Fitzhugh Mullan
Institute for Health
Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

Research Report

The Changing Community Health Center Workforce: 2007-2013

Leighton Ku and Tyler Bysshe

August 10, 2015

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U81HP26493. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

GW Health Workforce Research Center, 2175 K Street, NW, Suite 500, Washington, DC 20037
Contact: Leighton Ku, Milken Institute School of Public Health, George Washington University, lku@gw.edu

Community health centers (CHCs) represent an important and unique component of America's health care system. Grounded in a tradition of community-oriented primary care, CHCs provide comprehensive primary care to low-income patients in medically underserved areas and seek to improve the overall health of their communities. The great majority of CHC patients have incomes below twice the poverty line and are either covered by Medicaid or are uninsured. [1] Because of the limited range of services available to their patients and in their communities, CHCs typically provide a broader array of services than a regular private medical practice. CHCs offer other health services, such as dental, mental health or vision care, as well as enabling services, such as health education, case management, transportation or language assistance. They often host other health or social service programs, such as Women, Infants and Children nutrition programs (WIC), Ryan White HIV/AIDS community and clinical services, Head Start, child care or even public housing. A number CHCs are dedicated to serving homeless patients, migrant farmworkers and their families or those living in public housing.

This report focuses on 2007-13 workforce trends for CHCs, specifically those receiving grant funding under Section 330 of the Public Health Service Act from the Health Resources and Services Administration (HRSA).[2] The data are reported through the Uniform Data System (UDS), [3] based on reports filed by CHCs for each calendar year. The UDS contains data about patients, staff, diagnoses, care rendered and finances at the grantee level. (A grantee typically operates multiple sites or clinics where services are delivered.) We include data from all 50 states, the District of Columbia and U.S. territories. As of 2013, there were about 1200 CHC grantees.

In this report, we focus on staffing composition trends at CHCs, as measured by the number of full-time equivalent (FTE) staff by job category. Sometimes CHCs use staff who are paid as consultants (e.g., specialty clinicians or IT consultants) or services provided under contract to CHCs (e.g., contracted pharmacies); they are not included in the UDS staff counts.

The Growth of Community Health Centers

As seen in Table 1, CHCs have 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. In recent years, CHCs have also sought to diversify their funding and while more than a third of patients were uninsured in 2013, the percent of total patients who were uninsured has declined slightly from 38.9 percent in 2007 to 34.9 percent in 2013. It is reasonable to expect that implementation of health insurance expansions in 2014 will lead to even further reductions in the percent of patients who are uninsured, particularly in states that expand Medicaid that could permit further growth. [4]

---

[1] Shin P, Sharac J, Rosenbaum S, Paradise J. Community health centers: a 2013 profile and prospects for sustained expansion. Kaiser Family Foundation. March 2015

[2] CHCs are also sometimes known as Federally Qualified Health Centers (FQHCs). FQHC status entitles them to special payment policies under Medicaid, Medicare, CHIP and the health insurance marketplaces. There are about 100 "FQHC lookalikes" which meet the same qualifications as regular CHCs and have FQHC status, but which do not receive grants from HRSA.

[3] We gratefully acknowledge access to the UDS data provided by the Bureau of Primary Health Care, HRSA.

[4] Ku L, Zur J, Jones E, Shin P, Rosenbaum S. How Medicaid expansions and future community health center funding will shape capacity to meet the nation's primary care needs: a 2014 update. Geiger Gibson / RCHN Community Health Foundation Research Collaborative Policy Research Brief # 37, June 18, 2014.

Table 1. Key Characteristics of Community Health Centers, 2007-13						
Year	# Community Health Centers	# Total Patients (mil.)	# Patients per Health Center	% Uninsured Patients	# Total Staff FTEs (1,000s)	# Total Staff per 10,000 Patients
2007	1,059	16.1	15,157	38.9%	104.9	65.4
2008	1,080	17.1	15,854	38.3%	113.1	66.0
2009	1,131	18.8	16,582	38.2%	123.0	65.6
2010	1,124	19.5	17,322	37.5%	131.7	67.6
2011	1,128	20.2	17,930	36.4%	138.4	68.4
2012	1,196	21.1	17,644	36.0%	148.2	70.3
2013	1,200	21.7	18,106	34.9%	156.8	72.2
Cumulative % Change 2007-13	13.3%	35.4%	19.5%		49.5%	10.4%

From 2007 to 2013, the total number of staff rose by almost 50 percent to 157 thousand full-time-equivalent staff. Most of the growth in staffing is related to general increases in the number of patients: more patients require additional staff and more insured patients increase overall CHC revenues, which in turn provides funds to support more staff. (Note: CHCs are non-profit.)

