2021

Recommendations for Priorities to Support National Health Service Corps Efforts to Address the U.S. Health Care Workforce Shortage 2021-2023

NATIONAL ADVISORY COUNCIL ON THE
NATIONAL HEALTH SERVICE CORPS

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NACNHSC serves as a forum to identify priorities for the NHSC and bring forward and anticipate future program issues and concerns. The Council functions as a sounding board for proposed policy changes by using the varying levels of expertise represented on the Council to provide advice on specific program areas and ongoing initiatives. In addition, NACNHSC develops and distributes white papers and briefs discussing issues and concerns relating to the NHSC with specific recommendations for necessary policy revisions.

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Sincerely,

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Executive Summary

In its capacity as a sounding board for policy, the National Advisory Council on the National Health Service Corps (NACNHSC) has identified key priorities for supporting HRSA's Bureau of Health Workforce (BHW) core aims of increasing access to health care, increasing the health workforce supply, improving the distribution of the health workforce, and improving the quality of the workforce and health care. To this end, NACNHSC recommends support for programs, policies, and initiatives that 1) facilitate use of telemedicine, 2) increase health care providers' ability to leverage community resources, 3) expand and enhance processes to support timely and practical designations for health professional shortage areas (HPSAs) and maternal care target areas (MCTA), and 4) encourage sites to address health care provider well-being, resilience, and burnout.

Telemedicine increases access to primary and specialty health care by reducing travel burden and supporting communication across long distances. It expands workforce capacity and increases distribution equity by facilitating reach to remote or underserved communities. It can improve care quality by improving timeliness, care integration, and ability to obtain a second opinion, though research indicates a need for further assessment of factors affecting telemedicine's impact on quality as well as efforts to ensure equitable access to telemedicine.

It is imperative to acknowledge social determinants of health as major predictors of population health outcomes. It also is critical to acknowledge as the collective capacity of health care providers, community partners and other stakeholders to leverage assets that are critical for effective and sustainable practice in rural and underserved communities.

Ongoing efforts to reassess and update designations of priority areas in need of health care providers are essential for improving health workforce distribution. It is critical for designation processes to include obtaining stakeholder input and focusing on equity especially in critical areas of mental health and maternal health.

Providers in primary shortage areas are likely to be more isolated, have limited resources, and to manage patients with higher burden of disease. Supporting health care provider resilience and well-being is essential for recruitment and retention in areas with greater health care need. Supporting provider resilience and well-being is critical to achieve BHWs core aims. Research indicates that strategies to mitigate burnout should be addressed at the organizational or systems rather than at individual level.

Addressing each of these priorities will facilitate progress toward achieving BHW's core aims as well as NHSC's mission to support qualified health care workers in serving areas with limited access to health care.

Recommendations

NHSC participants are required to serve in HPSAs; the program is a core element of strategies to make health workforce distribution in the U.S. more equitable. As part of NACNHSC's support for these strategies, the Council recommends support for new and ongoing initiatives, programs, and policies that:

Recommendation 1: Deploy telemedicine training, equipment, and technologies that facilitate continuity of care, address social determinants of health, and otherwise support NHSC to reduce workforce distributional imbalances.

Recommendation 2: Promote engagement between NHSC participants and community partners, to coordinate resources that address social determinants of health.

Recommendation 3: Affirm efforts to modernize and validate Health Professional Shortage Area (HPSA) and Maternity Care Target Area (MCTA) designations.

Recommendation 4: Affirm evolving and ongoing efforts to promote recruitment and retention by supporting clinician resiliency at NHSC sites.

Introduction

NACNHSC supports the Health Services and Resources Administration (HRSA) Bureau of Health Workforce (BHW) core aims for its programs, which are to 1) increase access health care, 2) increase the supply of health workers to meet the demand for care, 3) improve distribution of the health workforce to be more equitable, and 4) improve the quality of the health workforce and the care they provide. The Council has identified four priority areas that will facilitate NHSC in supporting these aims and meeting NHSC's mission to "build healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care." These priorities are: 1) use of telemedicine, 2) applying community-centered approaches to health, 3) updating and validating Health Professional Shortage Area (HPSA) and Maternal Care Target Area (MCTA) designations, and 4) supporting resilience among providers who serve high-need communities. This report presents the recommendations we make for each of these priority areas, summarizes the research providing the rationale for each recommendation, and describes how recommendations link to NHSC work and BHW aims.

