Restoring the Healthcare Workforce for Equity Project

Funded by the Center for Disaster Philanthropy

HEALTHCARE READY

Needs Assessment: Restoring the Community Health Center and Clinic Workforce Beyond the Pandemic

Centering health equity in restoring and rebuilding the healthcare workforce

February 2024

Glossary of Acronyms and Terms

CDP	Center for Disaster Philanthropy
CDRT	Community Disaster Resilience Tool
Clinic	The term "clinic" is used to refer to free and charitable clinics.
FQHC	Federally Qualified Health Center
Health Center	The term "health center" is used to reference community health centers, which may include federally qualified health centers (FQHCs), or health center look-a-likes
HRSA	Health Resources and Services Administration
CDC	Centers for Disease Control
NACHC	National Association of Community Health Centers
NAFC	National Association of Free and Charitable Clinics
FQHC	Federally Qualified Health Center
NHSC	National Health Service Corps
PCA	Primary Care Association
THCGME	Teaching Health Center Graduate Medical Education
HPSA	Health Professional Shortage Area
CMS	Centers for Medicare and Medicaid Services

Executive Summary

Disasters profoundly influence the management and treatment of patients living with chronic conditions and other individuals who are socially and medically vulnerable. As made evident throughout the COVID-19 pandemic and other crisis events that have disrupted access to healthcare, those who bear the greatest impact are communities already facing structural and systemic inequities that contribute to disparate health outcomes. This includes communities of color, low-income, medically fragile, and others who are more likely to live in at-risk environments.

Recognizing the substantial losses and the debilitating effects of burnout experienced among the healthcare workforce, Healthcare Ready launched the ***Restoring the Healthcare Workforce for Equity Initiative*** with the overarching goal to create and amplify resources to restore and help rebuild this essential workforce. Funded by the Center for Disaster Philanthropy (CDP) COVID-19 Response Fund, the initiative focuses on people working in community health centers ("health centers") and free and charitable clinics ("clinics") across the U.S.

This needs assessment was conducted to better understand the impacts of the COVID-19 pandemic on healthcare workforce trends, and to identify resources emphasizing support surrounding mental health, addressing burnout, and ways to foster inclusive and diverse workplaces. Using data collected from a literature review, analysis of population data from Healthcare Ready's Community Disaster Resilience Tool (CDRT), and discussions held with member associations and representatives for health centers and clinics, this research found:

- Health centers and clinics, which serve racially diverse, low-income, and underinsured or uninsured populations across the U.S., are losing workers at higher rates than other healthcare organizations, such as hospitals, signifying potential risks to care currently being received by more than 31.5 million and two million Americans, in health centers and clinics, respectively.
- Based on an analysis of population data and COVID-19 case rates and deaths from March 1, 2020 to March 1, 2021 (onset of the pandemic to the period when vaccinations became more widely available), counties in the U.S. that saw disproportionate COVID-19 cases and deaths, are spread across regions of the U.S. along southern, gulf states which are also at greater risk for future natural disasters.
- The COVID-19 pandemic had a profound impact on volunteers who were no longer able to provide their services due to the lack of personal protective equipment, disagreements in worksite policies, social distancing requirements, as well as the increased risk of the disease to older adults (as volunteers tended to be older). These volunteers have yet to reengage in volunteer activities at the same levels as prior to the pandemic.
- Impacts from the pandemic are continuing to reverberate through health centers and clinics where workers left their positions due to pandemic-driven stress, which have led to staff shortages that are now harder and taking longer to fill than prior to the COVID-19 pandemic. These conditions can exacerbate the rate of burnout experienced by clinical and non-clinical staff, and lead to a cycle of reduced capacity, which could worsen healthcare access and drive health disparities in the future.

- Leaders play a critical role in fostering positive workplace culture, which is essential to engendering feelings of inclusion and belonging, and necessary to support a diverse workforce. Policies within healthcare facilities and practices at all levels must be rooted in equity to combat increasing shortages and worsening conditions for the mental health and resilience of healthcare workers.

At a time when health centers and clinics are more essential than ever, signified by a rising demand in services, health center and clinic leaders are often constrained by the resources available to address common causes of worker burnout, even when they are passionate about doing so. Policymakers and leaders are an essential element to providing the necessary investments for restoring people at all levels of work in healthcare facilities, including non-clinical staff who are often overlooked.

Enhancing the resilience and resources of frontline workers in health centers and clinics is crucial to maintaining healthcare access for medically underserved communities. Supporting and restoring this workforce will require the following:

- Adequately federal funding to implement policies, such as the Community Health Center Fund and the Federal Tort Claims Act, to help the health center and clinic workforce operate fully and effectively to provide care to underserved communities. More funding is needed to sustain key graduate education programs covered by the Community Health Center Fund, such as the National Health Service Corps (NHSC) and Teaching Health Center Graduate Medical Education (THCGME).
- Investments in community resilience and preparedness from multiple levels (individual, facility, and systems), including taking an equity-centered approach in addressing workforce challenges and concerns before, during, and after disasters.

Vulnerable populations face the greatest threat in absorbing cumulative impacts from repeated disasters. This includes immediate concerns following a disaster (e.g., lack of access to medications, disruptions in services to manage acute and chronic conditions, displacement), and longer-term impacts, which can be associated with changes in policies or community investment, and affect systemic access to healthcare services. As it pertains to the healthcare workforce in health centers and clinics, leaders at all levels must take action to make necessary investments to address existing health inequities, and to restore and rebuild frontline workers for responding to our next major disaster.

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Introduction

Healthcare Ready's ***Restoring the Healthcare Workforce for Equity Initiative***, funded by the Center for Disaster Philanthropy (CDP) COVID-19 Response Fund, was launched in 2022 with an overarching goal to enhance support and resources for individuals working in community health centers and clinics.

