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# In-Depth Analysis: The FQHC Provider Shortage

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## Scope of the Shortage

Provider shortages at FQHCs are severe and getting worse. In 2024, a Commonwealth Fund survey found that over 70% of health centers reported not having enough primary care physicians, nurses, or mental health specialists.[2] Similarly, TechTarget reports that 70% of centers say their PCP slots are short-staffed; 77% have too few behavioral health providers; and 70% lack sufficient nurses.[7] These shortages have grown substantially in recent years. FQHCs cared for 31 million patients in 2023 (up 2.7 million since 2020), most of whom have few other care options. The net effect is a widening gap between patient needs and available staff.

## Contributing Factors

Several interlocking causes explain why FQHCs struggle more than typical providers:

- **Geography and Population:** Many FQHCs serve rural or under-resourced communities. Rural areas often have few local health professionals and less appeal for new graduates. Even urban centers that serve vulnerable populations may be in low-income neighborhoods lacking amenities. Practitioners consider quality of life factors (schools, jobs for spouses, etc.), so FQHCs in hard-to-reach areas need extra incentives to recruit.
- **Funding and Reimbursement Constraints:** FQHCs rely on a mix of federal grants, Medicaid reimbursement, and sliding-scale fees. Because Medicaid and uninsured patients form a large share of their patients, FQHCs typically can't pay market rates. Limited budgets hamper sign-on bonuses and competitive salaries.
- **High Patient Complexity and Burnout:** FQHC patients often have multiple chronic conditions, mental health needs, and social challenges. This leads to heavier workloads. Providers in these settings report high burnout; nationally, 68% of FQHCs surveyed had lost 5–25% of their workforce during the pandemic, citing stress and infections as key reasons.[12] Constantly backfilling critical positions becomes an unsustainable cycle when clinicians quit due to burnout, creating even more strain on remaining staff.
- **Administrative and Credentialing Delays:** FQHCs face stringent reporting requirements and slow hiring processes (e.g. lengthy credentialing for new hires and billing staff). Any delay in onboarding can leave health centers understaffed for weeks or months. Though not unique to FQHCs, this burden compounds the challenge in already lean organizations
- **Competition from Other Providers:** Private hospitals and health centers often poach available clinicians with better pay and benefits. FQHCs struggle to compete with salaries offered elsewhere. Additionally, urban FQHCs must offer something more than just a salary to retain talent.

Combined, these factors mean that even mission-driven clinicians may be hesitant to stay long-term in FQHC roles. Providers often want to serve underserved communities, but lower salaries, heavy workloads, and burnout make it difficult to keep staff engaged.

# Strengthening the Workforce Pipeline

Leverage Federal Recruitment Programs: FQHCs can tap federal incentives to attract clinicians to underserved areas. For example, the National Health Service Corps (NHSC) offers loan repayment and scholarships to providers who commit several years to a Health Professional Shortage Area. Health centers are explicitly eligible for NHSC awards.[5] Similarly, the J-1 visa waiver program allows

foreign medical graduates to practice at FQHCs in exchange for service in underserved areas. The Teaching Health Center GME program subsidizes community-based residency programs, creating a pipeline of primary care physicians. FQHC leaders should aggressively market these benefits when recruiting. Education about NHSC and targeted recruitment to NHSC-approved sites are proven strategies to fill rural and community health center gaps.

Build Training Pipelines: Beyond federal programs, health centers can develop local partnerships. Partnering with medical, nursing, and physician assistant schools to provide rotations or clerkships at FQHCs gives trainees valuable experience in caring for underserved communities. Some centers host residencies or fellowship programs (e.g. family medicine, psychiatry) funded by grants. Graduates of these programs often stay nearby. FQHCs should also consider "grow-your-own" strategies: supporting local high school or college students in healthcare career paths, offering internships, or training community health workers who can advance into clinical roles. Investing in future talent can assist in reducing long-term gaps.

Flexible Employment Models: To broaden the candidate pool, offer creative work arrangements. Part-time roles, split-sites, or job-sharing can attract clinicians who cannot commit full-time (e.g. parents, retirees, or semi-retired physicians). Telecommuting options (for clinicians with remote telehealth visits or case reviews) also extend reach: an urban FQHC could hire a psychiatrist from another state to do virtual consultations, for instance. Per-diem and outside staffing arrangements give health centers relief in the long or short term. In combination with the above incentives, flexible jobs make FQHC positions more attractive.

