

The National Health Service Corps: An Answer to Family Planning Centers' Workforce Woes?

By Rachel Benson Gold

A decade ago, a landmark Institute of Medicine (IOM) report entitled *America's Health Care Safety Net: Intact but Endangered* described the nation's safety-net providers as the "default system for caring for many of the nation's uninsured and vulnerable populations." These providers, the report continued, "uniquely offer care that addresses the clinical and social needs of vulnerable patients who remain outside the economic and medical mainstream." The report described a group of core safety-net providers that maintain an "open door" policy to offer access regardless of clients' ability to pay and serve a clientele that is disproportionately uninsured, enrolled in Medicaid or otherwise vulnerable. Core safety-net providers, according to the IOM report, typically include public hospitals, community health centers, health departments and, in many communities, family planning centers, school-based health programs and agencies offering HIV services.

Safety-net providers of all types face the daunting and intertwined challenges of recruitment, retention and retirement. Chronic budget issues have long left safety-net providers unable to compete with the compensation packages offered by private providers, which can lead to both high turnover of qualified staff and vacancies that remain unfilled for prolonged periods. The current state budget crises have added staff cuts, hiring freezes and furloughs to an already perilous situation for both health agencies and the community-based organizations they support.

At the same time, the supply of health care professionals is simply not keeping pace with the demand. For example, the United States already

faces a shortfall of 400,000 nurses, a number widely expected to grow in coming years. The Trust for America's Health estimates that the country has 50,000 fewer public health workers than it did two decades ago, and the workforce that remains is aging: One in five local health department employees is likely eligible for retirement. In addition, a report newly published in the *New England Journal of Medicine* concludes that many states lack the provider capacity to adequately meet the surge in demand likely to occur in 2014, when the Medicaid expansions under health care reform come online.

Need for Family Planning Nurse Practitioners

Family planning centers face all these workforce challenges, including stiff competition from hospitals and private-sector providers for a limited supply of trained staff. They also continue to grapple with the lingering effects of the economic downturn. Almost half of family planning centers surveyed by the Guttmacher Institute reported staff layoffs or hiring freezes during 2009.

Layered on top of those common challenges, however, family planning centers face a unique workforce gap, as they try to ensure an adequate supply of nurse practitioners and other midlevel clinicians with training in the delivery of family planning services. Nurse practitioners, physician assistants and nurse midwives are the mainstay of the family planning center workforce, comprising 60% of the clinical services providers at Title X-funded centers. But it is also an aging workforce, a specific issue for family planning centers, because it puts a widening gap between clinicians and their reproductive-age clients. At

Health Quarters, a Title X grantee in Massachusetts, for example, all of the nurse practitioners are nearing retirement.

Supply lines for nurse practitioners have been complicated by changes in education and credentialing standards in recent years. Most states now require nurse practitioners to hold a master's degree in nursing to enter into practice, and a "doctor of nursing practice" is slated to be the training requirement for new nurse practitioners by 2015—a requirement that likely will add an additional year of training for current master's-level providers. Although this additional training, according to a recent review of the Title X program by the IOM, will likely benefit clients by giving them access to more highly trained professionals, it also raises important questions about "whether it will exacerbate shortages in the available nurse practitioner workforce and how it might affect the cost of hiring nurse practitioners."

This move toward increased credentialing for nurse practitioners led to the demise of a highly successful training program funded by Title X. Between 1972 and 2000, this program gave more than 5,000 nurse practitioners specific training for working in publicly funded family planning centers. In addition to focusing on the training needed specifically to serve as a clinician in such a center, the program trained a culturally and linguistically diverse cohort of nurses, most of whom were recruited directly from the locale they would return to serve. This focus offered the same sort of grounding in their local communities that family planning centers seek by using community health workers (related story, Summer 2010, page 8). Although the nurse practitioners who were trained under the Title X program were "grandfathered in," many of them are nearing retirement, and family planning programs are struggling to recruit replacements who bring the same skills, diversity and community connection.

The phasing out of the Title X training program is also meaning that family planning centers are having increasing difficulty finding staff with specific training in family planning, as opposed to

general primary care. As a result, family planning centers are finding themselves in the unenviable position of trying to hire higher-level, and therefore higher-paid, staff who need on-the-job training in providing contraceptive and related services.