Community health centers and clinics are responsible for providing crucial primary and preventive care services to diverse communities in underserved areas. Each year, over 31.5 million Americans (one in 11 individuals) seek care across 15,000 community health center delivery sites operating in the United States (U.S.) and U.S. territories.[1,2] Free and charitable clinics similarly serve as an important safety net for uninsured and underinsured patients, providing vital care to two million patients each year.

The services provided through community health centers and clinics are indispensable to those who might otherwise go without essential medical care. The individuals who work in these facilities—both clinical and non-clinical staff—are at the heart of communities' readiness to navigate recovery from disasters.

The impact of COVID-19 has been profound, reshaping various aspects of society, including healthcare systems domestically and worldwide. Beyond the immediate health implications, the pandemic has exacerbated existing disparities and highlighted the critical importance of health equity. According to the Centers for Disease Control (CDC), health equity, is the "state in which everyone has a fair and just opportunity to attain their highest level of health."[3] Health inequities stem from historical injustices and modern-day oppression. The healthcare system was not designed to be equitable, and those in power always have an upper hand. In some instances, policies and practices have had detrimental long-standing effects on Black and brown communities, such as redlining, mass incarceration, disparate drug enforcement penalties, unequal distribution of resources, and lack of access to healthcare, among many other examples. Health is a basic human right and it is fundamental to ensure fairness and justice in healthcare access and outcomes.

The impact of COVID-19 on health equity and the healthcare workforce cannot be overstated. Supporting a diverse workforce is not only a matter of social justice but also essential for delivering culturally competent care and addressing the needs of diverse patient populations. Patients report increased satisfaction and improved health outcomes when the workforce is reflective of the patient's demographics.[4] Black and brown healthcare workers faced a unique challenge during the pandemic—the intersection of their lived experience as a Black or brown person and their role as a healthcare provider. To create a welcoming and supportive work environment for them to thrive, their lived experiences must be valued and not exploited. It is no easy feat to work long hours and then have to come home to experience the same injustices that your patients have been fighting through all day. One issue of particular concern is burnout. Many healthcare workers were stressed out from having to deal with issues such as racial discrimination and bias, demanding workloads, stress, vicarious trauma, negative workplace culture, and limited resources and support systems. All of which have led to record number of employees leaving their organization or the field entirely.

It is imperative to foster a more inclusive and supportive work environment that speaks to the unique experiences of Black, brown, and other from underrepresented racial and ethnic minority healthcare workers. Many organizations lack cultural humility which can lead to unwelcoming and non-inclusive

work environments. In one study by the National Institutes of Health (NIH), minorities and women ranked their organization lower when asked about culturally competency.[5] Representation matters not only within the workforce but also in addressing the needs of diverse communities. By acknowledging and valuing the lived experiences of Black and brown healthcare professionals, organizations can enhance retention rates and promote a sense of belonging. Failure to recognize and address the specific challenges faced by these groups may lead to further attrition and exacerbate existing disparities in healthcare access and outcomes.

Even though the pandemic has been declared over, it continues to strain healthcare systems. Many workers, particularly those from marginalized backgrounds, are still facing unprecedented levels of stress and burnout. Without meaningful efforts to support and retain a diverse workforce, healthcare organizations risk losing valuable talent and exacerbating disparities in care delivery. Prioritizing health equity and supporting a diverse workforce is not only morally imperative but also crucial for building more resilient and inclusive healthcare systems in the face of ongoing challenges. Strategies to improve an organization's culture include embedding diversity into the mission and values, staff from all levels should be engaged in decision-making, be transparent to share successes and opportunities to improve, and start recruitment efforts much earlier by engaging with the community to get persons of color interested in healthcare.[6]

Addressing burnout among the diversity of individuals and their lived experiences of those who work in healthcare requires systemic changes within organizations, including efforts to promote diversity, equity, and inclusion, provide resources for mental health support and self-care, and address systemic inequities in patient care and workplace culture. It also requires acknowledging and addressing the unique stressors and challenges faced by Black, brown and healthcare workers from other historically marginalized communities within the broader context of healthcare disparities and social injustice.

Better understanding the implications of responding to a pandemic on the magnitude of COVID-19 is critically important to ensure the public health workforce is trained and prepared for the next disaster.

To add to the literature on the gaps, needs, and possible solutions, Healthcare Ready conducted a needs assessment to gather data and evidence from the literature, key informant interviews, and a roundtable discussion. This needs assessment seeks to highlight impacts of the COVID-19 pandemic on the workforce of health centers and clinics, and opportunities to increase support to ensure the sustained capacity of this indispensable workforce against future disasters. In line with the broader goals of this initiative, this needs assessment also takes a closer look at the connections between structural racism, bias, and mental health and well-being of the healthcare workforce.

Research for this report was conducted from January 2023 to January 2024. Methods include a review of publicly available literature,[a] and interviews with four representative stakeholders, including community health center staff, state primary care associations, and the National Association of Free and Charitable Clinics (NAFC),[b] as well as a roundtable with leading institutions

[a] Search terms included: COVID-19 Impact on Healthcare Workforce, Health professional shortage areas, Healthcare shortages in the U.S., Healthcare professions with shortages, Medically underserved areas, Demographic composition of healthcare professions in U.S.

[b] Interviews ranged from 30 minutes to 60 minutes in length. Each interview was catalogued and used as primary examples/case studies in relation to findings and themes from the literature. Interviewees were interviewed in a semi-structured question set ranging from 8-10 questions over Zoom. Interview questions are included in Appendix B.

invested in advocating for greater diversity and support for healthcare workers, especially those who work in underserved communities.

The insights from these activities can inform best practices and enable decision makers to have a clear picture of the impact of COVID-19, especially the toll it took on individuals from historically underrepresented communities who work in healthcare, with a special focus on their mental well-being. Information gleaned from this report can guide decision-making to implement safeguards that protect staff's well-being and lower workforce attrition.

