NATIONAL ASSOCIATION OF Community Health Centers

MARCH 2016

STAFFING THE SAFETY NET:

Building the Primary Care Workforce at America's Health Centers

Community, Migrant, Homeless, and Public Housing Health Centers are non-profit, community-governed preventive and primary care providers with over 50 years of experience expanding access and eliminating barriers to care.

Now **serving over 24 million patients** nationally, Community Health Centers have more than doubled the number of patients served since 2000.[1] Health center patients are predominantly low income, uninsured or insured through Medicaid, and members of racial/ethnic minority groups. They also experience high rates of complex and chronic conditions.[2] Research consistently demonstrates that health centers effectively manage the care of their patient population and deliver needed savings to the health care system.[3]

A key ingredient to Community Health Centers' success in expanding access to high-quality, cost effective care is their workforce—in particular, the medical, mental health, substance addiction treatment, oral, and other clinical staff at health centers, as well as the interdisciplinary health professionals who facilitate access to care and improve health outcomes for their patients. Health centers now employ over 170,000 staff, the majority of whom directly deliver needed health and wellness care services. The number of health center clinical care staff has approximately doubled since 2005.[4] However, as the health care system transforms and demand for care increases, the challenge of recruiting and retaining a strong clinical workforce has become particularly acute among the nation's health centers, which are located in and serve communities with few alternatives for primary and preventive care.

This brief presents results from a recent national survey conducted by the National Association of Community Health Centers (NACHC), and offers a snapshot of health center clinical workforce needs and priorities. Even though findings demonstrate that health centers are often able to innovate and adapt to address clinical workforce challenges, findings also reveal an unequivocal need for more focused attention and support for Community Health Centers in their consistent efforts to bring high-quality, committed primary care team members to their patients and communities.

Workforce challenges are one of the primary barriers to health center patient growth. If all health center clinical vacancies were filled today, health centers could serve 2 million more patients.

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CARE TEAMS AT HEALTH CENTERS

Each health center employs a unique mix of health professionals to expand access to comprehensive, coordinated, continuous, and accountable primary and preventive care. The health center care team model includes clinical and non-clinical, as well as traditional and non-traditional, health and wellness professionals to meet patients' complex medical, behavioral, oral, and other health care needs. For example, health centers are hiring new nurse practitioners, physician assistants, and certified nurse midwives at faster rates than they are hiring new physicians, and they are twice as likely to hire these non-physician providers than other practice settings.[5] Most health center care teams make extensive use of medical assistants and community health workers/promotoras.[6] In addition, more than 10% of health centers' total workforce include staff whose daily jobs enable patients to obtain health and social services, from community health workers/promotoras, care managers, health educators, transportation staff, and interpreters.[7]

Health centers will continue to make greater use of diverse care teams as they progress to meet rising demand for care, further improve community health, and make greater gains in system efficiency goals. Innovations in care team design are based on each health center community's specific needs, preferences, and resources. Increasingly, these innovations are strengthened by health centers' engagement in interprofessional health professions training opportunities. As the health center workforce continues to expand and evolve, this brief offers a snapshot of their current staffing priorities.

HEALTH CENTERS' CURRENT CLINICAL VACANCIES

Clinical vacancies are important indicators of capacity challenges because they represent existing and funded positions for which a health center is actively recruiting but cannot fill. While some vacancies represent new positions or natural turnover, others may be symptomatic of overall national workforce challenges. Health centers, however, are at a particular disadvantage because they serve isolated or otherwise underserved communities that face challenges in recruiting and retaining high quality staff.

Almost all health centers (95%) are experiencing at least one clinical vacancy today. The most common clinical position health centers report to be currently vacant is family physician (Figure 1).[8] More than two-thirds (69%) of health centers indicate that they are currently recruiting for at least one family physician, while about half are recruiting for a nurse practitioner or medical assistant (Figure 1). Additionally, 56% of health centers report experiencing at least one opening for a behavioral health staff member, such as a licensed clinical social worker, psychologist, or other mental health/substance abuse professional (not shown in figure).

