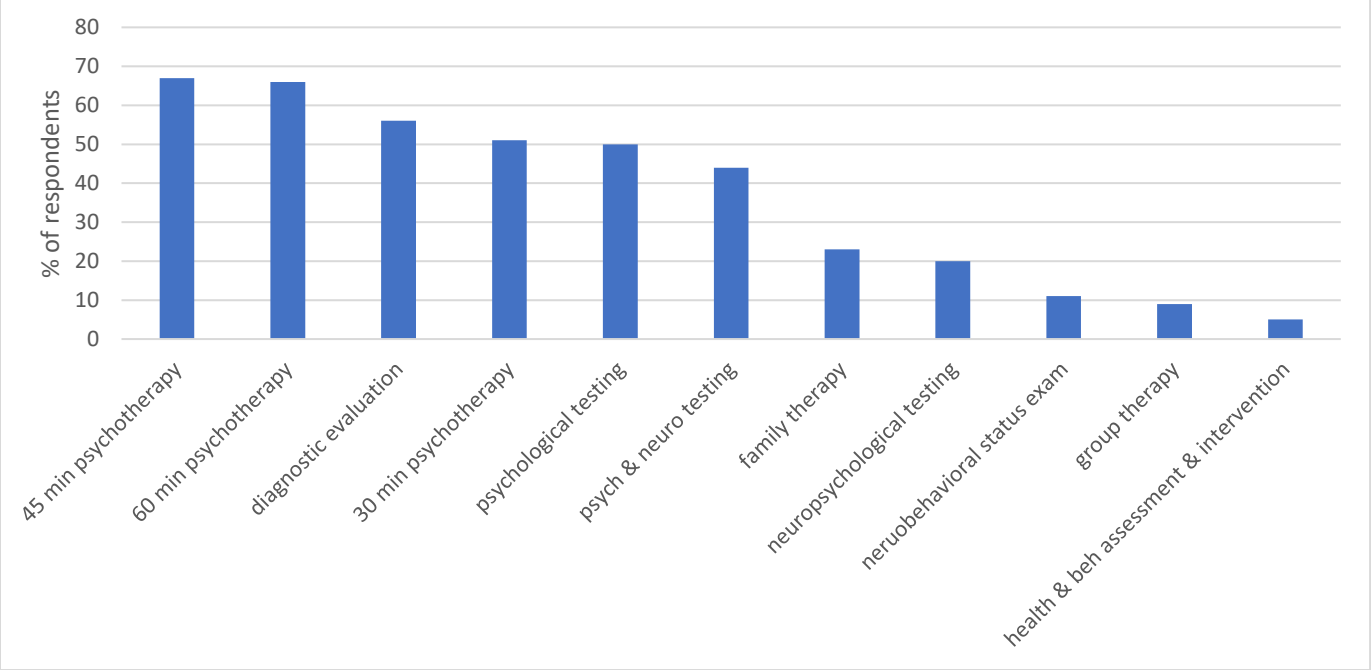


Figure 16: Concerns about reimbursement rates

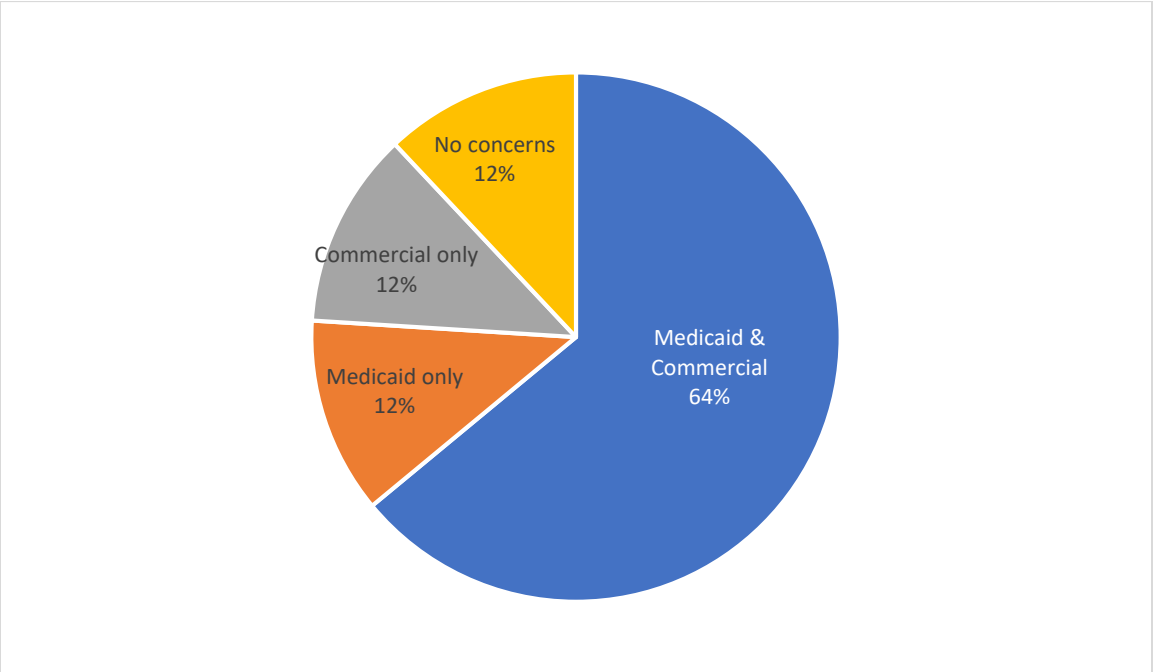
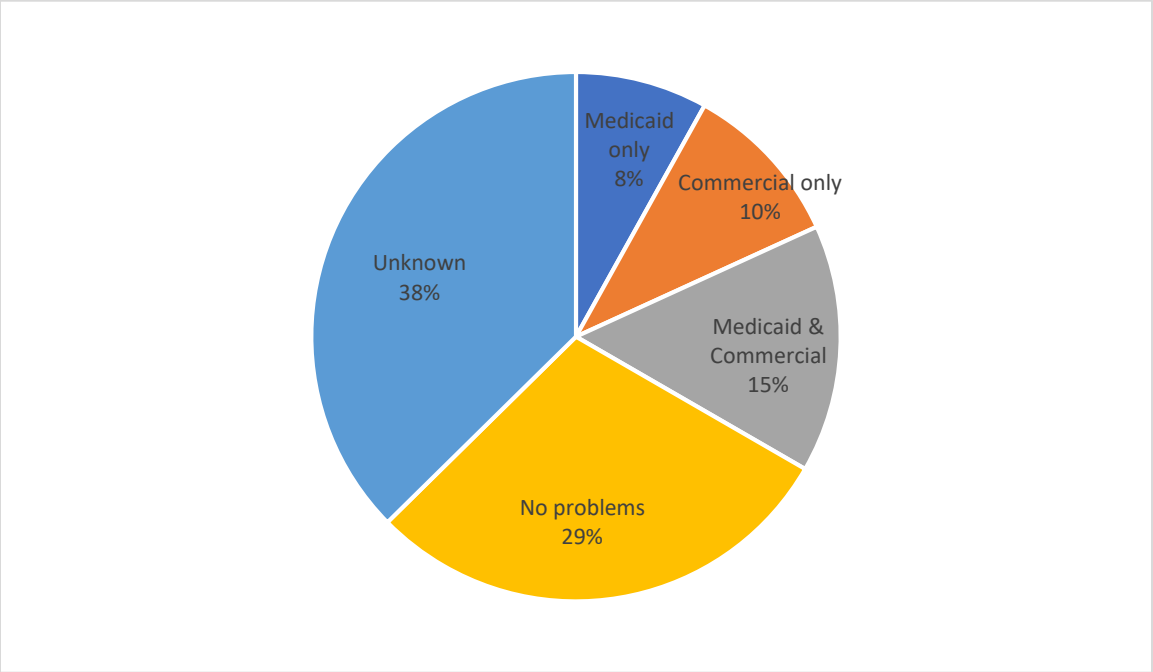


Figure 17: Problems with reimbursement in 2020



Covid-19 Changes and Telehealth Services

As expected, the most commonly reported changes during the Covid-19 pandemic were the use of telehealth therapy services (75%) and the use of protective barriers or personal protective equipment (PPE) when delivering in-person services (56%). Thirty-one percent of respondents indicated they offered assessment services via telehealth. Approximately one-third of psychologists reported that although their offices closed due to Covid-19, they were able to continue working from their offices (35%), while another one-fourth reported that they were required to work from home (23%). Of note, 34% of respondents reported that clients dropped out of treatment due to Covid-19 restrictions.

