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State Strategies to Support the Future of the Primary Care Physician and Nursing Workforce

High-quality primary care is foundational to a healthy society and well-functioning health care systems. The COVID-19 pandemic had a significant impact on the health care workforce, threatening access to essential services. The pandemic is exacerbating existing issues and accelerating early retirements and departures from health care professions, including [primary care physicians](#) and [nurses](#). These shortages [disproportionately affect rural and underserved areas and increase strain](#) on a primary care workforce already experiencing long hours, burnout, and fatigue. States are seeking to better understand the extent, location, and cause of such shortages and strategies that address immediate concerns in addition to longer-term solutions to recruit and retain a workforce that can meet the diverse and evolving needs of our nation.



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This paper outlines workforce challenges and aligns them with policy strategies and implementation examples to address these challenges. In some cases, there are new issues for which policy strategies have not yet emerged due to the evolving nature of the problem. For example, throughout the COVID-19 pandemic, an increased reliance on [travel nurses](#) has distorted pay and had a ripple effect on sector-wide costs. Although the situation has stabilized in some areas, other providers and payers, including states, are still struggling to stem rising costs.

In summer 2022, the National Academy for State Health Policy (NASHP) convened state officials and national associations for a discussion focused on health care workforce recruitment and retention, with a focus on physicians and nurses in primary care. Based on a virtual convening, individual interviews, and desk research, NASHP developed this toolkit of resources for states, health systems, and academic institutions exploring innovative strategies to address health care workforce challenges. States seeking additional support can contact Elaine Chhean at echhean@nashp.org.

Strategic Investments in Workforce Strategies

States are experiencing workforce shortages across many sectors, including various health care professions. Simultaneously, states are receiving unprecedented short-term funding from the federal government and considering the most strategic use of such funds. When states identify a health care workforce shortage, it triggers an exploration into the specifics of the shortage to inform the relevant policy strategies. States benefit from access to [quality health care workforce data](#), including specialty, practice address, populations served, and where providers completed their education. For example, Indiana identified that nurses who began their career as a certified nursing assistant (CNA) were more representative of the demographics of the communities they serve, an outcome the state was seeking. Based on this information, Indiana developed collaborations with community colleges to encourage CNAs to continue their education and become nurses.

The executive and legislative branches both play a critical role in setting forth policy vision and codifying policies in statute and regulation. Further, licensure boards have significant authority over the direction of individual professions and can drive change. Some states have [commissions, councils, or workgroups working collaboratively](#) across government and with providers, professional associations, and academic institutions that train future physicians and nurses. These groups can work together to develop and execute state-level strategies that can improve provider satisfaction, recruitment, retention, and health outcomes of patients and providers alike. For example, Vermont developed a [Health Care Workforce Development Strategic Plan](#) to provide recommendations to the legislature for strategic investments and development of the health care workforce, many of which the legislature funded in 2022.

Promoting Provider Well-being through Preventive Care, Protection of Confidentiality, and Destigmatization of Behavioral Health Treatment

Health care workers dedicate their careers to caring for others, yet they do not always access the help they need. There are multiple factors that can discourage health care practitioners from seeking treatment, including fear of retribution based on diagnosis and treatment information collected during licensure and credentialing, practitioner health programs that are punitive in nature, and fear of mental health conditions and treatment being reported to licensing boards or disclosed in malpractice lawsuits. Unfortunately, these barriers have intersected with the stressors brought about by the COVID-19 pandemic that include increased workload, staffing shortages, risk of infection, and hostility related to the pandemic and the COVID-19 vaccine. Longstanding stigma and pandemic-related stressors contributed to the suicide of an emergency room physician in New York City who worked long hours during the first wave of the pandemic and feared that she would lose her medical license after she received mental health treatment (which was not true in the state of New York). In response, Congress passed the bipartisan [Lorna Breen Health Care Provider Protection Act](#) with the goal of taking action to prevent suicide, burnout, and behavioral health issues among health care workers. The legislation includes \$130 million to be spent over three years for grants, a campaign conducted by the U.S. Department of Health and Human Services, development of federal policy recommendations, and a Government Accountability Office report on the success of the activities.