Recommendation 1: Deploy telemedicine training, equipment, and technologies that facilitate continuity of care, address social determinants of health, and otherwise support NHSC to reduce workforce distributional imbalances.

HRSA defines telemedicine and telehealth as, "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration." (HealthIT.gov, 2020). Non-digital telephones as well as digital technology support telemedicine. Telemedicine applications include document sharing, telemonitoring, clinical encounters and consultation between patients and care providers, consultations between care providers, and telementoring.

While telemedicine offers significant advantages to both patients and health care providers, patients in underserved communities often lack smartphones, internet access, and computers (Roberts & Malhotra, 2020; Chunara, 2021), thus limiting its widespread adoption benefits. People who are African American, Hispanic, lower income, lower education, older than 85 years, or have a disability are less likely than others to have access to a computer or smartphone with internet access (Roberts & Mehotra, 2020). Chunara et al. (2021) assessed electronic health records of patients in a large New York city health system and found that African American patients had less access to telemedicine than White patients. The Federal Communications Commission identifies lack of broadband access as a major problem for rural residents, nearly one-third of whom do not have access to broadband internet in their homes. (Roleff, 2021).

Telemedicine: Increase Access to Health Care

Telemedicine increases access to primary and specialty health care by reducing patients' travel burden and supporting communication between patients and providers, and between members of health care teams across long distances. Telemedicine is a central component of the Centers for Disease Control and Prevention (CDC) framework for providing health care (CDC, 2020) because it allows remote access. This advantage of telemedicine has been recognized since before the COVID-19 pandemic, with Rural Healthy People 2020 (Bolin et al., 2015) noting telemedicine's contributions and potential for facilitating care to patients in rural and remote communities. A few examples of many efforts that use telemedicine to increase access to care are: American Cancer Society's Quit for Life, a web- and telephone-based tobacco cessation intervention (Optum, 2016), remote therapy for rural patients (Bolin et al., 2015), and emergency medicine and stroke neurology care for rural hospitals and clinics in Mississippi (University of Mississippi Medical Center, (n.d.). The Centers for Medicare and Medicaid Services (CMS, 2020) identifies telemedicine as an important strategy for increasing rural communities' access to

maternal health care, noting examples such as the Babyscripts Diabetes Program to monitor blood sugar among women at risk for gestational diabetes, the Live Online program to connect pregnant women with specialists, such as mental health care providers and lactation specialists, and the U.S. Department of Health and Human Services' Text4baby app that provides information about topics related to healthy pregnancy and infant health.

Source: https://news.careinnovations.com/blog/policymakers-broadband-funding-key-to-bringing-telehealth-access-to-rural-areas

Telemedicine: Improve Supply Balance and Distribution Equity

Several studies have demonstrated that telemedicine improves workforce supply balance and distribution equity by facilitating reach to remote or underserved communities. For example, Toledo et al. (2014) demonstrated effectiveness of the Telemedicine for Reach, Education, Access and Treatment (TREAT) model for diabetes care, in which rural patients visited a local nurse educator who linked them to an urban-based endocrinologist via teleconference.

The California Virtual Dental Home project applies telemedicine to support dentists in providing remote supervision of dental hygienists and dental assistants who provide preventive and early intervention treatment and forward records for dentist review (Glassman et al., 2014). Project Extension for Community Health Outcomes (ECHO) is a tele-mentoring model that allows specialists to teach community providers about a broad range of topics, including maternal care, opioid addiction, HIV, mental illness, and cancer (RWJF, 2021).

In addition, telemedicine facilitates equitable health workforce distribution by making practice in underserved communities more attractive. Potter et al. (2014) conducted a survey and interviews with 292 clinicians and administrators of 16 rural hospitals. A large majority of participants (82%) indicated that availability of tele-emergency services contributed to recruitment and retention. By providing opportunities to communicate, connect, and collaborate with colleagues, telemedicine reduces isolation and workload, which has helped to prevent provider burnout and increase retention in underserved communities (RHI Hub, 2021).