Health centers on average have 13% of their clinical workforce staff positions currently vacant. This average vacancy rate is higher for family physicians (25%) and licensed clinical social workers (17%) (Figure 2). Health centers also have higher average vacancy rates for physicians than those experienced by hospitals (21% vs. 18%).[9]

FIGURE 1 PERCENT OF HEALTH CENTERS REPORTING A VACANCY FOR SPECIFIC CLINICAL POSITION

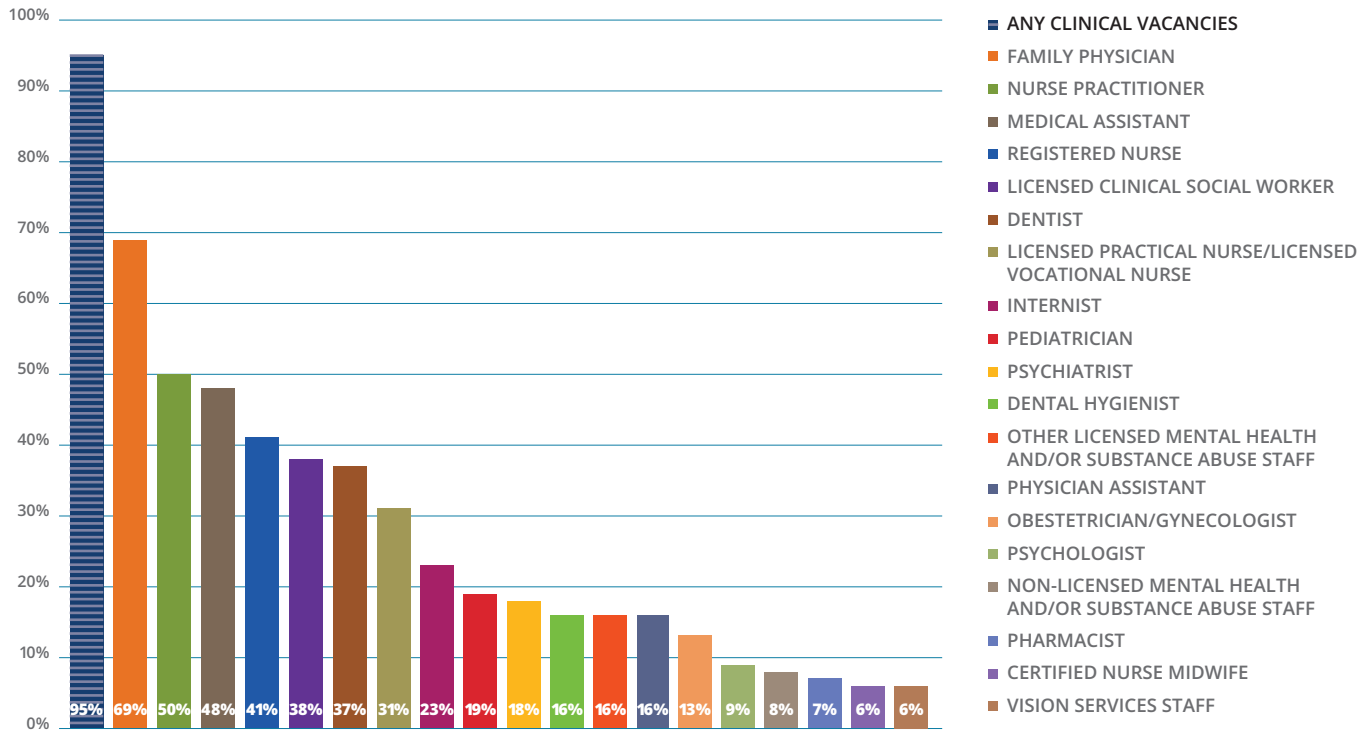
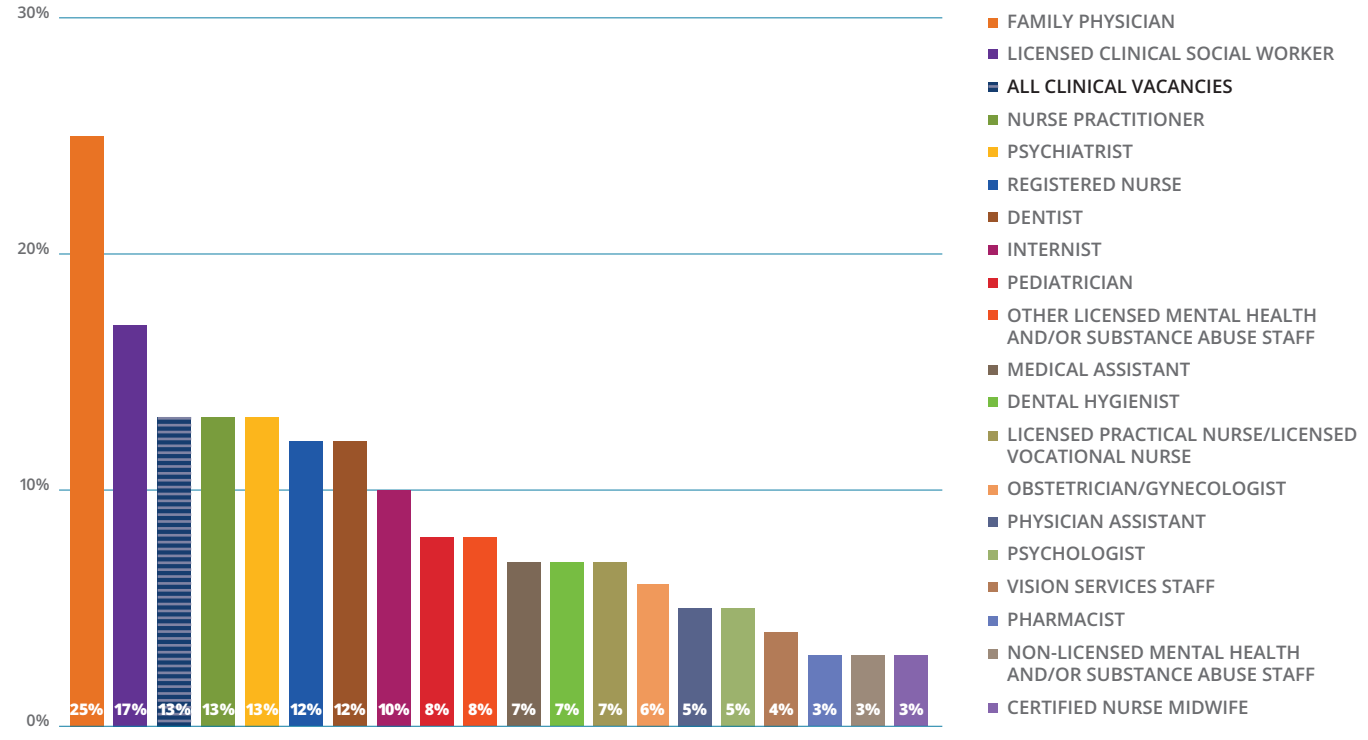


