CECA
Coalition to Expand Contraceptive Access

Expanding the Capacity of the Contraceptive Care Workforce: Environmental Scan Report

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ABSTRACT

The Coalition to Expand Contraceptive Access (CECA) is leading a collaborative process to identify **evidence-based, actionable strategies to expand the capacity of the contraceptive care workforce**. To inform the development of these recommendations, CECA conducted an environmental scan to summarize available evidence on innovative workforce strategies in areas adjacent to contraceptive care (e.g., primary care, behavioral health and substance use disorder care, and maternity care) to identify relevant strategies that might be adapted for the contraceptive care context. We identified six workforce development and capacity strategies:

1. Offering incentive programs to improve recruitment and retention
2. Integrating allied health professionals into the workforce
3. Innovating on funding and payment strategies
4. Expanding scope of practice regulations for advanced practice providers
5. Increasing diversity in the workforce
6. Implementing training and education opportunities

This report highlights examples of how these strategies have been implemented in various areas of healthcare and the available evidence describing their effects on workforce composition, access to person-centered care, and other outcomes of interest. Additional evidence is needed to support each workforce strategy described in this report, particularly how these strategies can demonstrate long-term impact, improve quality of care, and expand equitable access to person-centered care.

INTRODUCTION

The Coalition to Expand Contraceptive Access (CECA) is leading a collaborative process to identify **evidence-based, actionable strategies to expand the capacity of the contraceptive care workforce**. These recommendations will equip a broad range of stakeholders—including federal and state policymakers, clinical and academic institutions, health professions training and accrediting bodies, medical and public health professional organizations, researchers, and advocates—to strategically address workforce issues through coordinated policy, programming, and research action. Implementation of these recommendations will serve the ultimate aim of increasing access to quality contraceptive care—particularly respectful person-centered care—that meets the needs of patients and communities, regardless of where a person seeks care.

The contraceptive care workforce includes a range of professionals who deliver and support the delivery of reproductive health and contraceptive care services. This workforce comprises a broad range of healthcare professionals who provide reproductive health and contraceptive care services, including physicians (e.g., obstetricians/gynecologists, family physicians, pediatricians, and adolescent medicine providers), advanced practice clinicians (e.g., nurse practitioners, physician assistants, and nurse-midwives), nurses, pharmacists, midwives, doulas, medical assistants, health educators, and community health workers. By providing counseling and education; referring and connecting people to care; and prescribing, placing, and removing contraceptives, these professionals provide needed support for this essential health service.

The contraceptive care workforce faces several challenges related to the provision of accessible, high-quality, person-centered care, including:

- Inadequate supply of providers, especially in rural and underserved areas.
- Lack of specific, standardized training in sexual and reproductive health across health professional types.
- Difficulties hiring, retaining, and training staff.
- Payment and reimbursement barriers.
- Inconsistencies in service delivery across various provider types and service delivery settings.

The COVID-19 pandemic placed an additional burden on healthcare workers, especially reproductive healthcare workers who faced significant mental and emotional stressors, including anxiety, depression, and burnout.[1] The recommendations CECA developed and published in early 2023 outline strategies where: 1) practical or policy solutions might address these workforce challenges for the contraceptive care workforce to ensure the consistent delivery of high-quality, person-centered care and 2) help achieve sexual and reproductive health equity, where all people across the range of age, gender, race, and other intersectional identities have what they need to attain their highest level of sexual and reproductive health.[2,3]

To inform the development of these recommendations, CECA conducted an environmental scan to summarize existing available evidence on innovative workforce capacity strategies in areas adjacent to contraceptive care (e.g., primary care, behavioral health and substance use disorder care, and maternity care) to identify relevant strategies that might be adapted in the contraceptive care context. This scan builds on the findings of CECA's 2021 environmental scan, The State of the Contraceptive Care Workforce, and includes an update on recent literature related to the contraceptive care workforce.[4]

Key research questions for this environmental scan included:

1. What efforts to expand the capacity of the healthcare workforce have been undertaken in areas adjacent to contraceptive care? What efforts are related to…
    a. Education and training (e.g., loan repayment, continuing education)?
    b. Innovation in care delivery (e.g., interprofessional care delivery teams)?
    c. Reimbursement (e.g., changes in reimbursement rates)?
    d. Improving workforce diversity?
2. What is the impact of these efforts on the makeup of the workforce? Access to person-centered care? Patient outcomes? Other outcomes of interest?
3. What are the facilitators and barriers to implementing these efforts to expand the capacity of the workforce?
4. What questions about strategies to expand the capacity of the workforce remain unanswered in the literature?

Highlights from the 2021 Contraceptive Care Workforce Environmental Scan

- The contraceptive care workforce is made up of a variety of professionals who deliver, or support the delivery of, reproductive health and contraceptive care services, including physicians (such as obstetricians/gynecologists and family physicians), advanced practice providers (such as nurse practitioners and physicians assistants), and allied health professionals (such as health educators and Community Health Workers).