However, the ratio of staff to patients (the average number of staff per 10,000 patients) gradually rose to 72.2 FTE staff per 10,000 patients in 2013. The increase accelerated after 2009, which may have been in response to additional fiscal relief funding provided to CHCs under the American Recovery and Reinvestment Act and/or the increase in the percent of patients with Medicaid coverage. These factors increased revenues which could let CHCs hire additional staff to expand the number of patients served, develop infrastructure (e.g., health information technology) and enrich services (e.g., expand dental and mental health care).

CHC Workforce

CHC staff can be classified in four main categories[5]:

1. **Medical staff,** which include physicians (except for psychiatrists), nurse practitioners, nurses, medical assistants and laboratory or radiology staff.
2. **Other health professionals,** which include dentists, psychiatrists, other dental or mental health staff, vision staff, pharmacists and other health professionals.
3. **Enabling services staff,** which include case managers, patient or community educators, interpreters, eligibility assistance staff and transportation staff.
4. **Administrative and facility staff**, including overall administrative and finance staff, patient services (e.g., intake and records), information technology staff and housekeeping.

Table 2 shows the number of FTE staff in each category, the ratio of staff to patients and the percent distribution of staff from 2007 to 2013. As can be seen in the first two panels of the table, the number of staff and the ratio of staff to patients rose in all categories, but the steepest increase was among other health professionals, whose numbers climbed by 77% by 2013 and for which the staff to

[5] Every year HRSA provides an updated manual with more detail about UDS reporting requirements, e.g., Bureau of Primary Health Care, *Uniform Data System Manual for Calendar Year 2013. T*here are occasional changes or clarifications from year to year.

Table 2. Distribution of Major CHC Workforce Categories, 2007-13					
Year	Total CHC Staff	Medical Staff	Other Health Professionals	Enabling Service Staff	Administrative & Facility Staff
	Total Number of Staff FTEs				
	(1,000s)	(1,000s)	(1,000s)	(1,000s)	(1,000s)
2007	104.9	36.9	13.2	13.5	41.3
2008	113.1	39.7	14.7	14.3	44.4
2009	123.0	43.4	16.4	15.4	47.8
2010	131.7	46.5	18.4	16.1	50.6
2011	138.4	49.2	19.9	16.7	52.5
2012	148.2	53.1	21.8	17.7	55.6
2013	156.8	56.0	23.3	19.5	58.0
Cum. % Growth	**49.5%**	**51.8%**	**76.6%**	**44.7%**	**40.3%**
	Staff per 10,000 Patients				
2007	65.4	23.0	8.2	8.4	25.8
2008	66.0	23.2	8.6	8.4	25.9
2009	65.6	23.1	8.8	8.2	25.5
2010	67.6	23.9	9.4	8.3	26.0
2011	68.4	24.3	9.8	8.3	25.9
2012	70.3	25.1	10.3	8.4	26.4
2013	72.2	25.8	10.7	9.0	26.7
Cum. % Growth	**10.4%**	**12.2%**	**30.4%**	**6.9%**	**3.6%**
	Percent ot Total CHC Staff				
2007	100.0%	35.2%	12.6%	12.9%	39.4%
2008	100.0%	35.1%	13.0%	12.7%	39.2%
2009	100.0%	35.3%	13.3%	12.5%	38.9%
2010	100.0%	35.4%	14.0%	12.2%	38.4%
2011	100.0%	35.6%	14.4%	12.1%	37.9%
2012	100.0%	35.8%	14.7%	12.0%	37.5%
2013	100.0%	35.7%	14.9%	12.4%	37.0%

patient ratio grew by 30%. The number of medical staff rose by 52% and the ratio of medical staff to patients increased by 12%. The increase in staff to patient ratios signals an increasing intensity of services provided to CHC patients, both in terms of medical care and other health services. In contrast, there was relatively little change in the ratio of administrative and facility staff to patients.