Telemedicine: Increase Health Care Quality

Several studies have demonstrated telemedicine's potential to improve multiple aspects of health care quality, such as provider timeliness, communication, collaboration, and supporting continuous monitoring of chronic condition symptoms. McLean et al. (2013) conducted a systematic literature review that found telemonitoring reduces frequency of hospitalization for chronic heart failure, chronic respiratory conditions, and diabetes. A systematic review of telemedicine consultations for acute and chronic conditions found that intensive care unit telemedicine consultations reduce mortality, and specialty care telemedicine consultations reduce time in emergency care (Totten et al., 2019). In a study of 71 remote hospitals, 95 percent of clinicians and administrators agreed that tele-emergency services improved care quality at their facilities, specifically noting improved timeliness, care integration, and ability to obtain a second opinion (Mueller et al., 2014). Telehealth also facilitates patients in visiting their primary care providers after hours to address urgent care needs, which supports continuity of care, convenience, and lower costs (Barthelemy, 2021). Telemedicine supports smaller practices in sharing and coordinating resources to optimize care and increase efficiency (Pan American Health Organization, 2016)

Limitations to Consider

Researchers advise that telemedicine does not always improve care quality and that it is important to define measurable standards for telemedicine and to consider when in-person care is necessary (AHRQ, 2019; Ray et al., 2019; McLean et al., 2013). In addition, hospitals and health systems are often major rural employers, critical for local economies. Telemedicine may contribute to rural hospital closures, with associated job loss and economic losses (Davis, 2015). Telemedicine services do not replace access to critical and time-sensitive healthcare services, such as emergency trauma care and safe obstetrical delivery. In addition to ensuring equitable access to telemedicine, systems also must support equitable access to necessary in-person care (Esposito, 2020). As telemedicine utilization increases, many stakeholders, including the American Telemedicine Association, the Joint Commission, and State legislatures, call for establishing standards for telemedicine (Schinasi & Lo, 2019). Research demonstrates that standards for telemedicine practice are associated with better health outcomes (Wasson, 2020). NACNHSC supports efforts that assess and address telemedicine's limits, and work to overcome the digital divide while realizing the potential of telemedicine to improve health care quality. These efforts should include establishing evidence-based standards of care for telemedicine.

Conclusions

Based on the evidence for telemedicine as a resource that will support NHSC in reaching communities most in need of care, and in supporting efforts to achieve BHW's core aims, NACNHSC recommends providing NHSC participants and sites with telemedicine training,

equipment, and technology to address social determinants of health, support continuity of care, and improve distribution of the health workforce. NACNHSC also supports continuing Centers for Medicare and Medicaid payment parity for telemedicine after the COVID-19 public health emergency resolves.

Recommendation 2: Promote engagement between NHSC participants and community partners to coordinate resources that address social determinants of health.

Ability to leverage limited financial and community resources to improve patient and community health outcomes is a critical skill for health care providers who practice in HPSAs. Research indicates that only between 10 and 20 percent of population health changes are due to health care, with approximately 40 percent accounted for by social determinants of health, including ability to pay for health insurance or health care (LaPointe, 2018). While Medicaid and Medicare provide options for safety net insurance, many Americans remain uninsured or underinsured. During the first half of 2020, approximately 1 in 8 American adults was uninsured, and more than 2 in 5 were underinsured. Half of uninsured or underinsured American adults are challenged to pay medical bills or are paying long-term medical debt. One in four continuously insured adults who does not meet the threshold for underinsurance reports problems paying medical bills (Collins, Gunja & Aboulafia, 2020). Approximately 2.2 million people have income below the Federal threshold for Medicaid eligibility, but live in States in which they are eligible for neither Medicaid nor tax credits for insurance premiums, leaving them with no realistic option for insurance coverage. This population disproportionately includes people of color (Norris, 2021). Uninsurance, underinsurance, and medical costs disproportionately affect African American and Hispanic people, and younger adults (Collins, Gunja & Aboulafia, 2020). When patients lack adequate health insurance, health care providers are challenged to deliver high-quality care.