Even though telehealth services were prohibitive for some clients, over three-fourths of respondents (81%) said that they planned to continue utilizing at least some telehealth practices if insurance reimbursement would be equal to face-to-face appointments. Respondents noted the advantages to continuing to offer services via telehealth including increased access for rural populations, those with a physical disability, and the general "busy" clientele. A small percentage (12%) said that they will not use telehealth if they do not have to and another 6% were uncertain of their continued use of telehealth.

Well-being Interventions

Respondents reported that many of their clients struggle with social connections (78%), sleep (78%), diet (62%), and exercise (61%). As such, the majority of psychologists reported they "always" assess for all four issues: social connections (86%), sleep (83%), diet (62%), and exercise (60%). These four issues are also commonly addressed in treatment plans if appropriate, and the majority of psychologists reported that their clients tend to do better in these areas after treatment (see Table 3).

Another common well-being issue is medication adherence which is assessed at intake by 63% of respondents and included in the treatment plan by 46%. Additionally, 37% of respondents stated that their clients struggled with medical adherence, which was often better after treatment (44%). While most respondents indicated they assess for safety behaviors (67%) and domestic violence (67%) during intake and more than half of respondents include these areas in treatment planning (53%), these areas are not commonly reported as areas of struggle (30% for safety behaviors and 14% for domestic violence).

Respondents identified a number of unmet needs and health issues in their clientele including obesity (58%), chronic disorders (51%), access to affordable (49%) and quality (38%) healthcare within a reasonable distance (46%), and ability to pay for medication (41%). Although the most frequent obstacle to health and well-being in clients was internal motivation (76%), financial (69%), geographic (45%), and physical (44%) barriers were also commonly reported. Other obstacles included Covid-19 restrictions and language/cultural barriers. Most psychologists reported using a variety of methods to intervene in clients' physical health needs including referring them to other health professionals (75%), helping them obtain resources to address their

needs (42%), addressing factors related to physical health in the treatment plan (i.e., stress; 70%), and directly addressing physical needs in treatment plans (40%).

Table 3: Assessment and treatment of well-being issues

	During intake I always assess	My treatment plans often address concerns related to	Clients do better in this area of well-being after completion of treatment with me
Exercise	60%	46%	49%
Diet	62%	44%	44%
Sleep	83%	66%	69%
Medication adherence	63%	46%	44%
Social connectiveness	86%	76%	73%
Safety behaviors	67%	53%	56%
Domestic violence	67%	11%	18%

Professional Issues

Prescription Privileges

Ten percent (n = 23) of respondents reported an interest in prescription privileges training, however only 3% (n = 6) have started the training. Another 10 respondents indicated that they are unsure of whether they want to pursue training and five reported that they may in the future, but not now. The main barrier reported was problems obtaining supervision (30%). Based on open ended responses, time (6%) and cost (6%) were the most commonly reported barriers. Some respondents were also concerned with liability and lack of training (2%). Additional reasons cited for respondents' uncertainty of pursuing prescription privileges included confusion over policies (n= 3), concern for competence (n = 2), liability (n = 1), and not wanting to have more student loan debt (n = 1). Taken together, if the major barriers of availability, time and cost were mitigated, there may be more psychologists interested in training for Rx privileges.

Practicing in Iowa

The majority of respondents reported that they chose to work in Iowa because it is close to their family or friends (60%, see figure 18). Other important variables included quality of life (40%), cost of living (38%), opportunities for preferred type of employment (30%), being trained here (27%), having access to resources (15%) and opportunities to work with a particular clientele (15%). Additional reasons noted were outside factors (such as spouses' employment, 3%), identifying the need for practitioners in Iowa (1%), and the ability to seek prescriptive privileges (1%). Although the percentages were small, it is important to note that three people specifically stated that they chose to work in Iowa due to the prescription privilege opportunity.

The most common barriers reported to working in Iowa were the lack of diversity (43%), legislative barriers (28%), and being isolated from friends/family (15%, see figure 19). In open-

ended responses, participants reported issues with poor mental health services and/or professional identity (4%), low professional density (2%), and dominance of conservative political leanings (2%).