- Recent evidence indicates the importance of collaborative practice among an interdisciplinary team of professionals to ensure the delivery of quality sexual and reproductive health services, particularly in light of projected shortages in the workforce, increased demand for services, and the potential for reduced access in communities that already face barriers to accessing contraceptive care.

- Barriers to engage the full scope of the contraceptive care workforce include inadequate opportunities for hands-on clinical training in sexual and reproductive health, a shift toward generalist education and training in nursing and other health professions programs, and regulatory barriers related to scope of practice and reimbursement.

- Although many opportunities for provider training on contraceptive care exist, few trainings have been evaluated and published in the literature. Evaluations of provider training in the published literature focus primarily on interventions related to provider training for long-acting reversible contraceptives (LARC) provision, LARC provision for adolescents specifically, and the provision of patient-centered contraceptive counseling. Published evidence on provider training for contraceptive care provision is needed to strengthen the evidence base.

- Research gaps remain in understanding:
    - How to effectively support an interprofessional team of contraceptive care providers to provide contraceptive care.
    - How to increase the capacity of primary care providers to provide contraceptive care.
    - How to improve quality of care and patient experience with contraceptive care delivered by a variety of professionals.

METHODS

This environmental scan identified peer-reviewed and grey literature describing innovative strategies to expand the healthcare workforce in areas adjacent to contraceptive care delivery. Evidence related to workforce development strategies in behavioral health, maternal health, primary care, and other areas where significant investments have been made in healthcare workforce development were considered relevant to the scan.

The inclusion and exclusion criteria for this scan were purposefully broad to identify and retrieve as much potentially relevant information as possible. Databases searched to identify relevant articles included Google Scholar and Google Search. The search was limited to literature published since 2015 and relevant to the U.S. context. CECA also conducted stakeholder outreach discussions with representatives of organizations involved in past or current workforce expansion efforts to supplement the findings of this scan.

UPDATES TO CECA'S 2021 REPORT ON THE CONTRACEPTIVE CARE WORKFORCE

In an effort to expand the findings of CECA's 2021 report on the contraceptive care workforce (undertaken as part of an effort to craft recommendations for policy-ready contraceptive access research), CECA summarized new research related to workforce capacity in contraceptive care, including workforce supply and distribution, training and education, and other key topics.[4,5] This section summarizes those findings. The methods for the conduct of the 2021 environmental scan are described in the previously published report, The State of the Contraceptive Care Workforce.

Key Highlights

- New research on the contraceptive care workforce primarily explores: 1) the composition of the contraceptive care workforce, 2) pharmacist-prescribed contraception, 3) contraceptive training for specialty providers, and 4) challenges facing the workforce.
- While a range of providers make up the contraceptive workforce, there are significant differences in provider distribution, types of contraception provided by specialty, and Medicaid participation.
- Recent evidence explores the role of providers (such as pharmacists, internal medicine physicians and school-based health center providers) and relevant topics (including training, implementation approaches, perceptions of service provision, and effects of service provision).

Composition of Contraceptive Care Workforce

Recent research has described the makeup of the contraceptive care workforce. In 2022, researchers at the George Washington University (GWU) Institute for Health Workforce Equity published a study examining the types of health professionals who offer six contraceptive methods—the IUD, implant, shot, oral contraception, hormonal patch, and the vaginal ring—using a national prescription database.[6] The study found OB/GYNS (73.1%) and nurse midwives (72.6%) were frequently contraceptive prescribers, compared to approximately half of family medicine physicians (51.4%) and even fewer pediatricians (32.4%) and internal medicine physicians (19.8%).

The study found significant differences across states in terms of distribution of providers and Medicaid participation.[6] For example, Medicaid acceptance rates were generally higher among OB/GYNS and lowest among internal medicine physicians. The study also found a significant distribution among provider types offering IUDs and implants. While 92.8% of OB/GYNs provided IUDs and 56.2% provided implants, the next highest LARC providers were family medicine physicians, where 16.4% provided IUDs and 13.7% provided implants. The GWU research team also released an online, interactive contraception workforce tracker with options for state and county-level analysis.

Pharmacist-Prescribed Contraception

A number of studies exploring various aspects of pharmacist-prescribed hormonal contraception have been published in the past year. In 2021, CECA also published an environmental scan report on the state of pharmacist-prescribed contraception exploring implementation approaches, provider and patient perspectives on the service, outcomes of interest, and barriers and facilitators to implementation.[7] Since that effort, a systematic review was published summarizing the evidence on pharmacist-prescribed contraception uptake, implementation, and impact.[8] Across the included studies, payment and reimbursement challenges and liability concerns were the most frequently mentioned barriers to service provision, while serving communities with a need for pharmacist-prescribed contraceptive services was the most commonly mentioned facilitator. The systematic review found that, while the majority of relevant research articles assessed uptake of pharmacist-prescribed contraception, more research is needed to demonstrate the effects of the service on expanded access.

