Health Workforce Policy Brief
September 2015

Fitzhugh Mullan Institute for Health Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

The Changing Community Health Center Workforce: 2007-2013

Leighton Ku, Tyler Bysshe, and Xiaoli Wu

BACKGROUND

Community health centers (CHCs) represent an important and unique component of America's health care system. Because of their mission of comprehensive and community-oriented primary care, CHCs typically provide a broader array of services than most other American medical practice settings. CHCs often face challenges attracting and retaining staff, both because of their locations in disadvantaged communities and the challenges of offering competitive salaries with limited safety net resources. This descriptive analysis examines how CHC workforces have grown and changed from 2007 to 2013.

METHODS

The authors used the 2007 to 2013 Uniform Data System (UDS) across the U.S., including the territories. Staffing is measured in full-time equivalent staff.

FINDINGS

As seen in Table 1, CHCs experienced continuous growth between 2007 and 2013. The number of patients grew about 35 percent from 16.1 million in 2007 to 21.7 million unduplicated patients in 2013. The total number of staff rose by almost 50 percent during the same time period. Medical staff grew by 51.8%, other health professionals by 76.6%, enabling service staff by 44.7%, and administrative and facility staff by 40.3%. The ratio of staff to patients rose by 10.4%, indicating that the intensity of services offered climbed, particularly the expansion of other health services like mental health and dental care.

In comparison, the number of people employed in private U.S. ambulatory care settings rose 11 percent from 2007 to 2013, while non-health employment fell 2 percent. The staffing increases are noteworthy since CHCs are located in medically underserved areas and areas with health professional shortages, which can make it difficult to hire additional staff.

The composition of the CHC workforce changed somewhat because of large increases in mental health, dental, advanced practice (or mid-level,

KEY FINDINGS

1. Findings from the study point to variation in the use of telehealth services across regions, but overall a potentially lower than expected rate of telehealth usage among sites with NHSC providers. In particular, it is alarming that the 2010 study of CHC telehealth use found a slightly higher prevalence (38%) than we find in 2015 (35.6%).

2. Sites located in states with more favorable telehealth coverage and reimbursement policies, were more likely to use telehealth, as were sites located in states with telehealth grant funds.

3. Perhaps the most actionable finding for HRSA is that states with the lowest grant funds and the most restrictive coverage and reimbursement policies have the lowest telehealth usage rates. These may provide an opportunity for HRSA to target funding to sites in those states.

such as nurse practitioners and physician assistants) clinician, and information technology staffing.

CONCLUSION

The dominant feature of changes in CHC staffing is growth in the size of the workforce, which has been primarily driven by the overall expansion of the number of CHCs and sites and increases in the number of patients who receive care at these safety net facilities. The staffing increases are noteworthy since CHCs are located in medically underserved areas and areas with health professional shortages, which can make it difficult to hire additional staff. Programs such as the National Health Service Corps have been essential to support increases in the number of health professionals who can work at CHCs. Increases in staff-to-patient ratio indicate that the intensity of services offered to patients has climbed over time, particularly the expansion of other health services like mental health or dental care. While CHCs are often viewed as providing primary care services similar to regular medical practices, the nature and staffing of CHCs encompasses a broader perspective of the meaning of comprehensive primary care services. In addition, some of the changes, such as the increased use of advanced practice clinicians, mental health and information technology staff, reflect broader pressures to transform primary care practices in the U.S.

POLICY IMPLICATIONS

Two distinctive features of CHCs are their rapid growth and the diversity of staffing and services offered, related to a broad view of comprehensive primary health care. The growth was fueled by both increases in federal funding for Section 330 (the core grant for CHCs) and Medicaid growth. The shifts in staffing reflect both nationwide secular trends in primary care organization, as well as specific HRSA initiatives that encouraged development of Patient-Centered Medical Homes, increased integration and availability of mental health and dental services, and use of electronic health records. Continued funding for the National Health Service Corps, which helps place clinicians in health professional shortage areas, has helped maintain and increase the supply of CHC clinicians, enabling them to practice in medically underserved areas where it would otherwise be difficult to recruit clinicians.

Table 1. Key Changes in Community Health Center Workforce, 2007-13

	# CHC Patients (mil.)	Number of Staff in Thousands					Total Staff/ per 10,000 Patients
		Total CHC Staff	Medical Staff	Other Health Professionals	Enabling Service Staff	Admin & Facility Staff	
2007	16.1	104.9	36.9	13.2	13.5	41.3	65.4
2008	17.1	113.1	39.7	14.7	14.3	44.4	66.0
2009	18.8	123.0	43.4	16.4	15.4	47.8	65.6
2010	19.5	131.7	46.5	18.4	16.1	50.6	67.6
2011	20.2	138.4	49.2	19.9	16.7	52.5	68.4
2012	21.1	148.2	53.1	21.8	17.7	55.6	70.3
2013	21.7	156.8	56.0	23.3	19.5	58.0	72.2
Cumulative % Change 2007-13	**35.4%**	**49.5%**	**51.8%**	**76.6%**	**44.7%**	**40.3%**	**10.4%**

Source: Uniform Data System reports

This work is funded through HRSA Cooperative Agreement U81HP26493: Health Workforce Research Centers Program