Figure 18: Reasons to live in Iowa

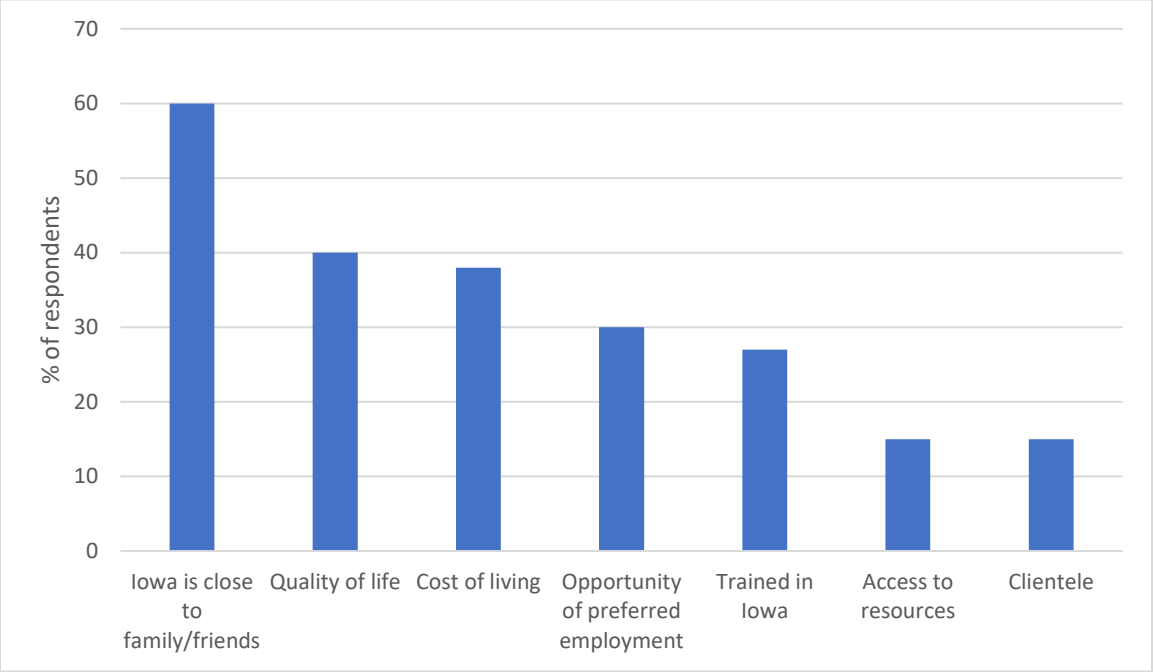
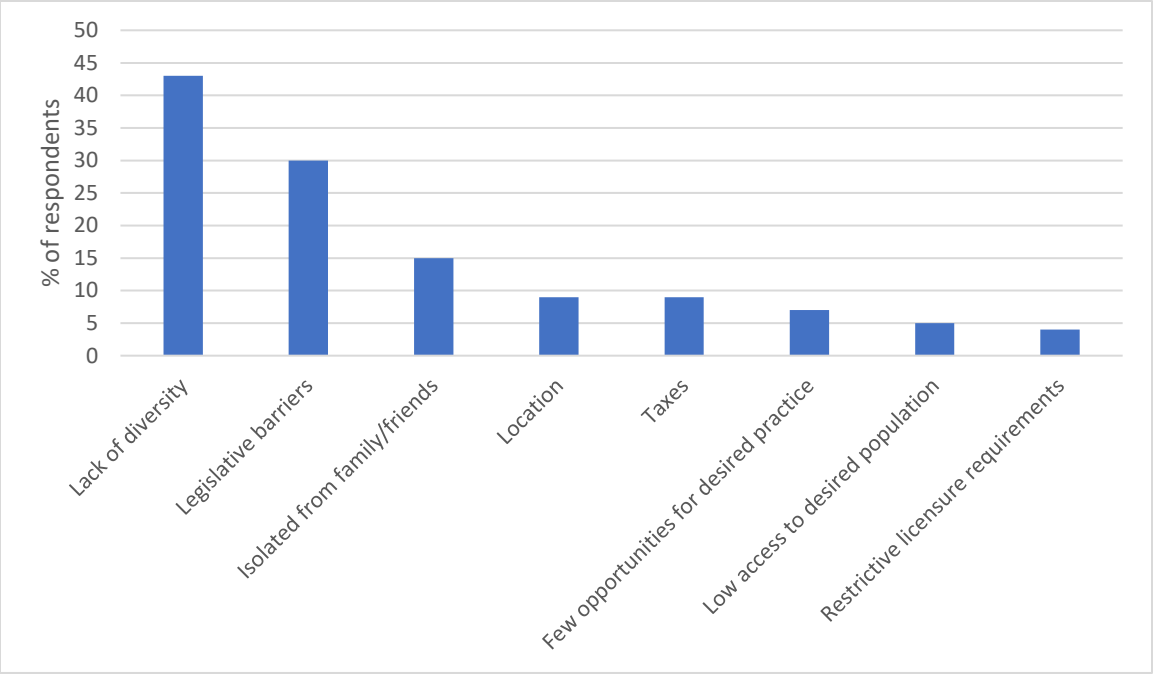