Research on long-term effects of pharmacist-prescribed contraception services is underway. A recently published study assessed the impacts of pharmacist-prescribing on contraceptive continuation over a 12-month period across four states—California, Colorado, Hawaii, and Oregon—and found no difference in effective contraceptive use, perfect use, or switching when contraception was prescribed by a pharmacist compared to another clinician.[9]

Recent studies have also explored training considerations to prepare pharmacists for contraceptive service provision—for example, one study reviewed curricular considerations to prepare pharmacists to provide contraception, and another study assessed the effect of the American Pharmacists Association contraceptive training program on pharmacists' knowledge, attitudes, and preparedness to offer contraception.[10,11] Patient and pharmacist perspectives on the service were also of interest. A recent study synthesized the literature on patients' and pharmacists' perspectives on pharmacist-prescribed contraception and found that most pharmacists and patients across the 15 relevant studies were supportive of the service provision option.[12]

Contraceptive Training for Specialty Providers

Recent studies on the contraceptive care workforce expanded the evidence on provider training. A 2021 study published by researchers at the University of California, San Francisco assessed the effect of contraceptive provision training offered to 260 school-based health center (SBHC) providers and health educators from approximately 160 SBHCs.[13] The research team found an increase in knowledge, counseling skills, and provision practices among SBHC providers at 3-months post-training.

Several recent articles considered contraceptive training for internal medicine physicians. One qualitative study of implementation methods in internal medicine clinics described models for LARC training integration into residency curricula and common barriers to integrating contraceptive practice in internal medicine clinics and residency curricula, including lack of standardization for training and assessment models for proficiency.[14] One study described the implementation and short-term evaluation of a contraceptive counseling curriculum, using a shared decision-making framework, for internal medicine residents.[15] The training was offered to nearly 60 residents and demonstrated improvement in contraceptive knowledge and comfort, with contraceptive counseling immediately following curriculum delivery. Another study described increases in LARC provision and use in an internal medicine residency clinic as a demonstration of the role of internal medicine primary care clinics to expand contraceptive access and the importance of training opportunities.[16]

Considering a longer-term training experience, a 2022 study explored the implementation and qualitatively assessed a 2-year women's health training pathway in the internal medicine specialty; the six program participants found the training relevant and appropriate.[17]

Challenges Facing the Contraceptive Workforce

A qualitative study published in 2022 described challenges and opportunities to support clinic staff in Southern family planning clinics.[18] The article described recruitment and retention as a key challenge facing the workforce. Study participants identified strategies to address this challenge, including the need for career advancement opportunities, investment in management, prioritization of staff retention, and opportunities for self-care among the clinic staff. A related study explored recruitment and retention challenges and opportunities among abortion providers in the South and identified the need for increased compensation and networking and training opportunities.[19]

FINDINGS ON EFFORTS TO EXPAND HEALTHCARE WORKFORCE CAPACITY

This section summarizes the findings of this environmental scan to identify strategies to expand the healthcare workforce in areas adjacent to contraceptive care delivery. Findings focus on six key areas:

1. Offering Incentive Programs to Improve Recruitment and Retention
2. Integrating Allied Health Professionals into the Workforce
3. Innovating on Funding and Payment Strategies
4. Expanding Scope of Practice Regulations for Advanced Practice Providers
5. Increasing Diversity in the Workforce
6. Implementing Training and Education Opportunities

Offering Incentive Programs to Improve Recruitment and Retention

Key Highlights

- Incentive programs, such as loan repayment and scholarship programs, are often implemented as a health workforce development and capacity strategy. Federal funding for these programs is generally administered by the Health Resources and Services Administration (HRSA) and serve the primary purpose of attracting healthcare providers to practice in underserved areas.
- The available evidence on incentive programs is dated and primarily focuses on the HRSA National Health Service Corps loan repayment programs. Available evidence demonstrates mixed results on satisfaction and retention. Further research should examine how incentive programs impact satisfaction, retention, diversity, healthcare access, and quality of care.

Incentive programs, such as loan repayment programs and scholarships, for health professionals has been implemented in various areas of healthcare—particularly as a strategy to expand the capacity of the primary care and behavioral health workforces.

Several federal incentive programs are available to the healthcare workforce, especially to increase healthcare access in underserved communities facing health professional shortages. For example, the Health Resources and Services Administration (HRSA) National Health Service Corps (NHSC) offers loan repayment programs for primary care medical, dental, and behavioral health providers through the NHSC Loan Repayment Program, NHSC Rural Community Loan Repayment Program, and NHSC Substance Use Disorder Workforce Loan Repayment. Allied health professionals, such as substance use disorder (SUD) counselors with state-issued licenses or certifications, licensed professional counselors, and licensed clinical social workers, are also eligible for NHSC loan repayment programs. The HRSA Bureau of Health Workforce (BHW) offers a Nurse Corps Loan Repayment program for advance practice registered nurses, registered nurses, and nurse faculty for two years of service in a designated healthcare shortage area or eligible nursing school.