Other social determinants of health include basic needs such as housing, food, utilities, and employment (Hood, Gennuso & Swain, 2020; Marmot et al., 2013). Lack of resources to meet these needs has a major impact on individual and community health, which clinical care alone cannot address. Community-centered health care offers non-clinical strategies for providers to mitigate negative impact of social determinants of health through collaborations and partnerships, connecting people to community resources, peer support, and strengthening community capacity to address social determinants of health (South, 2015).

Community-centered Health Care: Increase Access to Health Care

Community health workers and social prescribing are two non-clinical, low-cost strategies for addressing communities' needs for health care. Community health workers (CHW), local lay people who serve as advocates and liaisons between communities and health care and social service systems have served as key partners in community-centered care. CHWs typically are paid through grants rather than fee-for-service. Eliminating costs to patients increases access to primary prevention and health education and promotion services. CHWs also increase access to health care services through community outreach (Jack et al., 2016). Understanding the benefits of including CHWs on health care teams and how to collaborate with CHWs to increase care access and reduce costs are important skills for clinicians serving remote and underserved communities.

Source: https://seewhatgrows.org/community-gardens-important-community/

Social prescribing is the practice of referring patients to non-clinical resources and services that improve health outcomes. Clinicians may refer patients to resources that address basic needs such as housing and food, through approaches such as Housing First for homeless patients with complex medical problems (Brenner, 2020) and Emory University's Urban Health Initiative community garden project to increase access to healthy food. The garden also serves as a site for senior and intergenerational exercise programs. (Moore, 2021).

Community-centered Health Care: Improve Supply Balance and Distribution Equity

Community health workers and social prescribing improve the balance between health care service supply and demand by reducing need for acute and emergency care, and by offering services tailored to meet the needs of underserved communities. A systematic literature review found that CHWs reduce patients' need for urgent care, emergency care, and hospitalizations (Jack et al., 2016). A Housing First intervention for homeless patients with complex medical problems resulted in reduced emergency service utilization (Brenner, 2020). Understanding how to collaborate with CHWs and employ social prescribing are skills NHSC clinicians can apply to ensure they respond to communities' needs and reduce needs for acute care.

Community-centered Health Care: Increase Health Care Quality

A systematic literature review on the impact of CHWs found that CHWs improved health outcomes for chronic conditions such as asthma and diabetes (Jack et al., 2016). One example of CHW success is the University of Pennsylvania's Individualized Management for Patient-Centered Targets (IMPaCT) program, which assigns CHWs to promote health and support health decision-making for chronically ill patients who live in low-income neighborhoods. IMPaCT has resulted in reduced cigarette smoking, obesity, diabetes severity, mental illness, and hospital admissions (Kangovi et al., 2020). The United HealthCare Housing First intervention for

homeless patients with complex medical problems resulted in improved health outcomes (Brenner, 2020). Literature reviews have found that social prescribing has a positive impact on mental health and social well-being (Mossabir et al., 2014). Collaborating with CHWs and social prescribing are strategies that can support NHSC clinicians in delivering quality health care to communities most in need.

Limitations to Consider

While recognizing the potential for social prescribing, some researchers emphasize the need for more well-designed evaluations to provide evidence and guide continuous quality improvement. Systematic literature reviews indicate a need for rigorous evaluations with control groups, consideration of potential undesirable intervention outcomes, and analysis of social context (Bickerdike et al., 2017; Jack et al., 2016; Elliot et al., 2012).

Conclusions

Community resources can be critical for meeting patients' health needs. They can address social determinants of health, facilitate access to high quality care, and improve the balance between health care supply and demand. Understanding how to engage with community partners and use community resources to benefit patients' health is a critical skill for clinicians practicing in rural or underserved communities. Therefore, NACNHSC recommends supporting NHSC participants in learning these skills.

Recommendation 3: Affirm efforts to modernize and validate Health Professional Shortage Area (HPSA) and Maternity Care Target Area (MCTA) designations.