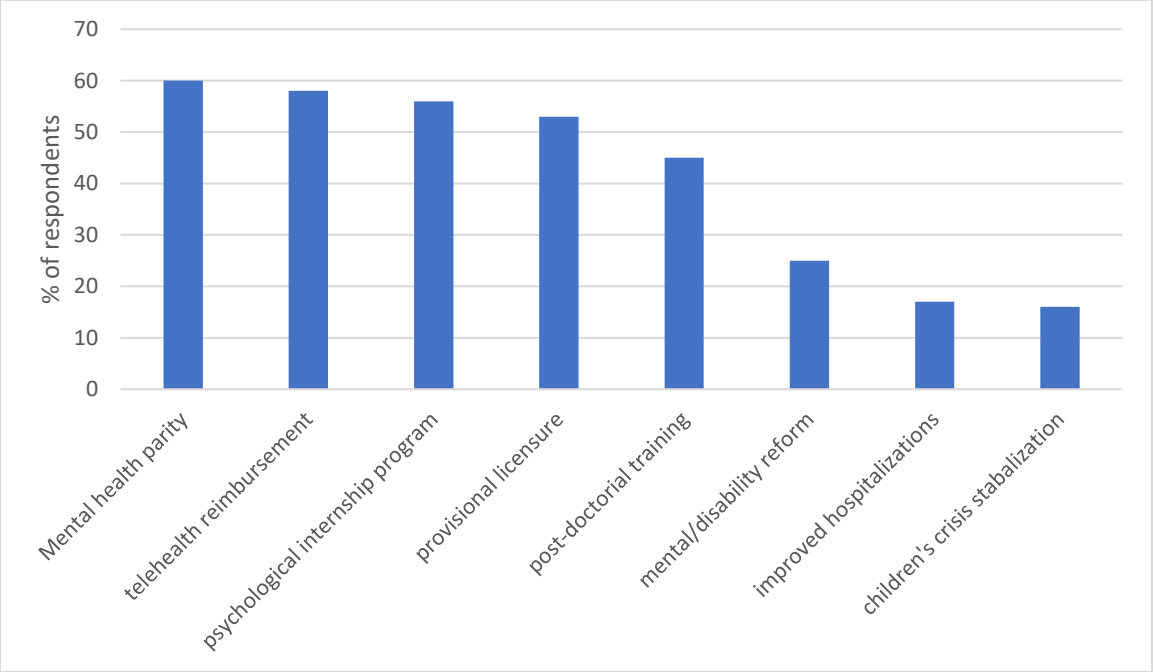
Figure 19: Barriers to living in Iowa



IPA and Organizational Membership

Only 43% of the respondents reported that they are current members of IPA, 19% are former members, and 24% have never been a member. The majority of the respondents were aware that IPA advocated for mental health parity (60%), telehealth reimbursement (58%), the creation of the psychological internship program (56%), and provisional licensure for post-doctoral trainees (53%, see figure 20). Less known advocacy by IPA included advocating for continued funding for post-doctoral training program (45%), securing Medicaid reimbursement for provisionally licensed post-doctoral psychologists (44%), mental health/disability services reform (25%), improved psychiatric hospitalization process (17%), and improved crisis stabilization programs for children (16%). Of note, a sizable number of respondents (30%) did not answer this question, which may suggest they did not know about IPA's role in advocacy or they chose not to respond to the question for other reasons.