FIGURE 2 AVERAGE HEALTH CENTER CLINICAL VACANCY RATES



HEALTH CENTERS' CURRENT CLINICAL VACANCIES (CONTINUED)

Health centers have particular difficulty recruiting certain provider types. Family physician is the most difficult vacancy to fill, with 66% of health centers indicating it as "very difficult" to fill. Additionally, 30 to 40% of centers rate internist, psychiatrist, and licensed clinical social worker vacancies as "very difficult" to fill (Figure 3).

Similarly, health centers report spending the most time recruiting for psychiatrist, family physician, and internist vacancies. On average, respondents spend over a year recruiting for a psychiatrist and nearly a year recruiting for family physicians, internists, and obstetrician/gynecologists (Figure 4).

Family physician also rates as the most highly prioritized clinical position to fill at health centers. When asked to select one currently vacant clinical staffing position as their highest priority to fill, health centers overwhelmingly identified family physician, with half of respondents selecting it (Figure 5).

The next most common responses were behavioral health specialist and dentist (10% and 8% respectively, of health centers prioritizing).

FIGURE 3 PERCENTAGE OF HEALTH CENTERS RATING SPECIFIC CLINICAL VACANCIES AS VERY DIFFICULT TO FILL

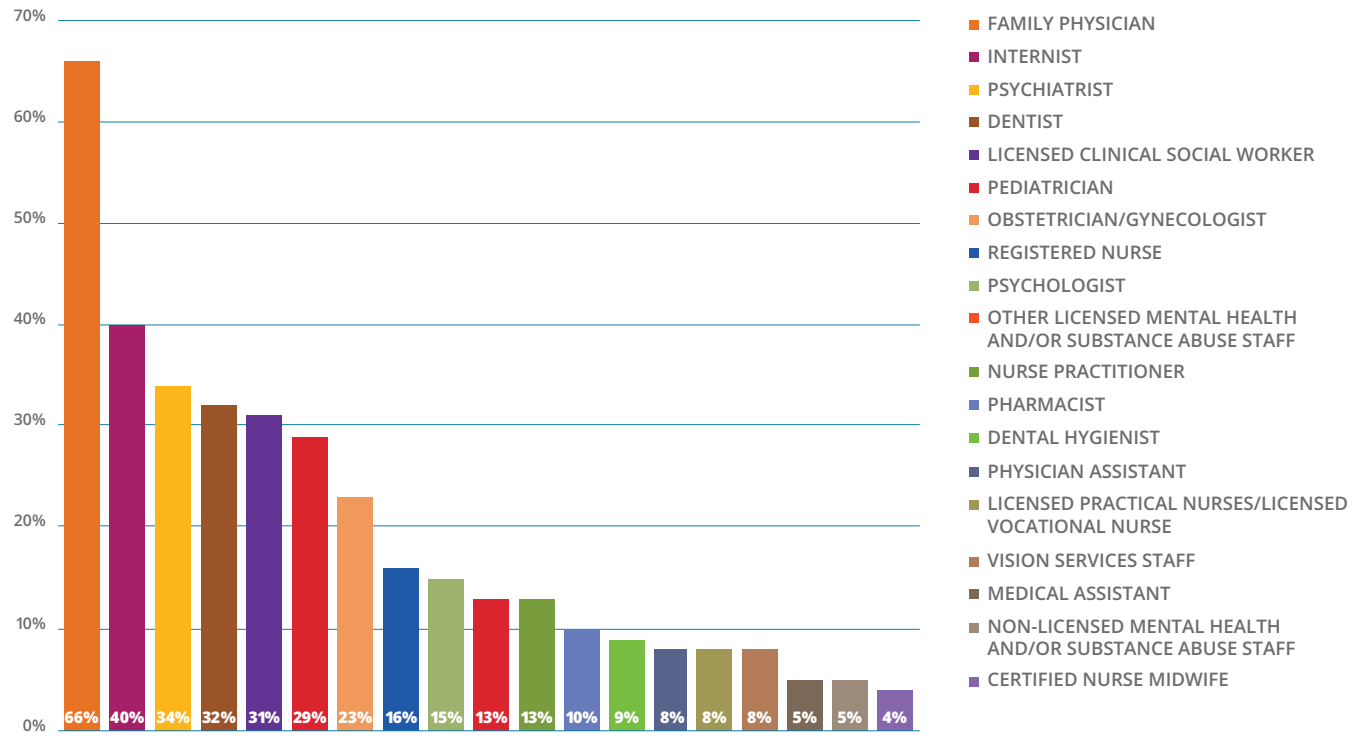


FIGURE 4 AVERAGE NUMBER OF MONTHS SPENT RECRUITING FOR SPECIFIC CLINICAL VACANCIES

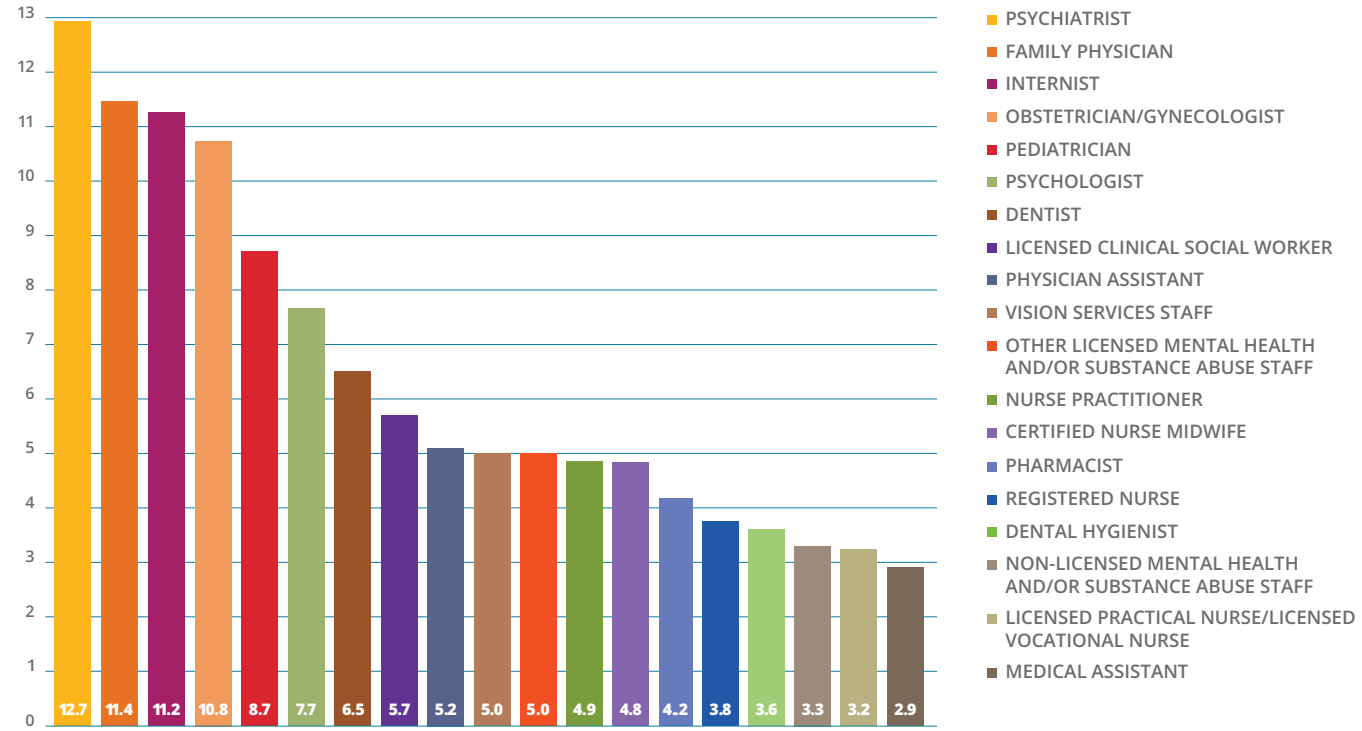
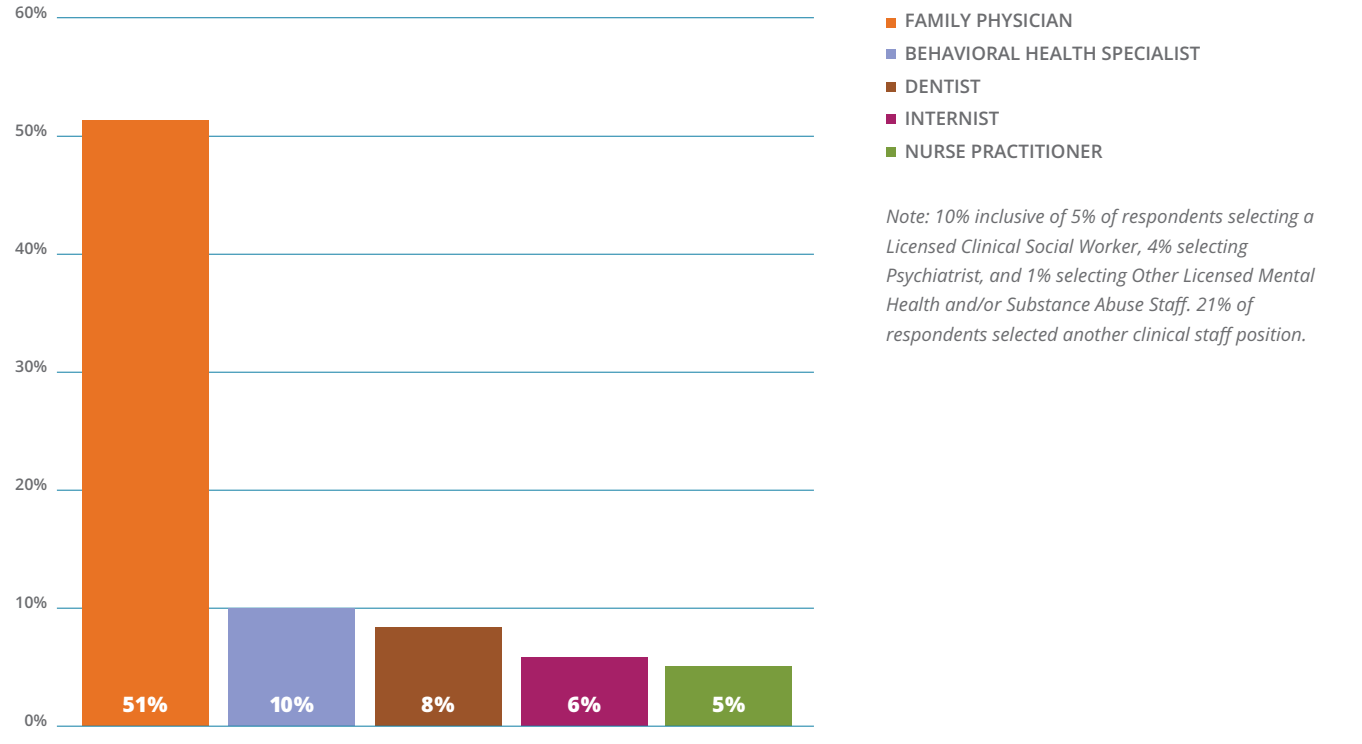