As federal action in this space continues, there are several potential policy strategies that states can implement to promote preventive care, well-being, and access to behavioral health services. Additional strategies to prevent burnout, closely related to promoting well-being, are addressed in a subsequent section of this toolkit.

- **Physician health programs (PHPs) can help physicians who are at risk of impairment and provide an alternative to disciplinary action.** [PHPs](#) can also verify compliance with health monitoring recommendations necessary for physicians to continue employment or return to practice. However, fears about time away from practice, license suspension or revocation, or having participation in a PHP disclosed to boards can make physicians reluctant to seek help; this makes it important to establish and clearly communicate available protections. States can work with health systems, academic

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institutions, and licensing and credentialing bodies to re-design PHPs and wellness programs to provide early intervention and destigmatize seeking help. For example, Virginia renamed its program from Impaired Physician Program to the [Health Practitioners' Monitoring Program](#) to reduce the stigma associated with seeking help.

- **Removing the physician's obligation to report participation in PHPs to licensing boards** can encourage physicians to seek help without fear of professional repercussions. Virginia removed this obligation with the passage of [HB 115](#) in 2020, with exceptions for physicians who are deemed a danger to themselves or to the health of their patients.
- **Wellness programs provide counseling or peer coaching to health care workers struggling with stress and burnout.** Virginia's [SafeHaven](#) program, established in 2020 by [Virginia House Bill 115](#), provides confidential peer coaching and counseling to physicians, nurses, and pharmacists, as well as medical, nursing, physician assistant, and pharmacy students. UC San Diego's school of medicine established the [Healer Education Assessment and Referral Program](#) to address the high levels of burnout, stress, and depression in the health care profession by educating medical students, faculty, and hospital staff about risk factors and offering confidential assessments of stress and depression.
- **Limiting licensure questions about diagnoses and treatment to only those necessary for safety can lower barriers to seeking treatment and ease physician concerns about their medical license being suspended or revoked.** Rather than asking about historical diagnoses or treatments, [California's physician and surgeon licensure application](#) only asks about current conditions that impair the ability to safely practice medicine and about current enrollment in drug, alcohol, or substance use recovery programs, with a note that "an affirmative answer...will not automatically disqualify [applicants] from licensure." [Colorado's](#) medical board does not require physicians to report mental health conditions if the condition is known to the Colorado Physician Health Program (CPHP) and the physician complies with all of CPHP's recommendations.
- **Grant funding investments may reveal new opportunities.** As part of the Lorna Breen Act, the [U.S. Health Resources and Services Administration](#) (HRSA) has provided \$103 million to over 40 medical institutions and universities to train health care workers on strategies that build resiliency and promote wellness. States may consider promoting or scaling the strategies and trainings developed by grantees that have positive results.

Preventing Burnout by Addressing Staffing Levels and Administrative Functions

There are numerous factors that contribute to burnout among health care practitioners, including understaffing, administrative burden, and limited time allocated to patient interaction. Even before the onset of the COVID-19 pandemic, [35 to 54 percent](#) of nurses and physicians reported symptoms of burnout. In May 2022, the U.S. surgeon general released an [advisory](#) acknowledging health worker burnout as an urgent public health issue and providing recommendations for how it could be addressed. To prevent the negative mental and physical effects of practicing medicine and avoid additional workforce and turnover issues, it is critical to address burnout in multiple domains. There are several policy strategies states can implement to prevent burnout:

- **Safe staffing policies address nurse staffing levels** and typically fall into three main categories. It is important to consider enforcement mechanisms, as requirements that lack enforcement may lack adherence.
 - **Hospital staffing committees** develop staffing plans based on patient needs. [Washington](#) state requires all hospitals to establish nurse staffing committees, with at least half of the committee composed of direct care nurses.
 - **Mandated nurse-to-patient ratios** exist in [California](#) for all hospital units and in intensive care units in [Massachusetts](#).
 - **Public disclosure of nurse staffing levels** is required in [five states](#) to provide transparency about staffing levels. However, some scholars have noted that the [variation](#) in how data are presented and how staffing is measured can make it difficult to effectively communicate this information to consumers.
- **Reforming prior authorization processes can alleviate administrative burden** and give providers more time to spend with patients. The U.S. surgeon general's [advisory](#) on addressing health worker burnout recommends streamlining prior authorization. This is also a high priority for physician groups such as the American Association of Family Physicians and the American Medical Association (AMA). In 2021, an [AMA survey](#) found that 88 percent of physicians described the burden associated with prior authorization as high or extremely high. Prior authorization reform includes three primary approaches:



BY THE NUMBERS

35-54%

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- **Reporting on prior authorization processes aims to increase transparency** by requiring insurers to disclose information such as the percent of claims approved, denied, or appealed. In 2022, Michigan passed [SB 247](#), which streamlines prior authorization requests and requires insurers to provide notices when requirements or restrictions are added or amended.
- **Clinical review criteria that align with generally acceptable standards of care** or are developed by a professional medical society may improve the clinical validity of prior authorization requirements. [California](#) no longer allows insurers to use their own clinical criteria for medical necessity decisions and instead requires the use of guidelines developed by nonprofit professional associations.
- **“Gold card” laws** exempt providers with high prior authorization approval rates from prior authorization requirements for certain services. [West Virginia](#) and [Texas](#) have both passed gold card laws, and [Vermont](#) is currently piloting a statewide gold card program.
- **Streamlining Electronic Health Record (EHR)** technology and clinical documentation requirements can help to shorten the amount of “[pajama time](#)” or “work after work” that physicians and nurses spend completing functions such as documentation, reviewing labs and diagnoses, and electronic communication with patients. The Office of the National Coordinator for Health Information Technology (IT) made a series of recommendations in the [Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs](#). The report addresses reducing reporting requirements, aligning health information technology with the clinical workflow, identifying ways to exempt clinicians engaged in alternative payment models from some documentation requirements, increasing standardization of data to support automation for prior authorization, and incentivizing providers to use certified technology that has adopted [recognized standards](#). While intended for a federal audience, the report’s recommendations have applicability for state policymakers and vendors.

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Ensuring an Adequate Supply of Nursing Faculty and Preceptors to Train More Nurses

Nursing faculty are vital to educating the future nursing workforce. According to a [2019 survey](#) by the American Association of Colleges of Nursing, there were 1,715 faculty vacancies (7.9 percent of positions) at 488 nursing schools across the country. In total, 84.1 percent of nursing schools reported a need for additional faculty. These shortages, which are likely to increase as nurse educator [retirements accelerate](#), contribute to qualified [applicants being turned away](#) from baccalaureate and graduate nursing programs. Insufficient training in educational methods can leave nurse faculty feeling [unprepared](#) for their teaching roles, even if they have deep clinical experience. In addition, in a competitive pay landscape, salaries for educators may not compete with those of practicing nurses. Compounding the issue is a lack of nurse preceptors, who help nursing students obtain necessary clinical hours and gain hands-on experience. Preceptors are sometimes, but not always, [compensated for training students](#), even though their [workload increases](#) when they do so. Potential state policy strategies to improve and sustain nursing education and training include:

- **Providing revenue and reducing workload for preceptors**, which can incentivize more nurses to become preceptors and reduce the stress associated with preceptorship. The Virginia General Assembly allocated \$500,000 for fiscal year 2022 to establish the [Nursing Preceptor Incentive Program](#) to compensate preceptors who would not have otherwise been paid. [Colorado](#), [Georgia](#), [Hawaii](#), [Maryland](#), and [South Carolina](#) offer tax credits to preceptors, with some requiring preceptors to practice in rural or underserved areas. In addition, ensuring rotations give exposure to primary care may encourage more nursing students to stay in the field. Because most training programs focus on the hospital setting, trainees may not realize the full extent of opportunities. In 2019, HRSA awarded more than \$37 million to support [innovative academic-practice partnerships](#) to support primary care training of advance practice registered nurses, with a focus on rural and underserved populations.
- **Ensuring faculty receive adequate training** in teaching can help ease the [transition](#) from clinical nursing to nurse educator. Many nurses with clinical experience have not received training to prepare them to teach in an academic setting and may feel unprepared for faculty roles. Some states require coursework in teaching and learning as criteria to become nursing faculty. In [North Carolina](#), nursing faculty must complete coursework in adult education, including curriculum development and evaluation. [Kentucky](#) requires faculty to complete coursework on adult education and curriculum development or be paired with a mentor and implement an educational development plan if they have no previous teaching experience.

Taking Measures to Ensure Provider Safety

Health care workers are [five times as likely](#) to experience workplace violence as workers in all other industries. In addition, research demonstrates that [physicians of color regularly experience racism from patients and colleagues](#), and physicians for whom English is a second language reported racism from patients significantly more than physicians of color overall. Recent [studies](#) and [news reports](#) indicate that misinformation about the COVID-19 pandemic has led to a rise in threats and violence. During the pandemic there has been an increase in verbal abuse and violence directed at [Asian American health care workers](#). Underreporting of workplace violence makes it difficult to understand the full scope of the problem and learn more about the circumstances surrounding such incidents to implement more preventive measures. There are several policy strategies states may consider to improve health care worker safety:

- **Violence prevention programs** established and maintained by employers are required in [nine states](#) as of March 2021. Employers may be required to conduct risk and threat assessments, create violence prevention plans that include health care workers in the development process, and track and report violent incidents. As one example, [California's](#) Workplace Violence Prevention in Health Care standard, which went into effect in 2017, states that employers must keep violent incident logs and develop and review violence prevention plans with employee input.
- **Protecting names and provider confidentiality** can help keep health care workers safe and prevent stalking and online harassment. In 2020, [Maryland](#) relaxed the requirement that health care workers use their full name on ID tags or badges, instead allowing them to use their first name, last name, or commonly used nickname instead. Colorado made doxxing, or revealing private information online with the intent to threaten safety, of public health workers illegal in [2021](#), and expanded the law in [2022](#) to include health care workers, child care providers, and other public officials.
- **Penalties for assault or threats** against health care workers have been established or strengthened in 38 states, with [Missouri](#) making it a class D misdemeanor to create a disturbance inside a health care facility or threaten patients or employees.

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Allowing Providers to Practice at the Top of Their License

During the pandemic, many states [temporarily modified scope of practice policies](#) to address increased demand and reduced supply of health care professionals. [Scope of practice policies](#) dictate the functions an individual with a professional license can perform to ensure that people are only engaging in activities for which they were trained. There is significant variation across states regarding scope of practice policies. (Here is additional information on [nurse practitioner scope of practice policies](#) and [physician associate policies by state](#)). Costly and administratively complex licensing requirements may become a barrier to recruitment. Further, providers may avoid practicing in a state in which they are unable to practice to the top of their license. In addition, with the [growth of telehealth during the pandemic](#), variation in state laws required health care providers to ensure adherence to both telehealth and scope of practice policies in each state in which they practiced. Potential policy strategies include:

- **Participating in interstate compacts** facilitates “borderless practice” for providers. [Interstate compacts](#) exist for a number of professions. While each has different policy requirements regarding the application process, cost, and governing state policies, all are intended to simplify the process of practice across state lines. Currently 39 states, territories, and DC participate in the [Interstate Medical Licensure Compact](#), and 39 states and territories participate in the [Nurse Licensure Compact](#). The [Advanced Practice Registered Nurse Compact](#) is not yet active but will be once seven states have enacted legislation to participate.
- **Improving data collection** about the current workforce and educational programs can help states make informed decisions about scope of practice policy. Scope of practice policy discussions are highly sensitive for practitioners, and professional associations do not always agree on approaches to reform. By leveraging [licensure and supplemental workforce data](#) in addition to educational institution data, states can collect uniform information across professions and training programs to determine where need is the greatest and where it may be worthwhile to test new policy options. This may eliminate or reduce the tension that often exists across professions related to scope of practice.

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Training Initiatives and Other Supports to Increase Diversity in the Workforce

The medical profession is not reflective of the diversity of the U.S. population. For example, Black, Hispanic, and Native Americans are significantly [underrepresented](#) in primary care roles. Cultivating a more diverse health care workforce [offers many benefits](#), including improved access to high-quality and culturally appropriate care, enhanced trust between clinicians and patients, increased patient choice and satisfaction, as well as a more diverse and representative pool of leaders within the health care profession. While some pathway programs for medical students have a focus on increasing diversity, most programs for nurses [do not have this explicit emphasis or targeted funding for underrepresented groups](#). It should be noted that there are some policy strategies that can improve both the diversity and distribution of the primary care workforce. For example, the [UC Programs in Medical Education \(UC PRIME\)](#), described in more detail in the following section, trains providers to practice in underserved communities but also recruits students from those communities, resulting in 64 percent of PRIME students coming from groups that are underrepresented in the medical profession. Potential state policy strategies to improve workforce diversity include:

- **Pathway programs from rural and underserved communities that offer supports and mentorship** can foster the development of a more diverse and representative primary care workforce. The [California Medicine Scholars Program](#) (CMSP) recruits students from community colleges in rural and underserved areas to increase the diversity of the physician workforce and improve access to culturally and linguistically appropriate care. Many students of color launch their college careers at community colleges, and CMSP aims to streamline their path to medical school by providing supports such as tailored advising, mentoring services, scholarships, and stipends. The program aims to assist approximately 200 students each year and received \$10.5 million as part of the state's 2021–2022 budget. While pathway programs at community and state colleges and universities can encourage students from underrepresented groups to enter medicine, states can also support initiatives that provide [high school](#) and middle school-aged youth with exposure to careers in health care.
- **Scholarships and loan repayment programs** have the potential to increase the diversity of the primary care workforce by reducing financial barriers to entry for American Indian/Alaska Native, Black, Latinx, and other students, who are more likely to come from lower-income families and report having [education debt](#). [State funding](#) that provides direct support to students through the form of grants, scholarships, and stipends can be particularly important in helping cover the costs

Cultivating a more diverse health care workforce offers many benefits, including improved access to high-quality and culturally appropriate care.

of academic training for systemically and structurally excluded groups. However, unless these programs explicitly [target underrepresented communities](#), they are likely to have a greater impact on improving access to care than increasing workforce diversity.

Reducing Workforce Maldistribution to Improve Access to Care

The unequal distribution of the primary care workforce means that many communities, especially in rural areas, lack access to care and experience unmet health needs. There are currently [96 million people](#), many of whom are uninsured, living in HRSA-designated primary care health professional shortage areas. While [primary care providers](#) are more likely to practice in rural areas than specialists, they are still [concentrated in urban areas](#), and existing market forces mean that access issues will persist without additional policy interventions. Potential policy strategies to improve the distribution of the primary care workforce include:

- **Improving collection of health workforce data** can help states respond strategically to improve the distribution of their workforce, much like it can help with objective decision-making regarding scope of practice. By [collecting information](#) about specialty, practice address, populations served, and where providers completed their education, states can better identify underserved populations, target funding for loan repayment and scholarship opportunities, and develop pathway and graduate medical education (GME) programs to increase recruitment and retention of providers to rural and underserved areas. Indiana partners with Indiana University to maintain [dashboards](#) that present information collected during licensure and renewal on geography, demographics, education, and practice and specialty, to inform policy decisions related to the health care workforce. [North Carolina](#) found that only 1 percent of its medical school graduates were practicing as primary care physicians in rural areas, a finding that could be used to develop more rural training tracks in medical schools and residency programs.
- **Supporting specialized training tracks and programs in medical schools and residency programs** that prepare students to practice in underserved areas can improve provider retention and access to care. Because individuals [tend to practice close to where they trained and are more likely to practice in safety net settings if they trained there](#), increasing access and funding to these programs can help meet the needs of underserved regions.

- California's [UC Programs in Medical Education \(UC PRIME\)](#) offers a supplemental, specialized curriculum to train students to practice in underserved communities in both rural and urban areas. Each of the eight PRIME programs has a specific area of focus, such as rural or urban underserved populations, depending on the populations served by each school and other local factors.
- Other training tracks, such as the [Frontier and Rural Medicine](#) program at the University of South Dakota School of Medicine and the [Rural Physician Associate Program](#) at the University of Minnesota, provide students with nine months of clinical training experience in rural communities, with the goal of encouraging primary care providers to practice in those areas.
- **Innovative state GME initiatives** have the potential to improve the distribution of the workforce by training physicians to work in underserved areas. The [California Oregon Medical Partnership to Address Disparities in Rural Education and Health \(COMPADRE\)](#) initiative is a collaboration between Oregon Health & Science University, UC Davis School of Medicine, and over 30 GME programs that aims to reduce health disparities and address physician shortages in Northern California and Oregon. COMPADRE provides specialized training to physicians to help them build strong connections with underserved communities, and the program's consortium model facilitates resource sharing and a more equitable distribution of students across the region. The initiative also leverages existing pathway programs, community colleges, and other partners such as federally qualified health centers to recruit students from diverse backgrounds who plan to practice in under-resourced areas. In another example, the University of North Carolina School of Medicine's [Fully Integrated Readiness for Service Training \(FIRST\)](#) program is an accelerated pathway program that includes three years of medical school, direct progression into three years of affiliated residency, and three years of practice support in a rural or underserved area of North Carolina. In addition to only financing three years of medical school, FIRST scholars are matched with loan repayment programs upon their placement in a residency program. States can partner with universities to support such programs. States may also consider how to allocate GME dollars to include initiatives that incorporate physician assistants and advanced practice registered nurses.
- **Leveraging modalities such as telehealth and mobile clinics** can improve access to care in rural and underserved communities. Though lack of [broadband access](#) and unfamiliarity with technology are barriers, telemedicine has been shown to improve access to care and health outcomes in [rural communities](#). During the COVID-19 pandemic, states have taken advantage of telehealth

funding flexibilities, some of which have paved the way for permanent policy changes. For example, [Arizona](#) requires permanent payment parity and allows providers licensed in other states to provide telehealth services to Arizonans with some restrictions. [Iowa](#) requires payment parity for telemental health services, and [Ohio Medicaid](#) permanently expanded the definition of telehealth, the types of eligible providers, and the types of telehealth services for which Medicaid can pay. [Hawaii](#) allows physicians licensed there to establish a physician-patient relationship via telehealth without an in-person consultation. In some states, temporary telehealth policy changes were made that will end based on the end of the public health emergency. Mobile health clinics can also improve access to [primary and preventive care](#) for rural and underserved populations and reduce emergency room visits and hospitalization costs, but [few receive state funding](#) and must rely heavily on philanthropic support. Increased flexibility and funding for telehealth services and mobile clinics can help promote access to care and mitigate workforce maldistribution issues in rural and underserved areas.

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