Urban and Rural Centers Face Different Issues

Although many family planning centers face workforce challenges, those in rural areas often must jump different hurdles than their urban counterparts. Centers in sparsely populated rural areas often do not have sufficient demand to support full-time clinicians. But Wanda Meredith, the family planning coordinator in Hill County, Montana, says that they are finding it increasingly difficult to find someone who can staff their clinic for the 10 hours a month they need. "It's just not enough to get someone to drive here from somewhere else, but it's too much for someone who is already employed here to try to squeeze it in." Moreover, to attract a clinician, the program would have to pay close to \$1,500 a year just to cover their liability insurance, a prohibitive amount for someone who is only working 120 hours a year.

The distances in rural areas can easily deter clinicians who might otherwise be willing. According to Sue Irvin of Central Montana Family Planning, a rural provider in the geographic center of the state, their regular nurse practitioner left in mid-2009. For a few months, they had a nurse practitioner who was coming in from three hours away, but the travel proved too difficult, especially during the harsh Montana winter. Since then, they have been patching services together using three different clinicians, some of whom have to drive close to three hours roundtrip to get there. Because clinician schedules are so variable, the staff maintains a list of women who need Pap tests; when a clinician is scheduled, they call down the list until all the scheduled slots are full. According to Irvin, they have been able to make do so far "taking it one day at a time," but she also notes that they have no clinicians scheduled past March.

For their part, urban providers sometimes struggle with finding clinicians willing to work with

disadvantaged inner-city populations with a variety of language needs. According to Kathy Miller of Public Health Solutions, a large Title X grantee in New York City, the ability to communicate in Spanish is essential given the population they serve; 60% of the agency's clients are Latina. Although Spanish is dominant, the agency's client base is diverse and their clients speak a multiplicity of languages, including Japanese, Polish, Portuguese, French Creole, French, Russian, Punjabi, Hindi and Bangla. Although the agency strives to have clinicians who can serve clients in their own language, it has also equipped every exam room with a dual handset phone linked to a national interpretation service that enables both the clinician and the client to communicate with an interpreter. The service, though, comes at a steep price: The system costs about \$3,500 to install and more than \$400 a month to operate.

Looking to the National Health Service Corps

Workforce issues are nothing new to safety-net health care providers; they have been grappling with this problem for decades. As one way to assist this critical network of providers address their workforce challenges, Congress created the National Health Service Corps (NHSC) in 1970. Since then, more than 30,000 physicians, nurse practitioners, nurse midwives, physician assistants and other clinicians have served in the NHSC and provided health care, especially in urban and rural areas where services are scarce; they frequently work at community health centers (CHCs). This important program has generally not been available to providers that focus primarily or exclusively on the delivery of family planning services to disadvantaged populations, even if they are located in areas with a shortage of providers. However, recent funding increases for and policy changes related to the NHSC may finally open this effort to family planning centers struggling to have the trained and credentialed workforce necessary to meet the needs of the communities they serve.

The NHSC operates two companion programs that both seek to expand provider capacity in areas that have been designated by the Department of Health and Human Services

(DHHS) as health professional shortage areas (HPSAs). The NHSC Scholarship Program provides up-front scholarships for individuals who commit to serving between two and four years in a community-based site in a high-need HPSA. The NHSC Loan Repayment Program offers fully trained primary care physicians, family nurse practitioners, certified nurse midwives, physician assistants and others up to \$60,000 to repay student loans in exchange for two years of service; at the end of the two years, participants may apply to "reenlist" for additional years to continue paying down their student loans. Between these two programs, the NHSC is supporting more than 7,500 clinicians working in more than 10,000 sites nationwide.

For an NHSC placement to become operational, both the individual clinician and the site must be approved. There is no question that the clinicians likely to seek work in family planning centers would be eligible. The application guidelines for the current year say that eligible primary care practice areas for physician assistants and nurse practitioners include adult, family and women's health; certified nurse midwives are also eligible to participate.

Obtaining approval for a specific family planning site has been more difficult. Traditionally, a large proportion of NHSC placements have been at CHCs; however, that does not at all mean that there are not, and have not been, NHSC placements working in family planning programs, including Title X-funded family planning programs. In 2006, CHCs represented 27% of all publicly funded family planning centers and 10% of those receiving Title X funds. Moreover, CHCs are a growing component of the family planning provider universe: The number of Title X-funded CHC sites doubled between 1994 and 2006, and the number of family planning clients served in those sites went up by 130%; nonetheless, CHCs still represent only 6% of clients served at Title X-funded centers.

