Community Health Centers Starving for Staffing

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Community health centers are currently clinically understaffed and will likely face increasing shortages that may limit their expansion, according to a study by the rural health research centers of both the University of Washington, Seattle, and the University of South Carolina, Columbia, and by the National Association of Community Health Centers (JAMA 2006;295:1042-9).

"Workforce shortages may impede the expansion of the U.S. [community health center] safety net, particularly in rural areas," reported Dr. Roger A. Rosenblatt from the University of Washington, and his colleagues.

The study surveyed 846 federally funded community health centers (CHCs) within the 50 states and the District of Columbia. Mailed questionnaires and telephone surveys asked CHC chief executive officers about staffing and recruiting patterns, use of federal and state recruitment programs, and perceived barriers to recruitment.

Responses were obtained from 79% of the population and revealed that funded clinical staff vacancies are common. The average CHC has 13% of its family physician full-time equivalent positions unfilled. Rural CHCs reported a significantly higher proportion of these vacancies, as well as recruiting difficulties, compared with their urban counterparts, with more than one-third of rural CHCs reporting that they had been trying to recruit a family physician for more than 7 months. "It would require more than 400 FTE family physicians to fill all the vacancies for this discipline," noted the authors.

Some of the greatest recruitment difficulties were reported for obstetrician/gynecologists and psychiatrists; rural locations reported more than 20% of funded positions vacant, and they had more recruitment difficulties, compared with urban CHCs. Dentists' vacancies also were indicated, with more than half of rural CHCs reporting a vacant position for 7 months or longer. Less difficulty was reported in recruiting nurse-practitioners and physician assistants, with no significant rural-urban differences.

When asked to indicate perceived barriers to recruitment and retention of both rural and urban CHC physicians and nurses, respondents consistently noted the inability to offer competitive compensation packages.

"The lack of spousal employment opportunities, lack of cultural activities and opportunities, lack of adequate housing, and poor-quality schools were perceived as disproportionately greater barriers for rural centers," noted the authors. Survey respondents suggested three potential interventions to address these perceived barriers: better capacity to provide annual salary increases, more National Health Service Corps loan repayment incentives, and greater visibility of CHCs as desirable practice opportunities during training.

"The clinical role of CHCs is dependent on primary care clinicians, both physicians and nonphysician clinicians," the authors wrote, noting that the declining production of family physicians from residency programs "may lead to serious workforce shortages, particularly in rural CHCs." Roughly 66% of the responding CHCs indicated their plans to expand as part of a federal 5-year initiative to increase spending on CHCs by at least $2.2 billion through fiscal year 2006.

However, the decline in "physicians choosing generalist careers may be the rate-limiting step in the nation's ability to staff CHCs and may lead to renewed shortages of safety-net and rural physicians generally," they wrote.

The authors made several suggestions, including the following, for federal and state governments, as well as for CHCs:

► Bolstering elements of the Health Professions Educational Assistance Act of 1976, the only federal program aimed at encouraging primary care clinicians who are likely to practice in underserved areas.

► Increasing the use of nurse-practitioners and physician assistants.

► Creating new alliances between CHCs and primary care training programs.

► Expanding the National Health Service Corps and related programs that provide financial incentives to attract health care clinicians to underserved areas.

► Developing new approaches to loan repayment plans.

► Creating additional incentives for rural areas. ■