# Enhancing Retention and Capacity

- **Telehealth and Virtual Care:** The most prominent solution has been expanding telehealth. During the pandemic, FQHCs massively scaled up virtual visits: as noted, telehealth usage went from just 24% of centers in 2018 to 96% in 2024.[6] This trend should not be allowed to slip. By maintaining strong telehealth programs, centers can share workforce across distances. For example, a behavioral health therapist could serve patients at multiple health centers via video, or a doctor in a city can "visit" rural patients remotely. Telehealth also appeals to providers seeking work-life balance: in one West Virginia FQHC, allowing doctors and nurses to conduct visits from home eased staffing pressure and burnout.[15] Importantly, FQHC leaders should ensure technology and billing support: that means investing in secure telehealth platforms (with high-quality audio/video and EHR integration) and coding claims correctly (using the right modifiers for telehealth) for services to be reimbursed fully. FQHCs

should also advocate for continued reimbursement parity. Equal payments for both telehealth and in-person would assist in bridging the provider gap.

- **Remote Patient Monitoring (RPM) and Care Teams:** Beyond visits, remote monitoring devices can lighten workloads. The WV FQHC example included RPM for chronic conditions: nurses reviewed patient data (like blood pressure readings) and alerted providers to issues.[15] This model lets fewer clinicians manage larger patient panels by triaging care needs. Additional nursing or technician support via RPM platforms effectively "adds staff" to the team; at Rainelle Medical Center, external nursing support integrated through RPM helped the center care for more patients than before.[15] FQHCs should explore grant-funded RPM and chronic care programs as ways to extend each provider's reach.
- **Leverage Allied Health and Team-Based Care:** Utilizing a full care team is essential. Nurse practitioners (NPs), physician assistants (PAs), pharmacists, social workers, and community health workers can all help shoulder tasks traditionally done by physicians. Expanding scopes of practice where allowed (e.g. enabling NPs to practice independently in primary care) can immediately relieve doctor shortages. Most health centers already hire many NPs and PAs; continuing to do so with appropriate support (mentorship, clear protocols) is key. For behavioral health, co-locating therapists or hiring psychiatric nurse practitioners (PMHNPs) has been a viable solution. Even if funding is tight, creative staffing arrangements (like contracting therapists/PMHNPs) can ensure these roles exist.

Outsourcing Non-Clinical Functions: FQHCs can reduce clinician burden by outsourcing or sharing administrative functions. Options include:

- **Telephonic Triage Lines:** Some health centers (or networks of centers) contract with nurse triage services. For example, the Kenosha Community Health Center partnered with a call-center nurse service to field hundreds of patient calls daily.[3] This means less staff time spent scheduling or triaging cases, freeing providers to focus on direct patient care.
- **Contract Staffing:** For shortfalls in certain roles (like behavioral health or specialty care), centers can contract with private practitioners (perhaps even on-site). RHIhub notes that FQHCs often supplement dental and mental health care by partnering with outside providers.[13]
- **Billing and IT Services:** Administrative load can be lessened by pooling resources or outsourcing revenue cycle management, compliance, and IT support. This also allows clinicians to focus on patients.

Improve the Work Environment to Reduce Turnover: Retention strategies are just as critical as recruitment. Providing reasonable work schedules, robust support staff, and opportunities for professional development can make clinicians stay. Some tactics include:

- Instituting formal employee wellness programs (e.g. counseling, stress management).
- Ensuring adequate coverage so no one provider is always overbooked.
- Offering tuition reimbursement or paid Continuing Medical Education (CME).
- Engaging staff in decision-making and fostering a supportive culture. Studies show that leadership support and manageable workloads are top factors in clinician retention.[9] While these measures may not have flashy headlines, they matter: reducing burnout by even a small amount means fewer vacancies to fill.