In 2021, the Biden-Harris Administration invested $1.5 billion for health workforce loan repayment and scholarship programs administered by the NHSC and Nurse Corps, representing a 27% increase in loan repayment and scholarship awards.[20]

HRSA also awards funds to states for state-based health workforce loan repayment programs (such as the HRSA BHW State Loan Repayment Program, which offers grants to U.S. states and territories to support primary care providers working in underserved areas) and the HRSA Substance Abuse Prevention and Treatment Block Grant (which states like New York are using to support loan repayment programs, scholarships, and other incentives for the SUD workforce).[21]

The available evidence on the impacts of incentive programs, such as loan repayment, on workforce outcomes are dated and focus primarily on NHSC programs. NORC at the University of Chicago is currently conducting an evaluation of HRSA's loan repayment programs focused on the SUD workforce, particularly considering the programs' expansion to licensed and certified clinicians and enhanced focus on addiction education and clinical training.[22]

A 2021 review of evidence on health workforce strategies published by the California Health Care Foundation found that the available evidence on loan repayment programs demonstrate mixed results, although loan repayment programs are generally associated with higher workforce retention rates compared to scholarship programs.[23]

Work satisfaction and retention among NHSC participants are also outcomes of interest in the evidence. One recent study documented factors associated with overall work satisfaction for licensed clinical social workers participating in the NHSC Loan Repayment Program, which included rural upbringing; age above 40 years old; high salaries; connection with patients; and satisfaction with administration, staff, and the overall practice mission.[24] A similar study assessed satisfaction among primary care, mental health, and dental clinicians in NHSC's Loan Repayment Program and found clinicians were satisfied overall with their work and practice, although they were less satisfied with their pay and time demands of the work.[25]

One study published in 2016 assessed retention among providers in Kansas who participated in the state loan repayment program, the NHSC Loan Repayment Program, or the NHSC scholarship programs.[26] The researchers surveyed approximately 110 providers and found that nearly half of the participants continued to practice at their sites after the mandatory incentive program timeframe.

More current research is needed to understand the effects of incentive programs on workforce recruitment, satisfaction, diversity, retention, and quality of care. Research is also needed to document the effects of expanding eligibility to include allied health professionals and the extent to which these changes lead to expanded access to care, both in general and for populations with greater difficulty accessing care. Comparative research on topics such as approaches to loan repayment and workforce composition and retention before and after loan repayment is instituted would also strengthen the evidence base.

Integrating Allied Health Professionals into the Workforce

Key Highlights

- Allied health professionals have been increasingly integrated into the healthcare workforce in primary care and across specialty area to expand workforce capacity.
- Credentialing requirements for allied health professionals vary, and there are ongoing discussions in the field regarding potential benefits (e.g., increased professional identity, access to reimbursement) and risks (e.g., increased barriers to entry into the profession) of standardized training and certification requirements. Yet there is scant data documenting the impact of CHW certification on outcomes of interest to help guide this debate.
- More research is needed to expand the body of evidence to include the broad range of allied health professionals and understand experiences providing services, preferences for the direction of the profession, effective curricula and training models, and optimal credentialing approaches.

Allied health professionals, such as health educators, community health workers (CHWs), and peer support specialists, have been increasingly integrated across the healthcare workforce in an effort to expand workforce capacity and the delivery of person-centered care. Allied health professionals are already working in reproductive health and contraceptive care delivery settings—for example, health educators often provide contraceptive counseling in reproductive health centers, and certified community health aides in the state of Alaska are providing contraceptive counseling and contraceptive implant insertion and removal services. In the global context, task sharing in reproductive health service delivery is also prominent, and allied health professionals often provide services as part of a care team.[27]

CHWs are commonly integrated into care teams across service delivery areas, including primary care, maternity care, and behavioral health. Given the role CHWs played in providing services to the community during the COVID-19 pandemic, the federal government has made significant investments in recruiting, hiring, and training CHWs as an integral part of the healthcare workforce.[28] The HRSA BHW also recently announced a funding opportunity for health professions schools, academic health centers, state and local government agencies, and other eligible organizations to support CHW training through the Community Health Worker and Health Support Worker Training Program.[29]

There has also been increasing attention on the role of doulas in providing care as part of the maternal health workforce, along with recent federal investments in recruiting, hiring, training, certifying, and compensating doulas.[30] In the area of behavioral health and SUD prevention and treatment, allied health professionals, including licensed counselors, social workers, and peer support specialists with lived experiences with substance use and/or mental health conditions, regularly support service provision.

Facilitators and barriers for the expansion of the allied health professional workforce are generally similar across professional types. Studies describe facilitators for expanding this workforce to include individual champions for allied health professionals as part of the care team, institutional commitment to integration of these professionals into workflows and care team structures, and supportive Medicaid billing policies and processes. Barriers include low wages, lack of sustainable funding, and limited career development and advancement opportunities.[31–34]

Certification and licensure considerations are also key for integrating allied health professionals into the workforce. Credentialing requirements vary by state, and there are ongoing discussions in the field regarding the advantages and disadvantages of standardized training and credentialing for allied health professionals.[35–38] Potential benefits of credentialing requirements for allied health professionals include a strengthened professional identity, consistent standard for the field, wider career opportunities, and higher wages. On the other hand, potential negative impacts of certification include greater barriers to entry for the profession, less connection to the community as the profession becomes more clinical, and increased regulations and restrictions on what services community providers are able to provide.