FIGURE 5 TOP 5 VACANCIES RATED AS HEALTH CENTERS' HIGHEST PRIORITY TO FILL



Note: 10% inclusive of 5% of respondents selecting a Licensed Clinical Social Worker, 4% selecting Psychiatrist, and 1% selecting Other Licensed Mental Health and/or Substance Abuse Staff. 21% of respondents selected another clinical staff position.

HEALTH CENTER RECRUITMENT AND RETENTION EXPERIENCES

Health centers face a variety of barriers in recruiting and retaining their highest priority clinical positions (Figure 6). The most highly rated challenges confronting health centers speak to the sharp competition for qualified staff and health centers' location in isolated or impoverished areas. Some health centers report challenges with recruiting candidates who have proficient language skills and/or cultural competency. Interestingly, responses related to challenges varied little when comparing the half of health centers that chose a family physician vacancy as their highest priority to fill with those that reported other positions as their highest priority.

Evidence shows that health centers draw from the network of other health centers across the country to recruit their clinical staff. When asked about staff hired in the past two years, 58% of health centers said they had hired a health professional who trained at their health center and 30% said they had hired a health professional who trained at another health center (Figure 7).

While departing clinical staff most often leave their health centers for private primary care practices and hospitals, a significant number transfer to other health centers (Figure 8).