# Leveraging Technology and Innovation

- **Telehealth Platforms and Policies:** As noted, modern telehealth requires not just hardware/software but thoughtful implementation. FQHCs should pursue high-quality HIPAA-compliant platforms that integrate with their EHR. Training staff to use telehealth effectively, including documenting and billing correctly, ensures sustainability and should be a top priority. FQHCs should also monitor telehealth metrics (utilization, no-show rates, claim denials) to continually refine their processes. Importantly, audio-only visits should be fully utilized: many Medicaid programs reimburse them, and they are easier for some low-income patients to access. FQHCs must code these visits properly to capture revenue correctly.
- **Data and Care Coordination Tools:** Beyond patient visits, technology for coordination can multiply staff impact. For instance, some health centers use Health Information Exchanges or alert systems to track when their patients go to ERs or specialists. Such tools reduce the need for social service staff to make manual inquiries - automated alerts instead prompt care teams to follow up. Centers should consider enrollment in regional information networks or care management platforms (sometimes funded by HRSA grants) to streamline case management. Any time a provider doesn't have to hunt for information and/or patients, it saves time and reduces stress.
- **Expanding Tele-Behavioral Health:** Behavioral health shortages are particularly acute (77% of centers reported too few mental health providers).[7] Tele-behavioral health can bridge this gap effectively. Many states and payers now allow remote therapy, even audio-only, to count the same as in-person visits. FQHCs should invest in tele-behavioral infrastructure and cross-state licensing where possible, so that a licensed counselor in one state can serve

FQHC patients in another. Hiring part-time tele-psychiatrists or PMHNPs to consult on complex cases is another model to amplify a limited local BH staff. Together, these strategies expand the recruiting pool beyond local limitations, opening access to a much broader network of qualified behavioral health professionals.

## Policy and Funding Considerations

- **Advocacy for Funding:** All the above solutions require stable funding sources. FQHC advocates stress that a reauthorized and expanded Health Center Fund is essential. The Federal government could also increase allocations specifically for workforce programs. State Medicaid agencies can help by ensuring telehealth and remote monitoring services are reimbursed. FQHC leaders should lend their voices to these policy efforts.
- **Reimbursement Parity:** As highlighted, payment policies greatly influence staffing. Ensuring Medicaid and Medicare pay FQHCs the same rates for telehealth as in-person visits removes a disincentive to offer remote care. The 2022 Medicare rule (mirrored in recent extensions) now lets FQHCs bill for mental telehealth at full rates, which should be fully embraced. FQHCs can also work with Medicaid MCOs to include telehealth in contracts at favorable rates. On the flip side, billing for telehealth requires precise coding (e.g. using the correct place-of-service and modifier codes), or centers risk denials that undercut revenue.
- **Value-Based Care Incentives:** Participating in ACOs or alternative payment models can give FQHCs more stable funding tied to outcomes. Telehealth and remote monitoring help meet value-based metrics (like reduced hospitalizations), which in turn can unlock shared savings. Centers should explore this approach as a way to smooth reimbursement volatility.

## Conclusion

FQHCs are at the front lines of care for vulnerable communities. The provider shortage is a profound challenge, but FQHC leaders are resilient and innovative. By understanding the specific factors at play and applying targeted fixes, health centers can begin to close the gap. Key takeaways: Expand and diversify your workforce pipeline (NHSC, training pipelines, part-time/locum clinicians); modernize care delivery (embrace telehealth and team-based models); nurture your staff (flexible schedules, support to reduce burnout); and advocate for policy support (funding, reimbursement parity). The evidence suggests these steps work. The path forward requires commitment at both the clinic and system level, but the outcome is worth it: stable staffing means accessible care for millions

of Americans who depend on FQHCs. With persistence and these strategies, FQHC leaders can indeed change the narrative from “we have no providers” to “we found a way through.”

## Why This Matters to Peregrine

Our mission is to support FQHCs in delivering high-quality, behavioral health care. Every provider shortage at a center directly impacts our shared goal: helping patients receive the care they need. Understanding and solving staffing challenges allows us to better tailor our solutions and to advocate for the resources our partners need. When FQHCs thrive with adequate staffing, enhanced technology, and stable funding, they improve patient outcomes. Thus, addressing the provider shortage is not just an industry imperative; it is fundamental to the health centers we serve and to our core mission of advancing equitable, sustainable behavioral health care.

Discover more actionable insights for FQHC leaders at
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