Methodology

Research for this report was conducted between January 2023 to January 2024. Data were gathered through literature review, interviews, and focus group convened to discuss key, impactful resources relevant to the field. The literature review was comprised of online searches for relevant academic journal articles, news articles, op-eds, white papers, industry reports, etc. through Google, academic journals, and industry sites from the period from January 2018 through September 2023.

Search terms included, but were not limited to:

- "COVID-19 Impact on Healthcare Workforce"
- "Health professional shortage areas"
- "Healthcare shortages in the US"
- "Healthcare professions with shortages"
- "Medically underserved areas"
- "Demographic composition of healthcare professions in US"

Sources primarily focused on data pertaining to the U.S. healthcare workforce, with an emphasis on sources that specifically referenced healthcare workers working in underserved areas.

To validate the information and themes found through the literature review, we conducted outreach to individual health centers, primary care associations, industry associations, and subject matter experts. Interviews were designed to last from 20-30 minutes and conducted via Zoom. Interviews were recorded with the interviewee's consent for the purpose of notetaking. Interviewees were also asked if they wished to remain anonymous or have quotes directly attributed to them or their organization. Data was also gathered via a focus group, consisting of representatives from several national organizations representing health centers, clinics, and advocacy organizations.

Background

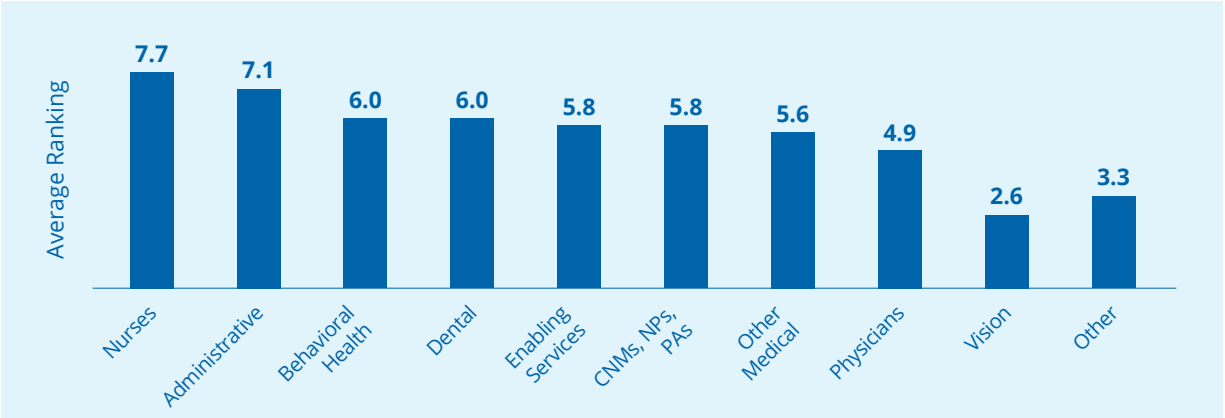
Shortages of healthcare professionals have been on the rise, affecting nearly all specialties, facility types, roles, and regions. Nurses and doctors, face particularly acute shortages that were made worse by accelerating rates of attrition during and since the COVID-19 pandemic. Conservative estimates by the Health Resources and Services Administration (HRSA) project shortages across all healthcare

specialty physician types by 2035, including a shortage of physicians (81,180 by 2035 for full time employees), and licensed practical nurses (141,580 by 2035 for full time employees).[7]

While there is an abundance of healthcare workforce research on workers in hospital settings, especially for clinical professionals, there is less available peer-reviewed research on healthcare workers in non-hospital settings, which includes community health centers and clinics. Therefore, workforce data collected by national membership organizations representing community health centers and clinics are referenced in this assessment, extensively.

The National Association of Community Health Centers (NACHCs) is the national membership organization for Federally Qualified Health Centers (FQHCs, or health centers). They represent the more than 1,500 health centers nationwide that provide primary care to more than 30 million patients in the U.S. These federally-funded (or federally supported) centers provide care to 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty, nationwide. Results from NACHC's 2022 workforce survey found that 68% of health centers are seeing rates of losses between 5-25% of their workforce, and 15% reported losing 25-50% of their workforce. Of these rates of attrition, nurses represented the largest category of workforce loss for health centers, followed by administrative staff, behavioral health, and dental. Further, community health centers, centers in rural areas, work environments without a remote option, small health centers, and centers with fewer financial resources are losing healthcare workers at the greatest rates.[8]

Figure 1: Health center roles with greatest losses observed within health centers (highest to lowest)



Source: NACHC 2022 Workforce Survey

The NAFC annual data report indicates similar trends. NAFC is the only nonprofit organization that focuses exclusively on the needs and issues of free and charitable clinics and pharmacies that serve the working poor, uninsured, and underinsured. Findings from NAFC's "2023 Data Report"[c] shows a reduction in workforce, primarily clinic volunteers, who were affected by COVID-19 related conditions and policies (e.g., social distancing requirements, insufficient personal protective equipment (PPE),

[c] Data from 2022.

stay at home orders, health concerns). As a result, clinics saw a net decrease of volunteers from more than 200,000 volunteers prior to the pandemic, to approximately 188,000 in 2022.[9]

Health Equity is Essential to Community Resilience

The "sustained ability of communities to withstand and recover from adversity" is defined by the CDC as community resilience.[10] Community health centers and clinics play a crucial role in addressing the complex health needs and various medical and social vulnerabilities of their patients. This stems from a historical interplay of policies that have significantly influenced public health. These safety net facilities are instrumental in providing effective care delivery and serve as vital points of health access, recognizing health access as a fundamental social determinant of health. Health equity, as a core principle, seeks to ensure that everyone, regardless of social determinants or systemic disadvantages, has an equitable opportunity to achieve their highest level of health.