Roughly half of CHC staff are health professionals, either medical staff (36% in 2013) or other health professionals (15%); the other half are enabling (12%) or administrative/facility staff (37%). The distribution of staff in these main categories has changed little, although the share who are other health professionals rose slightly and the share who are are administrative or facility staff declined.

Medical Staff

Medical staff are responsible for the core primary medical care services at CHCs. Physicians include those trained as Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs) in all specialties (except psychiatry, who are grouped with mental health professionals in the Other Health Professionals category). Most CHC physicians are primary care physicians (family medicine, internal medicine, pediatrics, or obstetrics/gynecology), although a small number are in other specialties. About one-fifth of all medical staff are classified as physicians (19% in 2013), a slight decline from 22% in 2007. Nonetheless, the number of CHC physicians rose 34% from about 8,000 in 2007 to 10,700 in 2013 (Table 3). Many physicians practice part-time at CHCs, so the number of individual physicians practicing at CHCs is larger than the number of physician FTEs expressed above.)

Table 3. Distribution of Medical Staff at CHCs

Year	# Physicians	# Advanced Practice Clinicians	# Nurses	# Other Medical Staff
2007	7,994	4,693	9,282	14,932
2008	8,441	5,138	9,807	16,323
2009	9,125	5,758	10,626	17,892
2010	9,592	6,362	11,365	19,224
2011	9,943	6,942	11,853	20,478
2012	10,445	7,555	12,551	22,512
2013	10,734	8,156	13,278	23,850
Cum. % Growth	**34.3%**	**73.8%**	**43.1%**	**59.7%**
	Percent of Medical Staff Category			
2007	21.7%	12.7%	25.2%	40.5%
2008	21.3%	12.9%	24.7%	41.1%
2009	21.0%	13.3%	24.5%	41.2%
2010	20.6%	13.7%	24.4%	41.3%
2011	20.2%	14.1%	24.1%	41.6%
2012	19.7%	14.2%	23.7%	42.4%
2013	19.2%	14.6%	23.7%	42.6%

There was a sharp increase in the number of advanced practice (or mid-level) clinicians, such as nurse practitioners, physician assistants and certified nurse midwives, rising 74% from 2007 to 2013 . CHCs are in the forefront of a broader national shift to expand the roles of non-physician clinicians. The advanced practice clinicians are being used both as complements and, in some cases, as alternatives, to physicians. In many states, nurse practitioners can now practice independently of physicians as primary care providers. Other analyses, however, have found that heaviest use of advanced practice staff occurred in smaller health centers with more uninsured patients.[6]

The number of nurses and other medical staff (e.g., medical assistants/aides, laboratory and radiology technicians, etc.) also rose in this period. The UDS data do not differentiate between different types of nurses, such as Licensed Practical Nurses vs. Registered Nurses, nor do they further specify medical assistants/aides. Other analyses have shown that CHCs vary in the extent to which they rely on nurses or medical assistants/aides to help provide primary care.[4]

While the overall level of medical care was increasing substantially during this period, it appears that non-physician staffing grew more rapidly than the number of physicians. This appears consistent

[6] Ku L., Frogner B, Steinmetz E, Pittman P. Community health centers use diverse staffing and can provide lessons for other medical practices, Health Affairs. 2015 Jan; 34(1):95-103.

with other national primary care trends which are emphasizing the use of team-based care and greater reliance on non-physician clinical staff. This may be particularly appropriate in CHCs which are often located in health professional shortage areas where it may be harder to recruit primary care physicians.

Other Health Professionals

CHCs offer a broad range of health services that extend beyond regular medical care, including dental, mental health, vision and pharmacy services. Thus, staffing in these areas has grown rapidly. Other services that are sometimes available at CHCs include nutrition, physical therapy, or community health aide services.