In order to achieve its mission of providing health care to communities that need it most, NHSC must have reliable, valid, current data on where those communities are. Currently, HRSA is in the process of updating its approach to HPSA scoring, HRSA also is developing processes and criteria for designating MCTAs.

HPSA Scores

HRSA analyzes health workforce data to determine minimum HPSA scores necessary for recruiting and hiring NHSC participants. Current and valid HPSA scores are essential for BHW and NHSC efforts to make the U.S. healthcare workforce distribution more equitable. HRSA designates primary care, dental, and mental health care HPSAs. Scoring criteria for all HPSA types include the population-to-provider ratio, percentage of population living below 100 percent of the Federal poverty level, and travel time to the nearest source of care outside the area. Primary care HPSA scoring also considers the Infant Health Index, which is the infant mortality or low birth weight rate, whichever is higher. Dental HPSA scoring also considers water fluoridation status. Mental health HPSA scoring also consider the percentage of the population older than 65 years, the percentage of the population younger than 18 years, alcohol abuse prevalence, and substance abuse prevalence.

From Fall of 2019 through September 18, 2020, HRSA requested and accepted input about potential approaches for updating the HPSA scoring process (McCutchen, 2019). HRSA currently is analyzing responses. Suggestions have included reducing scoring "volatility" and considering the implications of an aging population for health workforce needs (American

Hospital Association, 2020), considering rurality and/or setting aside minimum designations for rural/frontier areas, and considering additional indicators such as life expectancy, disability, all-cause mortality, and mental health status measured by the Behavioral Risk Factor Surveillance System or Youth Risk Behavior Surveillance System (National Organization of States Offices of Rural Health (NOSORH, 2020)). NOSORH also recommended changes to factor weighting, updating the definition of low-income, and improving national provider data resources. Akparanta (2015) analyzed the HPSA scoring process and recommended distinguishing primary care providers from specialists, considering whether providers accept Medicaid, and considering linguistic competence. NACNHSC recognizes that modernized, valid HPSA scores are essential for maximizing NHSC's impact on equitable workforce distribution. The Council supports prioritizing HPSA modernization and validation as essential for responding to communities' health care needs.

MCTA Designations

Alarming trends in U.S. maternal morbidity and mortality have resulted in efforts to designate areas in need of more maternal care providers. The U.S. has the highest rate of maternal mortality among industrialized nations, and is one of only two industrialized nations to have significantly increased maternal mortality since 2000. Figure 1 shows how U.S. maternal mortality compares to other industrialized nations. Maternal mortality in the U.S. disproportionately affects African American and American Indian/Alaska Native women (Declercq & Zephyrin, 2020). Figure 2 shows disparities in U.S. maternal mortality. Maternal morbidity also is increasing, and disproportionately affecting race/ethnic minorities (National Institutes of Health, 2020). NHSC's mission includes improving maternal health through increased access to maternal health care and improved maternal care workforce distribution. Designating areas in need of maternal health care providers is a critically important component of achieving these aims.

Figure 1.

U.S. Maternal Mortality Ratio Compared to Industrialized Countries with 300,000+ Births, 2017–2018