To meaningfully address diversity in the workforce, some of the issues that need to be grappled with:

- Recognizing and dismantling systemic barriers that hinder equitable opportunities for individuals from diverse backgrounds.
- Implementing inclusive hiring practices that embrace diversity and promote equal representation at all levels of the workforce.
- Fostering a workplace culture that values and respects differences, creating an environment where individuals feel included and can thrive.
- Providing equal access to professional development and advancement opportunities for employees from underrepresented groups.
- Continuously assessing and addressing bias or discriminatory practices within an organizational structure.

Addressing these issues requires action by workplace leaders and policy makers in order to tend to the spectrum of health systems needs that have been elevated in the wake of the pandemic.

Individual and Systems-Level Impacts of the Pandemic

Data from the literature review and interviews with key stakeholders contributed to observations on the following individual and systems-level impacts from the COVID-19 pandemic.

Workforce Burnout

> *In health centers, the primary factor contributing to increased burnout is mounting staff shortages causing increased workloads for all types of staff.*[11]

According to the U.S. Surgeon General's 2022 report on "Addressing Health Worker Burnout," the types of healthcare workers that have been most affected by burnout and negative impacts from the pandemic include health workers of color, immigrant health workers, female health workers, low-wage health workers, and rural and tribal area health workers. Factors that contributed to feelings of burnout that worsened during the pandemic, include stress associated with work, long hours, trauma, insufficient staffing, limited leadership support, lack of focus on workforce wellbeing, limited flexibility, extreme workload, and high administrative burden, and more.[12]

> *"Burnout is real. We do a lot of selfcare now, but it was exhausting," shared one licensed clinical social worker at a health clinic system in rural Arkansas, "At some point I did get to work at home, so that was actually less stressful for me, but I know burnout worsened for nurses in the clinic."*

Burnout among healthcare professionals has a significant impact, contributing to a heightened rate of professionals leaving their positions, as well as impacting employers' ability to recruit new staff.

A 2022 study conducted by the NACHC found that stress from the pandemic was the second most common reason staff at community health centers have left their positions.[13] Hazards and risks associated with the COVID-19 pandemic, such as inadequate PPE, and lack of policies and supports in place to feel safe and protected while still caring for patients, worsened attrition.[14] Further, higher patient loads simultaneous with fewer staff amounted to greater administrative burden on healthcare workers in care settings.

> *"The most burned-out people are often administrative, front desk staff—and not providers," according to one interview participant.*

One state primary care association (PCA) representative reported similarly that burnout appears highest for those with administrative responsibilities. "When we see high levels of burnout and well-being, we're seeing that mid-level managers across organizations are the ones that are leaving because they're responsible for their teams." Emphasizing the additional pressures those individuals faced, he explained, "they also need to report up and need to align with whatever leadership is saying. They're responsible for implementing many strategies."

Recruitment and Retention

Persistent challenges, such as increased patient volumes, inadequate access to personal protective equipment (PPE), inadequate compensation, and sustained stress/trauma related to caring for COVID-19 patients were all factors leading to increased turnover and attrition.[15] Delays in filling vacancies exacerbates existing challenges to sustain healthcare services in underserved areas.

Shared by a representative at NAFC, "It's not just recruitment, but retention that's an issue. It's taking clinics a lot longer to find people…it [used to] take clinics 2-3 months to fill a position. Now … [it's]

taking 6-9 months and sometimes they quit recruiting for that position and are trying to substitute medical students or other people to do that job."

One state primary care association shared, "From a workforce challenge perspective, there has been continued growing turnover…It's also taking longer to fill the vacancies. In our report we found it took 26.6 weeks to fill a position vacancy in 2022, from 22 weeks in prior years."

These delays not only hinder the timely provision of healthcare services but also deepen the existing challenges faced by underserved areas, leading to increased workloads and reduced quality of care for patients. Additionally, prolonged staffing gaps may result in decreased community trust and utilization of healthcare services, perpetuating disparities in access and exacerbating the overall health inequities within underserved regions.

> *"Another consequence [of workforce shortages] is that clinics are not able to provide certain services … and that in turn hurts the patient."*

Chronic Under-Funding and Inequity

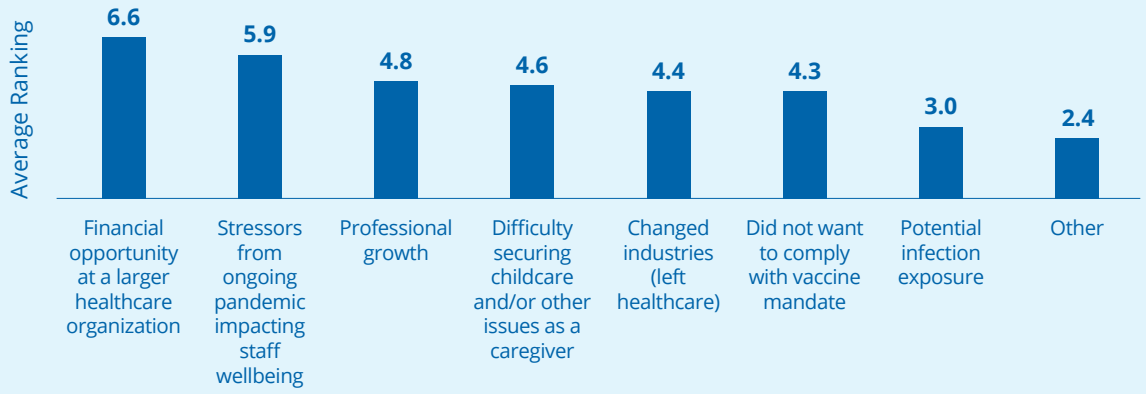
Long-term funding for non-clinical staff not only sustains their functions but also fosters a more productive and cohesive work environment for everyone involved in ensuring high-quality patient care. Highlighting the crucial role of non-clinical staff and the impact of long-term funding, it's important to recognize that addressing and preventing burnout requires a comprehensive strategy and resources to support all staff.