Most of the evidence regarding workforce development for allied health professionals is centered around CHWs and explores lessons learned for integrating CHWs into the workforce. A 2022 qualitative study of CHWs, program managers, and community members in California described opportunities and challenges related to CHW certification and found that while some CHWs were supportive of standardized certification and training opportunities, others felt certification might lead to a more clinical approach and reduce the sense of connection to the community across the profession.[35] Study participants also noted CHW certification might not address other challenges to integrating CHWs into care teams and emphasized the importance of involving CHWs in decision-making around certification for the profession.

A 2020 review of the evidence considered the impact of CHW certification on recruitment and retention, as well as quality of care and health outcomes.[39] The study found little literature documenting the impact of CHW certification on outcomes of interest. No studies identified in the review assessed the relationship between certification and recruitment, retention, training, or receptivity to CHWs among patients and their families, nor were studies identified that asserted patients' outcomes differ based on intervention by certified vs. non-certified CHWs. When discussing workforce development needs to advance the profession, CHWs described the need for continuing training and professional development opportunities, pathways for career advancement, and billing and reimbursement capacity (explored in the following section of this report). [37,40,41]

More research is needed to expand the evidence base on allied health professionals beyond CHWs to understand broader experiences and workforce development considerations for other professional types, especially community-based doulas. Additional efforts are also needed to document the impacts of credentialing requirements on allied health professionals and the communities they serve, as well as best practices and models for building a sustainable, connected allied health professional workforce.

Innovating on Funding and Payment Strategies

Key Highlights

- Innovative financing strategies are an increasingly prominent strategy to expand workforce capacity. Medicaid agencies in some states have already begun establishing policy to reimburse community health workers, peer support specialists, and community-based doulas for their services.
- Common challenges to Medicaid reimbursement for allied health professionals include administrative challenges, such as reimbursement processes, low reimbursement rates, and burdensome credentialing requirements.
- More research is needed to explore the effects of expanded Medicaid reimbursement on workforce makeup and capacity, service delivery, access, and lessons learned from states implementing these policies.

Innovative funding and payment strategies are being explored as a policy solution to strengthen the capacity of the workforce, particularly expanding Medicaid reimbursement policy to include allied health professionals. Some early work is emerging on impacts and lessons learned for these policy changes. For example, in 2019, more than 40 state Medicaid agencies reimbursed for SUD treatment services provided by allied health professionals, including peer support specialists and non-licensed counselors.[42] States generally require non-licensed allied health professionals providing SUD treatment be supervised by a certified or licensed professional to be eligible for Medicaid reimbursement. A 2019 study found a small positive association between Medicaid authorization of peer services for SUD treatment and the availability of peer services—about 60% of SUD treatment facilities in states that authorized Medicaid reimbursement for SUD treatment services offered peer services, compared to half of SUD treatment facilities in states not eligible for Medicaid reimbursement.[43] A 2020 study assessing the impact of state regulations and Medicaid plans on peer support specialists in the behavioral health workforce found higher Medicaid reimbursement rates were positively associated with peer service provision.[44]

States are also increasingly exploring using Medicaid to fund CHWs. In 2021, at least 21 states authorized Medicaid reimbursement for CHWs, either under a state plan or Section 1115 demonstration wavier, while other states offer CHW services through Medicaid managed care approaches.[45] For example, Minnesota uses fee-for-service payments to reimburse for eligible CHW services through its Medicaid program.[46] The state established a CHW scope of practice, a CHW peer network, and a

standardized 14-credit certification program that make CHWs eligible for Medicaid reimbursement. Comparatively, New Mexico's Medicaid program has contracted its managed care organizations to integrate CHWs into the care team.[46]

The evidence documents the persisting challenges for financing CHWs despite increasing Medicaid reimbursement efforts; one article noted services deemed reimbursable by Medicaid might not include the full suite of services CHWs traditionally provide.[47] Additionally, many CHWs work outside of healthcare settings in roles supported by temporary grant funding, creating an additional challenge for sustainable financing. The authors recommend that federal, state, and local governments and private funders extend grant terms for CHW initiatives and expand tasks related to CHW provision of health and social services to be eligible for Medicaid reimbursement. [47] This recommendation is in alignment with the National Association of Community Health Workers 2021 policy recommendations that emphasize the need for federal, state, and local governments and private insurers to provide direct reimbursement for CHW services; streamline grant and contract processes to ensure equity and diversity; and advance sustainable models for CHW services that include community integration and investment as well as opportunities for workforce development and career advancement.[48]