Maternal deaths per 100,000 births

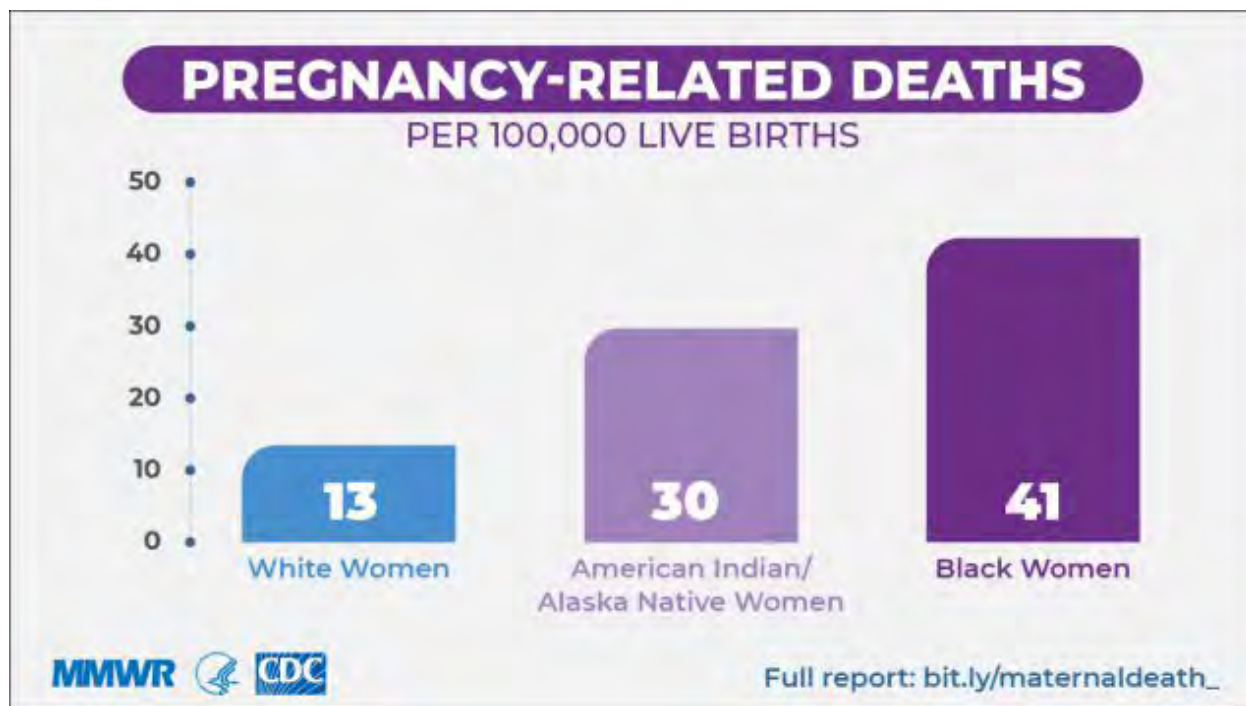| Country	Value
Italy	2
Spain	4
Japan	5
Australia	6
U.K.	7
Germany	7
France	8
Canada	10
Korea	11
U.S.	17.4
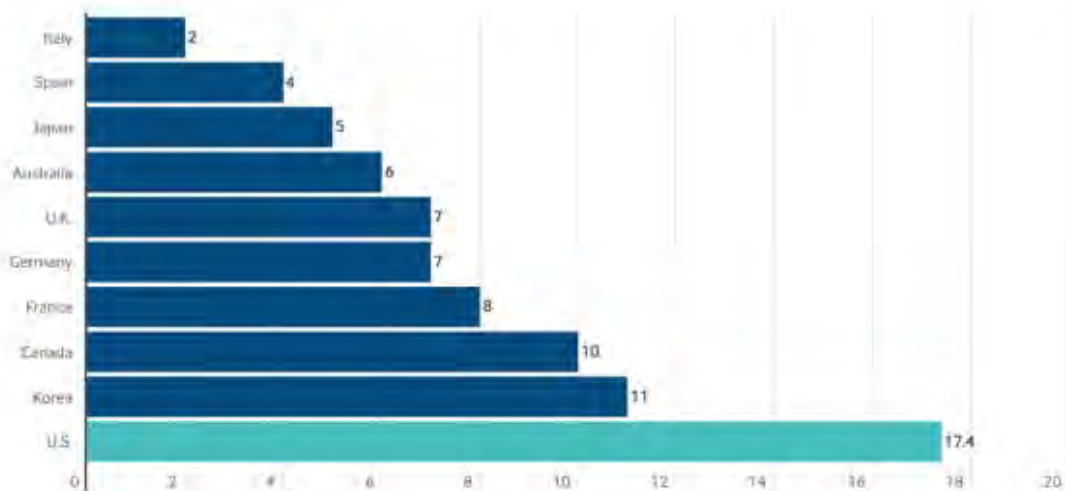
Source: Laurie Zephyrin, M.D., and Eugene Declercq, Ph.D., "Measuring Maternal Mortality," *To the Point* (blog), Commonwealth Fund, Feb. 6, 2020. https://doi.org/10.26099/c14w-nq52