The overall number of other health professionals rose 77% from 2007 to 2013 and the ratio of staff to patients increased by 30% (Table 2). In large measure the rapid growth corresponds to an evolution of the scope of comprehensive primary care services, as well as the recognition that medically underserved communities are often have shortages of other health professions and the disadvantaged patients seen at CHCs that often need other types of health care as well.

As seen in Table 4, the movement to integrate behavioral care with primary care has been particularly strong at CHCs and psychiatry and other mental health staffing has roughly doubled. HRSA encouraged these changes in recent years by offering additional Section 330 grants to expand the scope of services offered at CHCs. Greater co-location of medical and other health services services is more convenient for patients and increases the potential to coordination care for patients with multidimensional health needs (e.g., medical and mental health needs). The number of psychiatrists at CHCs increased sharply, but the majority of CHC mental health staff are licensed social workers or other licensed mental health professionals (e.g., ,family therapists). Compared to the increase in mental health staff, the growth of substance abuse staff has been modest. (More detail about certain positions

Table 4. Distribution of Other Health Professionals at CHCs

Year	# Dentists	# Other Dental Staff	# Psychiatrists	# Other Mental Health	# Substance Abuse Staff	# Pharmacy	# Other Professional Services
2007	2,108	4,792	264	2,450	698	2,166	714
2008	2,299	5,221	299	2,889	770	2,310	869
2009	2,577	5,896	348	3,339	822	2,479	951
2010	2,882	6,570	394	3,847	854	2,756	1,081
2011	3,097	7,255	380	4,049	852	2,995	1,246
2012	3,326	7,834	452	4,763	843	3,264	1,354
2013	3,479	8,371	488	5,206	853	3,471	1,423
Cum. % Growth	**65.1%**	**74.7%**	**84.9%**	**112.5%**	**22.2%**	**60.3%**	**99.4%**
	Percent of Other Health Professional Category						
2007	16.0%	36.3%	2.0%	18.6%	5.3%	16.4%	5.4%
2008	15.7%	35.6%	2.0%	19.7%	5.3%	15.8%	5.9%
2009	15.7%	35.9%	2.1%	20.3%	5.0%	15.1%	5.8%
2010	15.7%	35.7%	2.1%	20.9%	4.6%	15.0%	5.9%
2011	15.6%	36.5%	1.9%	20.3%	4.3%	15.1%	6.3%
2012	15.2%	35.9%	2.1%	21.8%	3.9%	14.9%	6.2%
2013	14.9%	35.9%	2.1%	22.4%	3.7%	14.9%	6.1%

was added after 2007, such as psychologists and social workers in 2008 and vision services in 2010. Because complete time series are not available, we do not provide separate totals for these functions and believe they would have been counted in other related subcategories.)

The number of staff in virtually all categories of other health professionals has grown. For example, even though the percent of other health professionals who are dentists declined from 16% in2007 to 15% in2013, the number of dentists practicing at CHCs rose from 2,100 in 2007 to almost 3,500 in 2013, growing by two-thirds.

Enabling Services Staff

A distinguishing feature of CHCs is the emphasis on providing services, such as case management, patient education, language assistance, transportation and other social services to address the broader social needs of disadvantaged CHC patients and to expand their access health and other services they may need. Case managers, for example, may help coordinate medical, other health and social services for patients with multiple needs. Interpreters help patients who have limited English proficiency. The overall number of enabling staff grew at a rate(44% from 2007 to 2013) similar to growth in overall staffing (49%), so the share of staff in the enabling service category remained relatively steady (Table 2).

As seen in Table 5, the exception is the number of eligibility assistance staff, who grew by almost 150% over the period, with particular increases in 2013. Over the years, CHCs have sought to expand the number of insured patients and increasingly used these staff to help patients enroll in Medicaid or the Children's Health Insurance Program and to help them enroll in managed care plans as well. The gradual reduction in the percent of CHC patients who are uninsured (Table 1) is likely related to the efforts of the eligibility assistance staff. CHCs play a particularly important role during periods of insurance expansions[7] and HRSA provided additional funds to CHCs to provide additional eligibility and enrollment assistance as the Affordable