According to the NAFC 2023 Data Report, 91% of clinics report funding as a top need for their organization.[16] Reflecting on reasons for shortages, a representative from NAFC shared, "Some things I've also heard around [workforce] needs is that there is a credential shortage, but we don't have the amount of funding available that these professionals are looking for. [Our clinics] cannot compete with the healthcare sector in general."

Commenting on roles that are in short supply, one state PCA said, "For health centers, [another] challenge is recruiting multilingual staff, given that health centers do see very diverse patient populations." Pointing to findings from their 2023 workforce development survey, "[we asked] 'What positions are [seeing] the greatest turnover?' And it's mostly clinical staff, medical assistants, dental assistants, and then followed by providers, and administrative staff."

Referencing the NACHC 2022 Workforce Survey (Figure 2), ***Financial opportunity at a larger healthcare organization*** was the most commonly cited reason for staff departures, emphasizing the need for sustained efforts in addressing workforce needs and resource allocation to enhance the overall healthcare landscape.

Figure 2: Reasons for Staff Departures from NACHC 2022 Workforce Survey



Source: NACHC 2022 Workforce Survey

The pervasive issues of healthcare workforce burnout, chronic underfunding, and challenges in recruitment and retention collectively undermine the foundation of effective healthcare systems. When healthcare professionals experience burnout, their ability to provide quality care diminishes, negatively impacting patient outcomes. Chronic underfunding, and recruitment and retention challenges exacerbates these issues by limiting resources and support necessary for maintaining a sufficient workforce. Limited access to timely and comprehensive healthcare services, coupled with the strain on an overburdened healthcare workforce, creates barriers to effective disease prevention, management, and treatment.

Assessing Disaster Risks Based on Regional Factors

To better understand the connection between areas of limited health access and COVID-19 health outcomes, we sought to identify geographic regions that experienced disproportionate impacts from COVID-19, and to understand the relationship between geographic Health Professional Shortage Areas (HPSAs) and COVID-19 outcomes.

Box 1: Data Conditions

- Had at least one characteristic related to social vulnerability (i.e., race, income, age, chronic condition prevalence), AND,
- Had at least one characteristic related to "COVID-19 burden" (i.e., COVID-19 case rates, COVID-19 death rates, COVID-19 vaccination rates). [d]

Using data from Healthcare Ready's Community Disaster Resilience Tool (CDRT) from the start of the COVID-19 pandemic (when a public health emergency was declared on March 1, 2020) to the period when vaccinations began being more widely distributed to the general public (March 1, 2021) we identified regions of the U.S. where social vulnerability and pandemic-related morbidity and mortality rates are higher than average and among the highest in

[d] CDRT Data from March 1, 2020, to March 1, 2021 (the period from the start of the public health emergency declaration to the beginning of vaccine distribution beyond frontline workers and to the general population) was used to conduct this analysis. See Appendix A for more information.

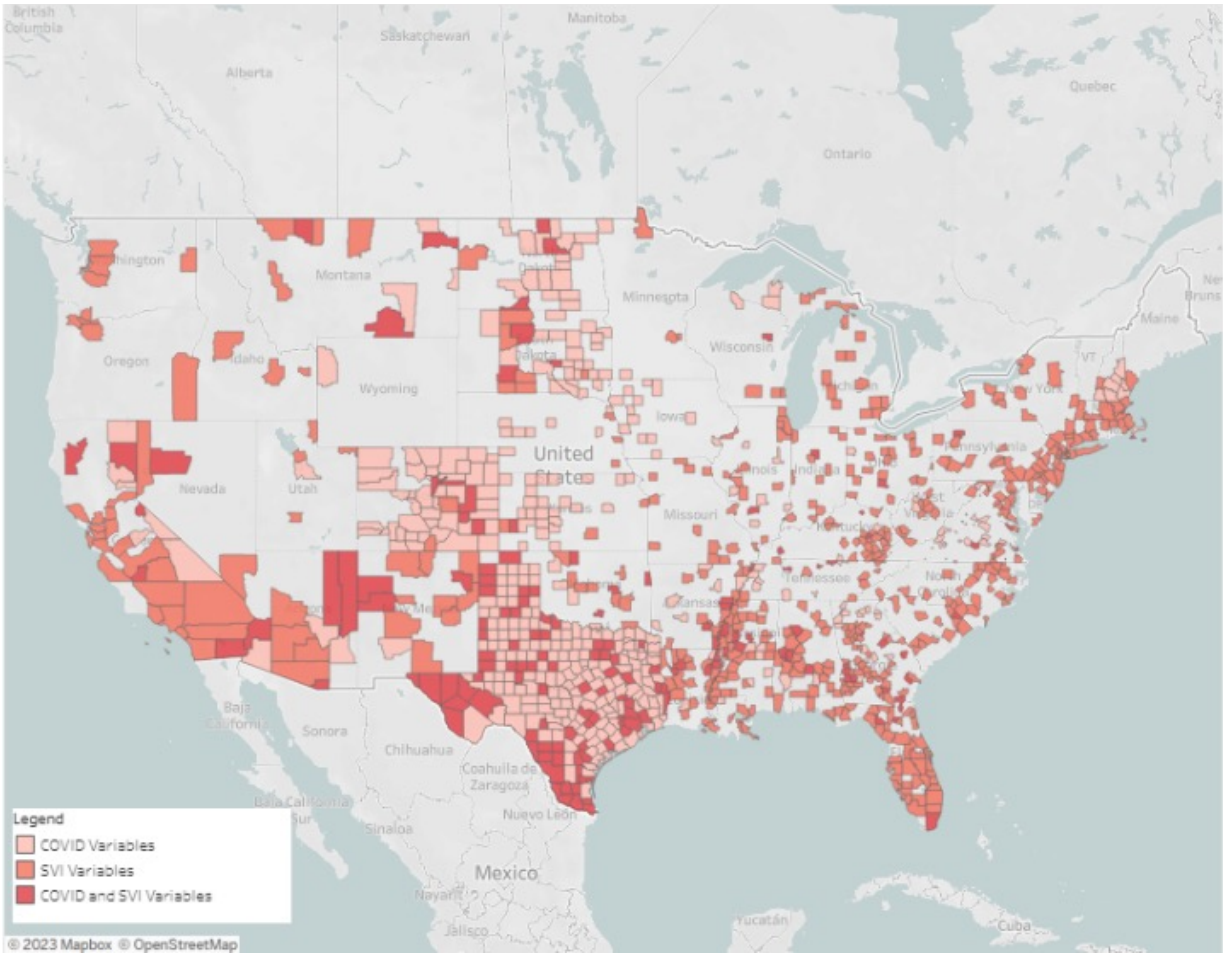
the country.[e] Assessing for the data conditions listed in Box 1, the analysis yielded forty-five counties (see red/striated regions in Figure 3) with higher than national average rates of social vulnerability and higher than national average COVID-19 pandemic-related variables.