Similarly, efforts to expand Medicaid coverage for doula services have increased in recent years. As of April 2022, five states were actively reimbursing for doula services on Medicaid plans, eight states were in the process of implementing Medicaid doula benefits, and more states are continuing to propose legislative action to advance access to doula care or establish doula pilot programs.[49] Oregon, for example, classified doulas as Traditional Health Workers and began reimbursing for doula services through the state's Medicaid program in 2014. To be eligible for Medicaid reimbursement, doulas must register with the state and fulfill training requirements. Doulas in the state can be reimbursed up to $350 per birth, depending on the services provided, and are able to bill Medicaid directly, through a supervising provider or through "doula hubs" that enable groups of doulas to bill together to reduce administrative burden.[50,51] Comparatively, Minnesota began covering doulas services through Medicaid in 2014. Doulas are required to be certified and work under the supervision of a licensed, Medicaid enrolled provider such as a physician, nurse practitioner, or certified nurse midwife. Providers bill the Medicaid program for eligible doula services.[51]

The National Health Law Program (NHeLP) is leading the Doula Medicaid Project to advance Medicaid coverage for full spectrum doula care and is tracking state Medicaid efforts for doula services. NHeLP also conducted a study on lessons learned among ten doula pilot programs in California in 2021. Through these efforts, NHeLP identified several common challenges to implementing doula pilot programs, including administrative challenges, such as reimbursement processes, low reimbursement rates, difficulty established supervisory relationships with providers, and costs associated with certification and training requirements. Those in the field warn Medicaid reimbursement linked to certification and licensing has the potential to encourage low reimbursement rates, create scope of practice requirements that make it harder for community members to become doulas, and perpetuate systemic racism by moving services away from communities to a more clinical model of care.[38,52]

One study describing lessons learned from states that were early adopters of Medicaid reimbursement for doulas services described engaging communities throughout the development and implementation process; reducing financial and administrative barriers, such as costly training requirements and burdensome Medicaid billing procedures, to facilitate access; and setting reimbursement rates to facilitate sustainable care delivery as considerations for improving programs.[52] NHeLP, along with other experts in the field, recommends that doulas are included in policy development to help ensure policies are appropriate, relevant, and facilitate access to services for people enrolled in Medicaid.

As these policies expand across states, more research will be needed to explore the effects of Medicaid reimbursement for allied health professionals on workforce composition and capacity, service delivery, and access. Lessons learned from states implementing policy to expand reimbursement for allied health professionals are needed to inform future implementation, including strategies to include allied health professionals in policy development and approaches to address documented challenges. To advance equity and expand allied health professionals' impact, consideration should also be given to expanding reimbursement beyond Medicaid, including Medicare and private insurance plans. Research should explore optimal models for such expansion and engage allied health professionals and patients in planning and design.

Expanding Scope of Practice Regulations for Advanced Practice Providers

Key Highlights

- Adjusting or eliminating scope of practice regulations to allow advanced practice providers to practice to their full training ability is a frequently discussed strategy to expand workforce capacity.
- Evidence demonstrates that states who allow greater practice authority are more likely to have a higher number of advanced practice providers, higher workforce growth, and expanded care provision particularly in rural and underserved areas.
- Policy changes implemented during the COVID-19 pandemic provide a unique opportunity to generate additional evidence on the effects of expanded scope of practice on workforce capacity, access to care, and quality of care.

Expanding scope of practice regulations for advanced practice providers to practice to their full training and capacity is another frequently discussed policy strategy to expand workforce capacity and reduce shortages. During the COVID-19 pandemic, several states temporarily expanded scope of practice regulations for advanced practice providers by revising or eliminating collaborative practice agreements for nurse practitioners (NPs) or waiving physician supervision requirements for physician assistants.[53–55] One recent study found Midwest states who expanded scope of practice regulations for NPs during the COVID-19 pandemic potentially reduced COVID-related deaths by 20 cases per day.[56] Since that time, governors in some states, including Arkansas and Massachusetts, have signed legislation to permanently expand scope of practice for advanced practice providers.[53]

A 2016 systematic review assessed the impact of NP scope of practice regulations on care delivery and access.[57] The evidence demonstrated states where NPs had greater scope of practice authority were more likely to have higher numbers of NPs, higher growth of the NP workforce, and expanded care provision particularly in rural and underserved areas. The review also found that scope of practice regulations were associated with workforce makeup and care team composition in community health centers. Community health centers in states with expanded scope of practice regulations used more advanced practice clinicians to provide care and experienced greater staffing choice and flexibility to meet patients' needs.