To increase equitable distribution of the maternal care workforce, the Maternity Care Act charges HRSA with establishing criteria for Maternity Care Health Professional Target Areas (MCTA). MCTAs are geographic areas within primary care HPSAs that have shortages of maternal care professionals. HRSA is developing designation scoring criteria, and issued a Request for Information with a comment period from May through September 2020 on issues such as whether care professionals should include certified nurse midwives. The Maternity Care Act requires HRSA to use MCTA designations to support decisions regarding distribution of maternal care health professionals, and to collect and publish data that support assessing availability of maternal care health services within HPSAs. Recommendations have included convening a planning group to consider how to weight factors comprising MCTA scores, considering a special designation for small population and frontier MCTAs, and coordinating with other maternal service efforts (NOSORH, 2020).

NACNHSC supports HRSA's decision to designate MCTA and ongoing efforts to update HPSA and MCTA scoring to improve health workforce supply and distribution. The Council commends HRSA for soliciting and considering stakeholder input on scoring, and for ongoing thoughtful analysis of how to address needs for maternal care.

Figure 2.

PREGNANCY-RELATED DEATHS
PER 100,000 LIVE BIRTHS

White Women: 13
American Indian/Alaska Native Women: 30
Black Women: 41

MMWR · CDC

Full report: bit.ly/maternaldeath_

The Council recommends that the MCTA designation process and results should support recruiting and retaining maternal care providers, facilitating collaborations among providers and health care organizations, and supporting health equity.

Limitations to Consider

NACNHSC encourages HRSA to ensure key stakeholders have responded to requests for information regarding HPSAs and MCTAs and that designations are based on the best available current evidence regarding need for applicable types of health care.

Conclusions

Valid designations of areas where health care is needed most is critical for achieving NHSC's mission. Designating areas where maternal care is needed most is an important step toward **addressing high rates of maternal mortality and maternal mortality disparities in the U.S.** NACNHSC recommends continuous efforts to maintain current, valid, relevant designations of where health care, including maternal health care, is needed most.

Recommendation 4: Affirm evolving and ongoing efforts to promote recruitment and retention by supporting clinician resiliency at NHSC sites.

It has long been known that health care providers experience significant levels of work-related stress and burnout leading to numerous adverse repercussions, including clinical errors, workforce turnover, and diminished quality of care. Our report, "Readiness to practice protocol for health care providers in underserved communities" (2021) identifies resilience and ability to adapt to circumstances with limited support as a critical component of readiness to serve HPSAs, and therefore critical for NHSC participants. This report also discusses factors associated with

practice in HPSAs that can contribute to provider stress and burnout as well as potential protective factors.

The COVID-19 pandemic highlighted many issues underlying provider burnout, well-being and resilience. The pandemic was a unique challenge because unlike other diseases managed by providers, taking care of patients and communities placed the physical and mental health of providers and their families at severe risk (Ellis, 2020).

Burnout, a long-term stress reaction characterized by emotional exhaustion, depersonalization, and lack of a sense of personal accomplishment, is prevalent among healthcare workers (AHRQ, 2017). Burnout negatively impacts the quality of health care (Tawfik et al., 2019), patient safety (Dyrbye et al., 2017), and the workforce supply (Tawfik et al, Willard-Grace, et al, 2019). While self-care may be necessary in the short-term, research shows that root causes are systemic, and long-term solutions should be at the systems level.

> *"This research on work conditions, clinician reactions (including satisfaction and burnout), and patient outcomes over the past 15 years has allowed us to make concrete recommendations to health systems on how to build healthier workplaces for providers and patients."*
>
> *Mark Linzer, M.D. Hennepin County Medical Center, Minneapolis, MN*

Strategies for addressing burnout, promoting well-being, promoting resilience

Research supports organizational approaches to prevent and ameliorate workforce-related stressors (Maslach, Leiter, & Jackson 2011). Successful organization-level efforts to improve provider well-being and resilience and reduce burnout recognize the importance of these outcomes. These organizations implement processes and policies to improve communication and teamwork, reduce pressure, and recognize high-quality work (Green et al., 2020; Linzer et al., 2015).