The map highlights communities with higher social vulnerability and also experienced disproportionate impacts from COVID-19 (characterized by the highest COVID-19 case rates and COVID-19-related deaths).

As shown in the map, the most densely shaded regions (dark red) tend to be situated along the gulf coast, and southern border between the U.S. and Mexico, which are also considered to be regions at greater risk for natural disasters, such as hurricanes, wildfires, and other extreme weather events. (See Appendix 2 to find the states with highest areas of shaded counties.)

Figure 3

Figure 3. Darkest shaded regions show areas with higher than average social vulnerability and COVID-19 deaths and cases (population data taken from March 1, 2020 – March 1, 2021).



[e] Top 5% of all variables. See more on approach in Appendix A.

We subsequently sought to explore relationship between healthcare infrastructure and disease outcomes by evaluating the correlation between geographic HPSAs and the impacts of COVID-19, specifically focusing on case rates and death rates from the same time period as the initial analysis. This analysis indicated a strong correlation between regions with higher geographic HPSA scores and regions that experienced higher than national average COVID-19 case rates and death rates. While unsurprising in some respects, this data point highlights the connection between weaker healthcare infrastructure (i.e., fewer health professionals) and disparate health outcomes.

These findings do not demonstrate a causal association between HPSA scoring and health outcomes (nor is it intended to). However, it supports the usage of HPSA scoring data to serve as an indicator for identifying regions that may experience potentially disparate health outcomes following a disaster. These areas may have a higher need for healthcare service interaction, as was the experience during the COVID-19 pandemic.

Supporting Future Workforce Capacity

The following sections look at national policies and facility and individual-level strategies to sustain healthcare workforce capacity amidst future disasters. Leading strategies for ways to support the healthcare workforce were derived following a comprehensive analysis of recurring themes in the literature, combined with the valuable input from key stakeholders.

Combatting Contributors to Burnout

The pandemic shed light on the worsening issue of burnout in the healthcare workforce and the crucial influence of leaders to create changes in a working environment. When staff do not feel valued, they may feel detached from their work, leading to decreased motivation, and more burnout and turnover.[17] Positive mental health and wellbeing in the healthcare workforce is paramount to preventing negative effects of burnout, stemming workforce losses, and providing good patient care. Embracing mental health and wellness in the workplace can help staff feel seen, supported, and can help reduce negative factors that contribute to turnover and attrition. Healthcare workers report better work-life experience and have better patient health outcomes at health centers and clinics that prioritize physical, cognitive, and emotional wellbeing.[18]

Reflecting on recruitment and retention strategy at health centers with limited compensation flexibilities, one PCA noted, "If [a] provider doesn't have a sense of community…the health center has to be very intentional about offering retention incentives, such as loan repayment, retention bonuses… or build the community. In recognizing the immense challenges facing the healthcare workforce, leaders and team leads play a crucial role in ensuring staff feel supported, and implementing policies and systems that foster more inclusive and supportive work environments.

Some facilities use low or no-cost strategies to encourage a supportive culture to maintain healthcare workforce satisfaction. Shared one interviewee, "Some clinics are doing bonding events like staff lunches, potlucks, making sure that they are being intentional with scheduling and…investing in professional development." To this end, organizations are recommended to support wellness strategies for the healthcare workforce.[19] Health centers, clinics, and health organizations may support the healthcare workforce by employing mental health practices and tools.[20] Adding well-being metrics into performance

indicators for the organization is one way to elevate the importance of and the resources dedicated to fostering staff well-being in the workplace, which also shows commitment of leadership and the organization to embody supporting staff's emotional well-being as well as holding the organization accountable. Action coupled with accountability improve the likelihood of success.[21] Other strategies, too, can support positive mental health and well-being in the healthcare workforce can promote retention.

"Some clinics are giving staff time to do trainings for [their] selfcare…" shared NAFC about one of their clinics. "…[They] enforces policies of required breaks and lunch [hours]…policies like that are to make sure you have a non-toxic work environment and an attractive one to make sure that staff and volunteers want to stay there."

Improving Workplace Culture and Relationship to Leadership

Dissatisfaction with the workplace and leadership leads to staff attrition and can cause vacancies to be open longer. Staff look to leadership to implement changes to improve workplace environment through opportunities for feedback that is seriously considered.[22]

Research shows that physicians of color are more likely to practice in areas with high poverty rates, low health insurance coverage, and poor health outcomes.[23] Diverse teams are necessary for addressing the health needs of underserved communities because it has been shown to improve patient's satisfaction of care and increase access to medical care. Intentional efforts to cultivate feelings of belonging, and positive workplace culture where all workers are valued and respected is critical to support the needs of diverse teams. This requires leaders to acknowledge and address the roots of structural racism and bias that affect the work experience and career opportunities of healthcare workers of color. It also means providing workers with adequate support, mentorship, training, and recognition to help them thrive and advance in their profession. These policies and practices are not only beneficial for the healthcare workforce, but also for the communities they serve.