Unity Health Care, a CHC that is the Title X grantee in Washington, DC, has 40–50 NHSC placements at any given time, some of whom provide services as part of the agency's Title X

program. Mark Hathaway, medical director of Unity's Title X project, participated in the loan repayment program when first working in the agency's Title X project. According to Hathaway, the impact of the program on Unity's ability to recruit staff, including its family planning program, is substantial. Not only does the availability of loan repayment bring people to the agency seeking work, but most critically, it specifically brings people who are wanting to work with disadvantaged and underserved populations. As he puts it, the loan repayment program "casts a wide net for me to get qualified people interested in doing what we do."

But it has proven to be much more difficult for a freestanding family planning center to be approved as an NHSC site. For example, an application filed by Planned Parenthood of Southern New England has not been approved, even for sites in designated HPSAs. Nonetheless, one freestanding program, a site operated by Adagio Health in Indiana, Pennsylvania, has succeeded in being approved. The center is located in a rural area more than an hour northeast of Pittsburgh that is designated as an HPSA. The NHSC placement at the clinic is a women's health nurse practitioner who wanted to work in a disadvantaged community and who had ties to the local area. The NHSC made it financially viable for her to do so, enabling her to come close to wiping out her nearly \$50,000 in student loans. In addition, her placement allowed the agency to fill a slot that had long gone vacant.

Making It Happen

Most family planning centers that are located in designated HPSAs are likely to be able to meet the basic requirements for approval as an NHSC site. To do so, these centers must participate in Medicaid and the Children's Health Insurance Program, see all patients regardless of their ability to pay, utilize a discounted fee scale, have a need for health manpower, have appropriately used any NHSC personnel that have been assigned in the past, demonstrate community support for the assignment of NHSC personnel, show that they have had difficulty in recruiting staff, have sound management and demonstrate a willingness to provide training and mentoring

for NHSC placements. Many of these stipulations, such as serving individuals regardless of ability to pay and using a sliding fee scale, are already required for participation in Title X.

Moreover, many family planning sites should be able to clear most of the hurdles posed by a second-tier set of conditions for being given priority. According to the formal announcement for the current year that was posted in the *Federal Register*, priority will be given to programs that have a record of sound fiscal management and that can demonstrate that not having an NHSC placement would adversely affect their ability to serve their communities. Even the stipulation that priority sites provide primary care should not pose a barrier to family planning centers, because the program defines primary care as "health services regarding family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals." Clearly, the services provided at family planning centers are related to family or internal medicine, as well as obstetrics and gynecology.

The greatest challenge for family planning centers may be the requirement that, to be given priority, they must be part of "a system of care that provides a continuum of services, including comprehensive primary health care and appropriate referrals or arrangements for secondary and tertiary care." Although many family planning centers are not part of an agency that offers comprehensive primary care, they generally do have referral arrangements with these types of providers in their communities and regularly refer clients when circumstances warrant. And, of course, Title X specifically requires programs to refer clients for needed care that is outside the scope of the Title X project.

But there also may be opportunities that could help in overcoming this hurdle. A dramatic new influx of funding for the NHSC should give freestanding family planning centers reason to feel hopeful that they may finally be able to participate in this important program. The stimulus legislation enacted at the beginning of 2009 provided \$300 million in expansion funds to the

NHSC, and the health care reform legislation added an additional \$1.5 billion in new dedicated funding over a five-year period. According to Rebecca Spitzgo, director of the program within the Health Resources and Services Administration (HRSA) at DHHS, their goal is to more than double the size of the NHSC workforce in coming years. This influx of dollars may lead the program to be able to approve placement sites—such as some family planning centers—that meet the requirements for program participation, but fall slightly short of some of the elements needed to be given priority. In fact, in a November conference call to discuss program and policy changes for the current year, Spitzgo acknowledged that HRSA is looking at the eligibility of new sites and is trying to take a broader approach toward determining which sites are eligible. Hopefully, this will lead HRSA to recognize family planning centers as the key safety-net providers their clients view them to be, as it has been urged to do by the National Family Planning and Reproductive Health Association.

But for the doors of this critical program to swing open at last, family planning centers located in HPSAs will need to position themselves to be able to take full advantage of this emerging opportunity. To do so, they may want to take a fresh look at the referral arrangements and procedures currently in place with other providers in their communities and see what can be done to make them as strong and comprehensive as possible. Even further, family planning centers may want to assess whether it is time to look to establish more formal relationships with other safety-net providers in their communities as a way to ensure that family planning centers can effectively and efficiently “hand off” clients who need services beyond the scope of care they provide. Doing so could at once strengthen centers’ applications for NHSC placements while deepening relationships with—and positioning themselves as assets to—the more comprehensive systems likely to become ever more important as we move down the road of implementing health care reform.

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