Figure 20: Respondents' knowledge of IPA advocacy efforts



Key Findings, Recommendations, and Future Implications

The current survey examined psychologists' demographic characteristics, issues related to the business of psychology (e.g., billing/reimbursement), factors that influence the practice of psychology (e.g., delivering psychological services and access to care concerns), and how psychologists uniquely contribute to the well-being and public health of Iowans. The survey represents approximately 38% of Iowa license holders. Demographic information (e.g., residential status, age, gender) gathered from the survey were compared to demographic information obtained from the Iowa Department of Public Health. Comparison data were very similar, which suggests that the current sample of psychologists is fairly representative of the larger population of "active" psychologists practicing in Iowa. The following section outlines key findings, recommendations, and action items that can be taken to address the aforementioned areas.

1) Additional psychologists and psychological services are needed to treat rural Iowans in underserved areas. Most Iowa psychologists live in counties in the central (e.g., Polk, Story, Dallas) and eastern (e.g., Linn, Johnson, Scott) parts of the state and data suggest that psychologists are providing services to rural individuals at a rate below the proportion of Iowans living in rural areas. Results also suggest there are Iowans who do not have immediate access to psychological services due to a lack of psychologists living in rural areas. Innovative workforce development initiatives are needed to increase the number of psychologists who work and live in Iowa. There are a number of initiatives that could be explored to increase the psychologist workforce including incentivizing psychologists to work in rural and underserved areas, student loan repayment forgiveness/repayment, creating additional training opportunities for early career psychology psychologists, and creating a psychology training consortium.

2) Providing ongoing telehealth services is critical for Iowans in rural areas. More specifically, the enactment of tele-behavioral health policies at the state and federal levels, including audio only services, continues to be vital for individuals in rural areas to receive much needed psychological services. During the Covid-19 pandemic, of the majority of psychologists in the current sample used telehealth services and the vast majority of psychologists reported they would continue to utilize telehealth practices if insurance reimbursement were equivalent to face-to-face services. Individuals in rural areas often lack access to broadband services and they often identify as lower income, disabled, and racial or ethnic minorities. Addressing these barriers will ensure vulnerable Iowans in rural areas will receive the critical psychological services that they require.

3) Resources are needed to build the psychology workforce by training future psychologists to live and practice in Iowa. Previous survey data suggested there was a "graying" of psychology in Iowa (Kelly, 2006). Results from the current survey indicate that the majority of the sample was under the age of 60 and do not plan to retire for at least 15 years. This is an encouraging finding and may lend support to some of the recent initiatives that have been put into place to train psychologists to live and work in Iowa. Since 2008, the IPA Training Program and other entities have trained 48 psychologists and approximately 80% have continued to work and live in Iowa. In recent years, the number of post-doctoral fellowships has increased by 42%, in part due to

licensed psychologists being able to bill services provided by provisionally licensed psychologists.

Additional funding is needed to further expand training opportunities for psychologists in Iowa including post-doctoral training programs and exploring the creation of a pre-doctoral psychology internship consortium. Because relatively few training opportunities exist, many students from doctoral programs at the University of Iowa and Iowa State University complete their training out of state. Trainees may end up accepting a full-time position at the same institution where they completed their internship or fellowship. Building an internship consortium would provide additional training opportunities for students in Iowa's doctoral programs and help recruit out-of-state trainees to Iowa. Last, it may be advantageous to explore possible legislative changes that would allow pre-doctoral interns to obtain a provisional license which would allow them to bill their services under a licensed psychologist.

4) There is a need to recruit psychologists from diverse backgrounds to work and live in Iowa. For example, US Census (2019) data indicated that 4.1% of the population in Iowa identify as Black or African American compared to just .8% of psychologists from the current survey. Additional initiatives are needed to recruit psychologists from diverse backgrounds and educate the psychology workforce regarding issues of diversity, equity, and inclusion (DEI). Also, survey data revealed that 43% of respondents cited the lack of diversity in Iowa as a potential barrier to working in Iowa.

Recently, the Iowa Psychology Association lobbied national lawmakers to increase appropriations for critical psychology workforce training program. The Minority Fellowship Program (MPF) provides funding for training, career development, and mentoring for mental and behavioral health professionals to work with ethnic minorities. This program focuses on training students, including postdoctoral residents, to be culturally competent to work with minorities in underserved areas. It is strongly recommended Iowa establish additional funding opportunities to increase recruitment and retention of ethnic minority psychologists and to continue to train psychologists regarding DEI issues.