In a roundtable discussion held with representatives from six leading advocacy and professional associations representing (and/or in support of) healthcare workers, we discussed the current landscape of healthcare workforce and the tools and strategies needed to improve workplace culture.

The group consensus was that there is a need for improved workplace culture, emphasizing the importance of building trust and support between employees and leadership. Participants acknowledged the commitment demonstrated by organizations, particularly in the healthcare sector, to enhance services and investments in personnel well-being during crises. Notably, the conversation highlighted the HRSA Workforce Wellbeing Initiative's potential for broader application, despite resource constraints. The group explored strategies, including specific trainings, involving administrative and leadership teams, and tailoring approaches to meet unique organizational needs. (See Box 2 for a summary of the resources referenced during this discussion.) The collective agreement emphasized the importance of inclusive workforce practices, mental health support, and operational improvements to alleviate the burden on healthcare workers.

In addressing institutional and structural racism, participants suggested proactive measures, such as questioning unbalanced situations, promoting visible growth in addressing racism, and creating a consortium for sharing successful strategies among healthcare leaders.

Box 2: Resources and suggestions emphasized during the focus group discussion to support the following.

- Emphasize prioritizing all people, including childcare policies.
- Start with data, utilize workforce surveys, such as the HRSA survey on workforce well-being, and ensure policies cover the well-being of all healthcare workers.
- Address psychological safety, moral injury, and eliminate punitive policies. Refer to the Surgeon General's tips on workplace mental health.
- Establish protections for healthcare workers and change licensing board questions to encourage healthcare workers to get the help they need.
- Share well-being and resilience resources.
- Address trauma experienced by healthcare workers by supporting resilience and connecting workers with trauma-informed care, such as by providing a peer support line.
- Advocate for implicit bias training and culturally responsive care.
- Prioritize hyper-local trainings, leadership buy-in, and tailor resources to individual clinic needs.
- Amplify resources such as AAMC's "Continuum to Advance Racial Equity" and provided related resources.

Dismantling Institutional Racism and Combatting Non-Inclusive Workforce Practices

- Utilize ACU's Solutions, Training, and Assistance for Recruitment and Retention (Star^2) Center resources, training, and technical assistance on justice, equity, diversity, and inclusion resources to educate, train, and guide teams.
- Encourage staff to use NACHC's Ground Work self-paced modules on racial justice, cultural humility and implicit bias.
- Need to advocate for clinics to conduct research, use Maslach's burnout scale, and demonstrate the impact of burnout on staff.
- Call for a refresh of graduate medical education in the US, considering its impact on rural healthcare settings.
- Highlight racism and anti-DEI threats to healthcare workers, emphasizing data-driven solutions, parental leave, and DEI integration.
- Focus on recruiting diverse healthcare workers, maintaining flexibility, and ensuring open communication

Federal Policies for Sustaining a Healthcare Workforce Resilient to Future Disasters

Community health centers serve populations with more complex health needs, and patients receiving care through these centers are more likely to reside in areas with limited access to medications and other healthcare resources. This situation is the result of a complex interplay of factors and policies that have affected public health and pushed certain communities into areas with greater disaster risk. These factors make policy and other systemic decision-making critical and essential tools that are necessary to ensure long-term improvement of work conditions for those working on the frontline in healthcare.

Resources for workforce funding, recruitment, retention, and training are vital to healthcare centers and clinic operations, and therefore, addressing health disparities. Examples of essential programs supported by federal policies are summarized in Figure 4.

Figure 4: Key Federal Programs Essential for Workforce Pipeline and Development

The Community Health Center Fund (CHCF) provides around 70% of federal funding ($4 billion per funding period) to community health centers throughout the U.S. The fund is currently at-risk of expiring unless Congress passes full-year appropriations at new levels to match the current and growing need for health centers. The fund would ensure stable, multiyear base grant funding for the community health centers that receive this funding. A reduction in funding would majorly impact the healthcare workforce, patient safety, and health center resources. Decreased funding would also negatively impact health center's abilities to effectively prepare for, deal with, and recover from emergencies and disaster.

The National Health Service Corps (NHSC) helps primary health care providers work in areas with limited healthcare access. For over 50 years, the program has incentivized primary care, dental, and behavioral health providers to work in areas with limited healthcare access through loan repayments and scholarships. The NHSC has played an essential role in building a robust and diverse workforce in community health centers. Studies show that the use of NHSC supported providers increases capacity of community health centers without increasing cost of services for patients or health centers in underserved areas, rural areas, and urban health centers.

The Nurse Corps Scholarship Program covers tuition, fees, and other costs for students who agree to work in a health care shortage area after graduation. The program supports more than 600 clinicians at Community Health Centers.

The Teaching Health Center Graduate Medical Education (THCGME) program funds primary care medical and dental residencies, mostly at community health centers. Graduates of the program are more likely to work in rural and underserved areas than other physicians. Increasing support for this program can further its impact in stemming workforce shortages in community health centers. Increased numbers of providers in community-based settings support stronger recovery and resiliency during disasters and emergencies.

The Federal Tort Claims Act for Volunteer Health Professionals can provide essential support for volunteers at health centers and clinics through expansion to include entity coverage for free clinics, charitable clinics, charitable pharmacies. This would allow for more volunteers to serve rural and underserved communities, expanding services available for health centers and for clinics. Expanding its scope to include temporary locations and individuals providing care in emergency situations can help community health centers remain resilient and responsive in the face of disasters.