Table 5. Distribution of Enabling Staff at CHCs

Year	# Case Managers	# Patient/ Community Educators	# Eligibility Assistance Staff	# Other Enabling Staff
2007	3,365	1,823	1,292	7,007
2008	3,502	2,131	1,701	7,005
2009	3,820	2,133	1,996	7,449
2010	4,086	2,117	2,129	7,793
2011	4,415	2,084	2,242	7,946
2012	4,739	2,166	2,419	8,411
2013	5,008	2,250	3,185	9,076
Cum. % Growth	48.8%	23.5%	146.6%	29.5%
	Percent of Enabling Staff Category			
2007	25.0%	13.5%	9.6%	52.0%
2008	24.4%	14.9%	11.9%	48.9%
2009	24.8%	13.9%	13.0%	48.4%
2010	25.3%	13.1%	13.2%	48.3%
2011	26.4%	12.4%	13.4%	47.5%
2012	26.7%	12.2%	13.6%	47.4%
2013	25.7%	11.5%	16.3%	46.5%

[7] Paradise J, Rosenbaum S, Shin P, Sharac J, Alvarez C, Zur J, Ku L. Providing outreach and enrollment assistance: lessons learned from community health centers in Massachusetts. Kaiser Family Foundation. September 24, 2013.

Care Act expansions were progressing. Helping CHC patients get insurance helps the CHCs by helping to bring in insurance revenue, but also helps the patients by improving access to specialty, hospitalization and other services when they have insurance coverage. A common problem faced by CHCs is arranging for specialty care or hospitalization when their patients are uninsured.

Some of the enabling services provided by CHCs, such as community patient education, are not reimbursable under most insurance plans, but may still be critical in meeting the needs of CHC patients and in fulfilling CHCs role in improving health at the community level. In some cases, these functions may be supported by grant funding, such as core Section 330 funding or other federal, state, local or charitable sources. For example, Ryan White HIV/AIDS program funds can help support community-based HIV prevention education.

The range of additional service programs offered at CHCs is wide-ranging, including WIC (Women, Infants and Children) nutrition services, Head Start, child care, housing, environmental health, legal assistance and so on. A recent growth area has been in medical-legal partnerships in which legal assistance is made available to CHC patients, working in conjunction with local legal services attorneys. In some cases, CHC staff directly provide these services, while in other cases the services are provided though partnership programs.

Administrative and Facility Staff

Administrative and facility staff are the final major workforce category. As shown in Table 2, this has been the slowest growing category and the staff –to-patient ratio rose only 3.6% from 2007 to 2013. Most of the staff in this category are classified as management or support staff or as patient support staff. Patient support staff provide services like patient intake or records management.

An important subcategory is information technology (IT) staff. The number of IT staff FTEs grew 63% from 2008 to 2013, from 1,519 in 2008 to 2,473 in 2013. (IT staff were not separately reported in 2007, so they are not shown in the table.) Health IT has assumed greater importance throughout the health care sector. The American Recovery and Reinvestment Act of 2009 provided additional funding to increase IT infrastructure in CHCs and also created Medicaid and Medicare incentive payments to help support health providers' adoption of health IT and meaningful use of IT.[8] [9]

Conclusions

The dominant feature of changes in CHC staffing is growth in the size of the CHC 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.[10] Increases instaff-to-patient ratio indicate that the intensity of services offered to

[8] Cunningham M, Lara A., Shin P. *Results from the 2010-11 Readiness for Meaningful Use of HIT and Patient Centered Medical Home Recognition Survey*. Issue No. 26. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, November 3, 2011.

[9] Frogner B, Pittman J Health Systems Innov, forthcoming. 2015.

[10] Pathman D, Konrad T. Growth and changes in the National Health Service Corps Workforce with the American Recovery and Reinvestment Act. J Am Board Fam Pract. 2012; 25(5): 723-33.

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. The number of staff who provide other health services (e.g., dental, mental health, or vision care) and enabling services (e.g. case management, eligibility assistance, or language assistance) is almost as large as the number of staff engaged in medical care. And the relative share of staff who provide non-medical health services has been the area where staffing has grown the most.

The growth of CHCs over the past decade signifies the demand for this comprehensive model of health delivery and the importance of offering a broad range of services that can meet multiple health needs of patients.