While self-care skills are generally useful and resources may be helpful for addressing immediate needs to address stress, they are not adequate for preventing and mitigating provider burnout, which currently affects a large proportion of care providers. Solutions must be at organizational and systems level, including policies that make care providers' workloads and schedules more manageable. The American Medical Association's STEPS Forward program offers training in systems transformation to prevent burnout and support resilience. Developers emphasize the importance of measurement and evaluation to support continuous quality improvement (Berg, 2021). Several studies have shown that collaborative team-based care not only improves patient outcomes but also contributes to provider resilience and well-being (Smith et al. 2018). NACNHSC recommends providing NHSC participants with opportunities for training and practice in team-based care in order to achieve these goals as well as to improve patients' outcomes.

Current efforts to promote recruitment and retention by supporting clinician resiliency at NHSC sites

NHSC currently prioritizes clinician recruitment, retention, and resiliency. NHSC and BHW offer resources that support these priorities. NHSC requires sites to submit Recruitment and

Retention Plans that include strategies for promoting resiliency and preventing burnout (NHSC, 2021a). NHSC provides sites with guidelines for developing Recruitment and Retention Plans, which include a template, strategies for success, and links to resources and references (NHSC, 2021b). In addition, BHW supports workforce resilience programs, with three scheduled to launch in Fiscal Year 2022: Health and Public Safety Workforce Resiliency Training, Promoting Resilience and Mental Health among the Health Professional Workforce, and Health and Public Safety Workforce Resiliency Technical Assistance Center. NACNHSC commends these efforts and encourages NHSC and HRSA to continue to build on these efforts.

Limitations to Consider

While strategies such as team-based care, efficient workflow, and organizational culture of work-life balance and peer support can increase well-being and resiliency among health care providers, NHSC sites and participants have variable capacity to address health care provider shortages, lack of community resources, and public health emergencies. Training and organizational strategies are essential, but initiatives to address health care provider burnout will likely need to be individualized for each site, and possibly requiring support beyond the organizational level. Broader policy solutions are also necessary build and support leadership infrastructure to support and protect clinicians.

Conclusions

Based on the evidence for the urgent need to address health care provider burnout and support resiliency with systemic solutions, NACNHSC recommends support for work that identifies factors that improve provider well-being, prevent and mitigate burnout, and evidence-based strategies for systems transformation to increase provider resilience and well-being. This work will be essential for progress toward achieving NHSC's mission.

Call to Action

Addressing the NACNHSC's four priority areas- telemedicine integration, community-centered care, modernized and valid designation of health care shortage areas, including areas in need of maternal care providers, health care provider well-being and resiliency- will facilitate BHW's efforts to achieve its core aims. Each priority is directly related to BHW core aims of increasing access to health care, increasing the health workforce supply, improving workforce distribution, and improving workforce and health care quality. The NACNHSC recommends support for NHSC programs, initiatives, and policies that strategically address these priorities to support progress toward achieving NHSC's mission.

The Year 2022 marks the 50th anniversary of NHSC's work toward its mission to "build healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care." Over the last five decades, NHSC has supported through scholarships and loan repayments 63,000 primary care, medical, dental, and mental and behavioral health care providers. NHSC participants have provided care to patients most in need, serving on the frontlines to address major health issues such as the COVID-19 pandemic, the opioid overdose crisis, and HIV/AIDS. Currently, over 19,000 NHSC participants serve over 20 million patients (NHSC, 2021). Our recommendations aim to support this valuable program in continuing to address health care provider shortages by providing high quality health care to people who need it most.

Recommendation 1: Deploy telemedicine training, equipment, and technologies that facilitate continuity of care, address social determinants of health, and otherwise support NHSC to reduce workforce distributional imbalances.

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Recommendation 4: Affirm evolving and ongoing efforts to promote recruitment and retention by supporting clinician resiliency at NHSC sites.

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