More recent studies also support the findings of this review. Recent research demonstrates expanded scope of practice for NPs is associated with a higher supply of NPs in rural areas and areas with professional shortages, as well as increases in NP visits in community health centers.[58] Similarly, research on scope of practice regulations and the certified nurse midwife and certified midwife workforces found states with expanded scope of practice that enabled midwifes to practice more autonomously had a higher supply of midwives; however, there was no significant difference in the number of midwife-attended births per number of midwives in states with expanded scope of practice regulations compared to those with more restrictive regulations.[59]

Despite the potential benefits of expanded scope of practice regulations on access to care, research shows restrictive regulations are more related to political spending by physician groups than to healthcare access needs of the community.[53] More research is needed to document the impacts of expanded scope of practice across provider types and impacts on workforce capacity, access to care, and quality of care. The policy changes implemented during the COVID-19 pandemic provide a unique opportunity to generate additional evidence on this topic.

Increasing Diversity in the Workforce

Key Highlights

- Efforts to improve healthcare workforce diversity focus primarily on fostering interest in healthcare professions through pipeline programs and reforming health professional school admission processes. Holistic admissions processes and mentorship programs have shown promise for increasing participation by female students and students from groups underrepresented in medicine.
- Trainings to improve the quality of care delivered to diverse communities show positive short-term results, but there is limited evidence for sustained provider behavior change or effects on patient outcomes.
- Research is needed to expand the evidence base beyond recruitment into medical careers to explore workforce diversity efforts across professional types and considerations beyond recruitment, such as retention of underrepresented health professionals.

Increasing diversity in the healthcare workforce is a priority in the field, and the available evidence explores the implementation and effects of strategies to recruit, support, and retain underrepresented groups in health professions.

Efforts to improve workforce diversity in healthcare focus primarily on fostering interest in healthcare professions through pipeline programs and reforming health professional school admission processes (e.g., implementing holistic reviews of applicants). A 2021 review of evidence on health workforce strategies published by the California Health Care Foundation found the available evidence on pipeline programs demonstrated multicomponent pipeline programs with a combination of interventions, such as mentoring, social support, financial support, and intensive training, were promising as a strategy to increase workforce diversity in the health professions.[23] Pipeline programs generally resulted in positive effects for outcomes, such as improvements in academic performance and likelihood of enrolling in a health professions school. The review demonstrated postbaccalaureate premedical programs for students of color and students from disadvantaged background were also effective for increasing the number of underrepresented students who attend and graduate from medical school, choose careers in primary care, and practice in medically underserved areas.

In 2007, the Association of American Medical Colleges implemented an initiative to support medical schools in implementing a holistic review of applicants into the admissions process in order to consider mission-driven attributes and experiences and support building a diverse healthcare workforce. The available evidence demonstrated holistic review of medical school and residency applicants might increase the diversity of applicants who are selected for interviews, including a significantly higher number of female students, students traditionally underrepresented in medicine (defined as identifying as American Indian, Alaska Native, Black/African-American, Hispanic/Latino, Native Hawaiian, or Pacific Islander), and students who self-identified as disadvantaged.[60–62] Evidence also suggests that holistic review processes increase the number of matriculating residents who are traditionally underrepresented in medicine.

While the evidence on holistic review generally focuses on medical school and residency admissions processes, one 2014 study examined holistic review across health professions schools, including medicine, dentistry, pharmacy, nursing, and public health, and found the majority of schools reported an increase in diversity, with medical schools and dental schools more often reporting a switch to holistic review practices at the time of the study.[63]

Mentoring programs that offered mentorship throughout medical school along with opportunities to participate in lectures, workshops, and research, were also an effective intervention for increasing students who were underrepresented in medicine and female students in surgical residency programs.

Considering policy interventions to improve diversity in the healthcare workforce, evidence suggests state legislation on minority recruitment might improve workforce diversity. A 2015 study on the effects of state policy on minority recruitment for nursing careers found state legislation providing funding (such as scholarships, loans, and grants, for minority groups), along with legislation requiring institutions that received payments from Medicaid to submit formal, written plans for recruiting and retaining professionals from diverse racial and ethnic background, was associated with an increase in nursing enrollment among racially and ethnically diverse students.[64]

Recent commentaries on workforce diversity in healthcare recommend additional approaches to increase diversity. For medical school and other training institutions, this includes the need for institutional mission statements that highlight a commitment to diversity and equity; administrative and organizational leadership explicitly committed to student and workforce diversity; and, institutional accountability and commitment to integrating diversity into the curriculum, students services, and activities.[65,66]

Experts also reason that workforce diversity strategies must go beyond a focus on recruitment and diversifying the applicant pool to address systemic factors that perpetuate racism and bias in the professions and create barriers to recruitment and retention.[67,68] One commentary offered recommendations to integrate a quality improvement approach to incentivize workforce diversity, including evaluating diversity measures within institutions; the number of minority and female candidates interviewed for open positions (particularly leadership positions); and metrics on faculty promotion and pay equity.[68] The authors recommend these data be publicly reported, regularly reviewed by leadership, and tied to executive evaluation and compensation.[68]