5) Iowa psychologists are essential to the healthcare workforce by treating numerous mental health conditions in a variety of settings. Survey respondents most commonly cited treating depression, anxiety/phobias, mood disorders, posttraumatic stress disorder (PTSD)/trauma, bereavement/grief, and attention-deficit/hyperactively disorder (ADHD). Opportunities exist for psychologists to expand psychological services for patients presenting from historically disenfranchised backgrounds (e.g., indigent, homeless) and other specialty areas (e.g., pediatric psychology; neuropsychology; psychosis/serious mental issues; and alcohol/drugs abuse). Additionally, half of survey respondents reported treating individuals with medical conditions in 13 different practice settings across Iowa. This finding demonstrates the important work that psychologists are doing to address co-occurring mental and medical conditions across healthcare settings. Furthermore, there are several practice areas within health psychology that were under-represented in the survey (e.g., eating disorders; perinatal mental health; end of life care, and rehabilitation psychology). Future initiatives should focus on strengthening psychologists' presence in integrated healthcare settings (e.g., hospitals; primary-care clinics; skilled nursing facilities) and create new opportunities (e.g., practicums, internships, and post-doctoral

fellowships) to further support the important roles that psychologists play in addressing biological, psychological, and social issues in relationship to health.

6) Health Behavior Assessment and Intervention (HBAI) services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment/management of patients diagnosed with physical health problems (APA, 2020). These codes capture services related to physical health such as patient adherence to medical treatment, symptom management, health-promoting behaviors and increasing motivation to make behavioral changes, health-related risky behaviors, and adjustment to physical illness. However, a paucity of Iowa psychologists reported using HBAI codes even though 48% of respondents reported working with persons with medical conditions and 24% reported health psychology as one of their primary practice areas. It is likely that psychologists do not regularly use these codes because of low or no reimbursement. If psychologists readily used these codes, more Iowans would receive important services to address psychological factors that impact medical conditions. Additional advocacy work is needed at the federal and state levels to address barriers (e.g., reimbursement) for psychologists to use HBAI codes.

7) Psychologists are highly skilled health service providers who have expertise in conducting psychological assessments. Over half of the respondents reported doing some type of assessment in their clinical practice including assessments for ADHD, general diagnostic, intellectual disability, and personality. Respondents noted that reimbursement was not adequate for assessment, and in particular, educational testing. It is likely that more psychologists may conduct assessments if reimbursement rates were greater. Conducting assessments is a highly specialized skill set of psychologists and continuing to advocate for reimbursement for assessment services is paramount.

8) Iowa psychologists indicated a concern about reimbursement, and in particular, Medicaid. Over half of the respondents who bill insurance reported that they have concerns about reimbursement from both Medicaid and commercial insurance companies. Only a small percentage of the sample reported being in-network for Medicaid. A third of survey respondents who accept Medicaid reported they limit the number of clients they see due to a number of issues, including inadequate and slow reimbursement. Results suggest there are numerous barriers for individuals identified as low income, disabled, children, and elderly to receive care in Iowa, and such barriers need to be addressed.

9) Psychologists play an essential role in the public health of Iowans by enhancing physical and psychological well-being. Results suggest psychologists frequently assess and address issues related to social connections, sleep, diet, exercise medication adherence, safety behaviors, and domestic violence. Moreover, psychologists often use a variety of methods to intervene to address clients' physical health needs including referring them to other health professionals, helping them obtain resources to address their needs, addressing factors related to physical health in the treatment plans. Even with the plethora of research demonstrating the benefits of psychological interventions (Nathan & Gorman, 2015), there continues to be significant stigma and barriers associated with receiving such services. The general public and other healthcare professionals may benefit from receiving education regarding the multitude of psychologists'

roles and responsibilities. This could be accomplished through a public education campaign or targeted education for healthcare professionals highlighting the various roles of psychologists.

10) There are a number of psychologists in Iowa who are interested in pursuing prescription privileges. It will be important to provide Iowa psychologists education about prescription privileges and address potential barriers (e.g., supervision) to obtaining this certification in Iowa. Additionally, there is evidence to suggest that a handful of psychologists specifically chose to live and practice in Iowa because of the ability to prescribe. It may be beneficial to explore a targeted campaign to inform early career psychologists of the potential benefits (e.g., quality of life; cost of living; having access to resources) and opportunities of living and practicing in Iowa, including prescribing.

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