These programs are essential vehicles for supporting equitable healthcare access. Shortages of healthcare workers that have worsened in recent years and other trends associated with the trauma endured during and since the COVID-19 pandemic has diminished our current workforce capacity, and may worsen challenges related to healthcare access if not addressed. This raises the question: What lessons can we learn about community impacts from COVID-19, and what actions are necessary to restore and rebuild these communities?

Taking Action

Healthcare workers across all levels and roles in health centers and clinics demonstrate remarkable resilience and an unyielding commitment to patients, even in exceptionally challenging conditions as was evident through the COVID-19 pandemic and other disasters. Often, these professional challenges are concurrent to simultaneously mounting personal pressures, as health centers and clinics are often staffed by individuals who are local to the communities they serve, and/or may identify as members of the communities themselves. This brings to bear a crucial point: When crisis strikes a community, health center and clinic workers are likely to be personally affected.

The healthcare workforce is struggling to keep up with the current healthcare needs, and patient health outcomes are suffering as a result. Many of the issues are stemming from burnout—staff are being asked to work harder in under-resourced clinics with limited support—and this is taking a toll on their mental health and wellbeing. Events like emergencies and disasters (manmade or natural) continue to occur and at increasing rates. These events exacerbate existing health inequities and make it harder for the medically underserved to access quality, culturally competent care and other resources needed to achieve health equity.

It is vital that we take the lessons learned from the COVID-19 response efforts and create tools and resources that can help in recovery efforts, but also to help the public health and healthcare community to be better prepared for the next disaster. To this extent, Healthcare Ready created resources to support the healthcare workforce serving medically underserved communities. Those resources can be found at this link.

Appendix

Appendix A: Analysis of COVID-19 impacts using the Community Disaster Resilience Tool

This report defined regions "hardest hit" by COVID-19 using six specific parameters related to social vulnerability, race, income, age, chronic condition prevalence, and housing status.

To identify geographic communities of focus, data from March 1, 2020 to March 1, 2021 (the period starting the initial public health emergency declaration to the beginning of vaccine distribution beyond frontline workers and to the general population) was pulled from Healthcare Ready's Community Disaster Resilience Tool (CDRT).[f,g]

Table 1: Variables and Condition Criteria

The following variables and condition criteria were used for this analysis.

Social Vulnerability Variable	Condition Criteria
Race	The top 5% of counties in the U.S. with the highest non-white population per total population of the county
Income	The top 5% of counties in the U.S. with the highest percent of people living below the poverty line per total population of the county
Age	The top 5% of counties in the U.S. with the highest elderly population (defined by 65+) per total population of the county
Chronic Condition Prevalence	Top 5% of counties in the U.S. with a prevalence of over 15 chronic conditions (out of a possible 21, as defined by Centers for Medicare and Medicaid Services (CMS), 2018) higher than the national average of chronic conditions per total population of the county
Housing Status	Top 5% of counties in the U.S. with the highest rates of unhoused populations

COVID-19 Variable	Condition Criteria
COVID-19 Morbidity	The top 5% of counties in the U.S. with highest rates of COVID-19 cases per total population of the county
COVID-19 Mortality	The top 5% of counties in the U.S. with highest COVID-19 related deaths per total population of the county
Vaccination Rates	The top 5% of the counties in the U.S. with the lowest rates of fully completed COVID-19 vaccination (defined as two doses of COVID-19 vaccine) per total population of county

[f] According to the White House COVID-19 Health Equity Task force, established in January 2021, vaccines had reached more black and brown populations and those hardest hit and most vulnerable communities to the point where deaths declined by 90% in November 2021.

[g] Vaccines were first disseminated in December 2020, to first responders and those at highest risk.

Geographies with one or more social vulnerability variable and one or more variable related to COVID-19 burden, were considered to be an area most heavily impacted by the COVID-19 pandemic. This resulted in a list of 45 counties throughout the U.S.

Table 2: Number of Counties by State

State	# of Counties Meeting Criteria
Texas	**9**
Arkansas	**4**
Arizona	**3**
California	**3**
Colorado	**3**
Oklahoma	**3**
Alaska, Florida, Georgia, Montana, South Dakota, Tennessee	**2**
Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, Alabama	**1**

Appendix B: Interview Question Sets

Question set specifically for participants working in a community health center or free and charitable clinic:

1. What is your title at this health center/facility?
2. Can you briefly describe your role and/or main functions at this center?
3. How many people are on staff, including clinical, administrative, etc.?
4. On average, do you know how many patients your clinic serves in a year?
5. Are there any particular or unique services this facility offers that you want to note?
6. What are some things that negatively impact your ability to contribute to positive and comprehensive care for the patients you serve? What are some challenges you encounter that might impact your capacity to do your work? Feel free to name or describe as many as come to mind.
7. Are there any new challenges that have cropped up for you because of COVID-19 in serving the patient population?
8. It sounds like you have named a few specific challenges you have experienced in the healthcare workforce related to the covid-19 pandemic. What are some changes or solutions that can be implemented to better support you in caring for your patients and working at this facility? We are aiming to understand how you, as a person who works at a healthcare facility, could feel better supported in the work that you do.

9. You may or may not know this, and not knowing this is totally fine, but just going to ask: Has leadership or others at your facility attempted to address these challenges? What have they done to do so? What are some ways that leadership could better support you in your role and improve on the challenges you've described?

Question set specifically for participants working at a primary care association or membership organization:

1. What is your title?
2. Can you briefly describe your role and/or main functions?
3. What are some factors/conditions that have impacted how health center staff deliver quality, comprehensive care to their patients?
4. Are there any new challenges that have developed for health centers because of COVID-19 in serving the patient population?
5. It sounds like you have named a few specific challenges that health centers have experienced related to the covid-19 pandemic. How has the PCA supported health centers in addressing these challenges?
6. To what extent have you seen members address workforce challenges? What are some ways your members have tried to foster workforce resiliency?
7. Have there been external resources that you and/or your members have referenced, used, or implemented to support improving workplace culture or conditions? If so, can you share them?

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