In addition to recruitment and retention considerations, there have been significant investments in preparing the healthcare workforce to provide high-quality care to diverse communities. Topics such as “diversity, equity, and inclusion,” “cultural competence,” and “implicit bias” have become more prominent in healthcare provider trainings and assessments of institutional policies in healthcare organizations across the field. More recently, in response to the U.S. Black maternal health crisis, several initiatives and trainings to reduce bias and advance equity in maternity care have emerged. For example, the National Birth Equity Collaborative created a framework and actionable tool for anti-racist maternity care, called The Cycle to Respectful Care, that can inform provider training and education tools, communication and messaging for awareness about respectful maternity care, and patient-reported experience measures.[69] In response to the California Dignity in Pregnancy and Childbirth Act, which took effect in 2020 and required evidence-based implicit bias programs in maternal healthcare settings, the California Health Care Foundation launched an online training course called *Dignity in Pregnancy and Childbirth* for perinatal providers to understand and address bias and racism in maternity care.[70]

Across the healthcare sector, gaps remain in the evidence for interventions to improve care and advance equity for diverse communities. While much attention has been given to training interventions, the evidence suggests training might result in positive effects on short-term outcomes, including knowledge, awareness, and skills; however, the evidence on sustained provider behavior change and patient experience and outcomes is limited.[71,72] Future research is also needed to broaden the evidence base on what works for improving recruitment of diverse health professionals beyond the physician workforce, strategies to retain diverse healthcare professionals in the workforce, and lessons learned among organizations implementing these strategies.

Implementing Training and Education Opportunities

Key Highlights

- Training and continuing education are key elements to promote workforce development and expand workforce capacity, and training interventions of varying scales and implementation approaches are commonly integrated across the health professions.
- Long-term effects of provider training interventions continue to emerge as a research gap across service delivery areas.

Training and continuing education are key elements to ensuring the health workforce is equipped to provide appropriate, high-quality care aligned with the latest evidence. CECA's 2021 environmental scan on the contraceptive care workforce found that while many opportunities for provider training on contraceptive care exist, the evidence on effectiveness, especially long-term evidence, is scant, and few trainings have been evaluated and published in the literature.[4] Evaluations of provider training for contraceptive care in the published literature focus on a few specific training topics, primarily training for LARC provision, LARC provision for adolescents specifically, and the provision of person-centered contraceptive counseling. Outcomes of interest were generally short-term and centered around changes in knowledge, skills, satisfaction with the training, and intention to change care delivery approach. These outcomes were most often assessed immediately or shortly after training delivery.

Many provider training and education approaches are implemented in primary care, behavioral health, and maternal health and led by federal and state government agencies, academic institutions, health profession associations, training centers, advocacy organizations, and community-based organizations. Generally, there are similarities between the evaluation approaches and outcomes of interest for these adjacent service areas and those for reproductive health. For example, a 2018 systematic review of motivational interviewing trainings for SUD professionals found the most commonly assessed outcomes across studies were motivational interviewing skills, knowledge, and self-confidence.[73] Fewer than half of the included studies (n=12) evaluated whether participants maintained skills after the training concluded; the review did not note how long after training those studies generally assessed skill level. Although the study authors described the included studies as being of significantly improved quality opposed to previous reviews, the authors noted the lack of follow-up assessments evaluating participants' skills or linking training outcomes to consistent changes in behavior, and ultimately, changes in client outcomes.

Similar to the key takeaway for the evidence on provider training effectiveness in contraceptive care, there is a significant need for research evaluating long-term effectiveness of provider training across areas of healthcare on provider behavior change, quality of care, and client satisfaction with care.

CONCLUSION

This environmental scan summarizes the evidence describing efforts to expand the capacity of the healthcare workforce in fields adjacent to reproductive health and contraceptive care. Strategies include:

1. Offering incentive programs to improve recruitment and retention
2. Integrating allied health professionals into the workforce
3. Innovating on funding and payment strategies
4. Expanding scope of practice regulations for advanced practice providers
5. Increasing diversity in the workforce
6. Implementing training and education opportunities

Each of these strategies has applications for the contraceptive care workforce, and many are already being implemented to some extent in the reproductive health context. For example, an interprofessional workforce for reproductive health that includes advanced practice clinicians and allied health professionals was documented as a priority for the field in CECA's 2021 environmental scan on the contraceptive care workforce and is a workforce development strategy commonly implemented across the healthcare sector more broadly.

If implemented more broadly across the fields of reproductive health and contraceptive care, the workforce capacity strategies described in this report have the potential to expand the capacity of the contraceptive care workforce and begin to address workforce challenges related to recruitment, training, retention, and sustainability. However, there are specific considerations and challenges to overcome for implementing these strategies in the reproductive healthcare context. For example, while there have been significant investments in loan repayment and incentive programs to improve recruitment and retention in the healthcare workforce, reproductive health centers often do not have the appropriate designation to qualify as eligible sites, which may create a barrier to participation for reproductive health providers. Efforts are necessary to document specific workforce strategy considerations for the contraceptive care workforce and strategies to overcome implementation challenges. Across the healthcare field, additional evidence is needed to support each of the workforce capacity strategies described in this report, particularly on how these strategies can ultimately improve quality of care and expand equitable access to person-centered care.

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