FIGURE 6 IMPORTANT PROBLEMS FOR RECRUITMENT AND RETENTION

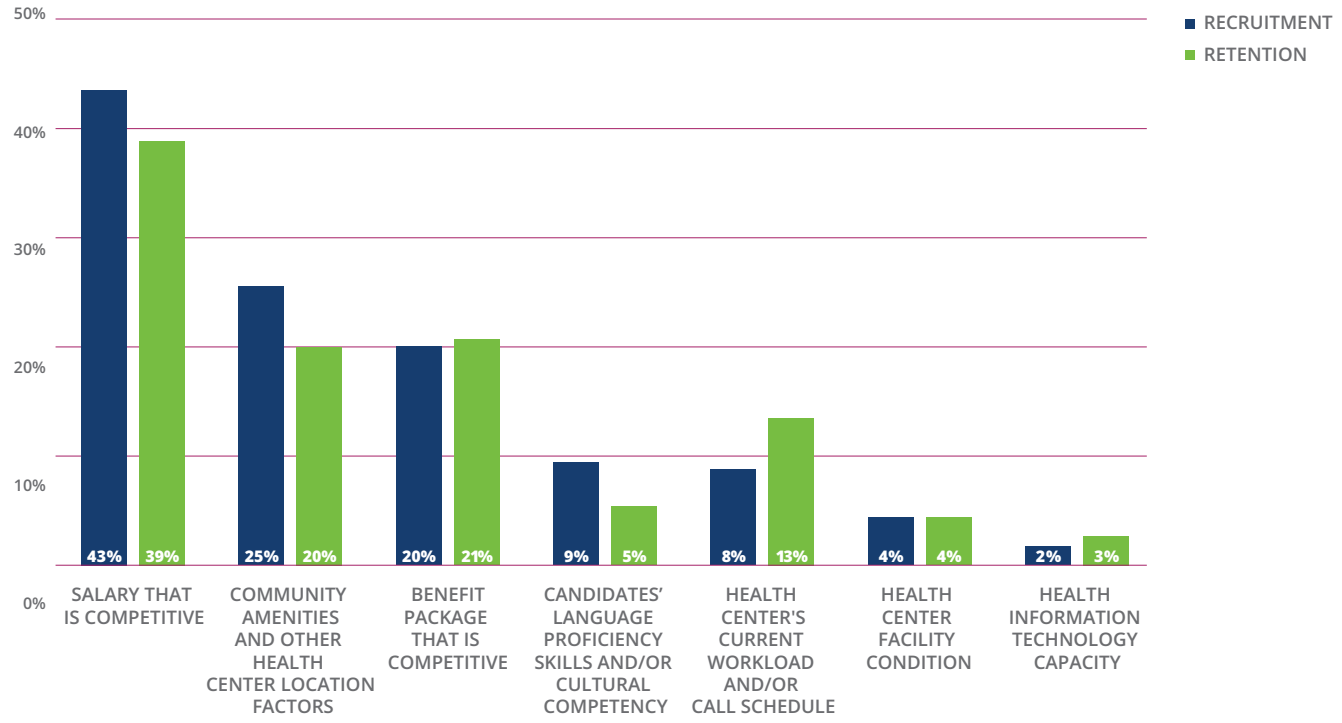
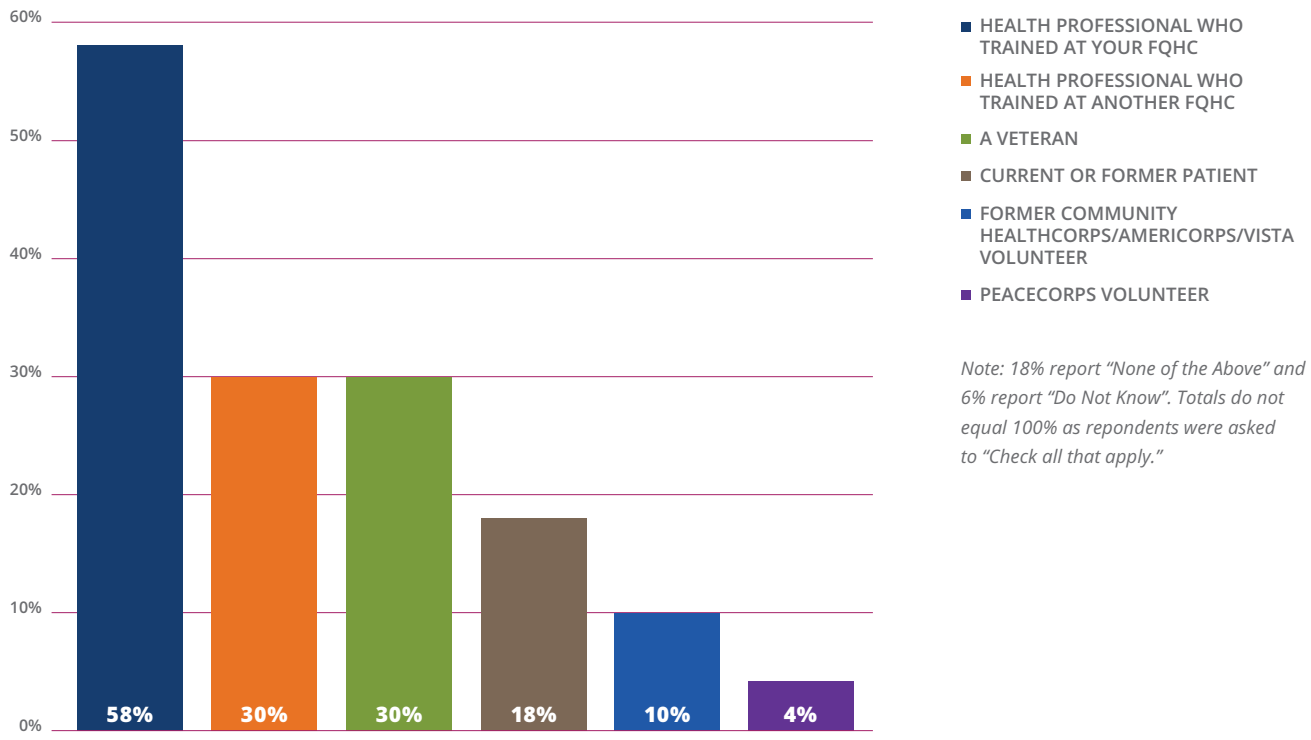
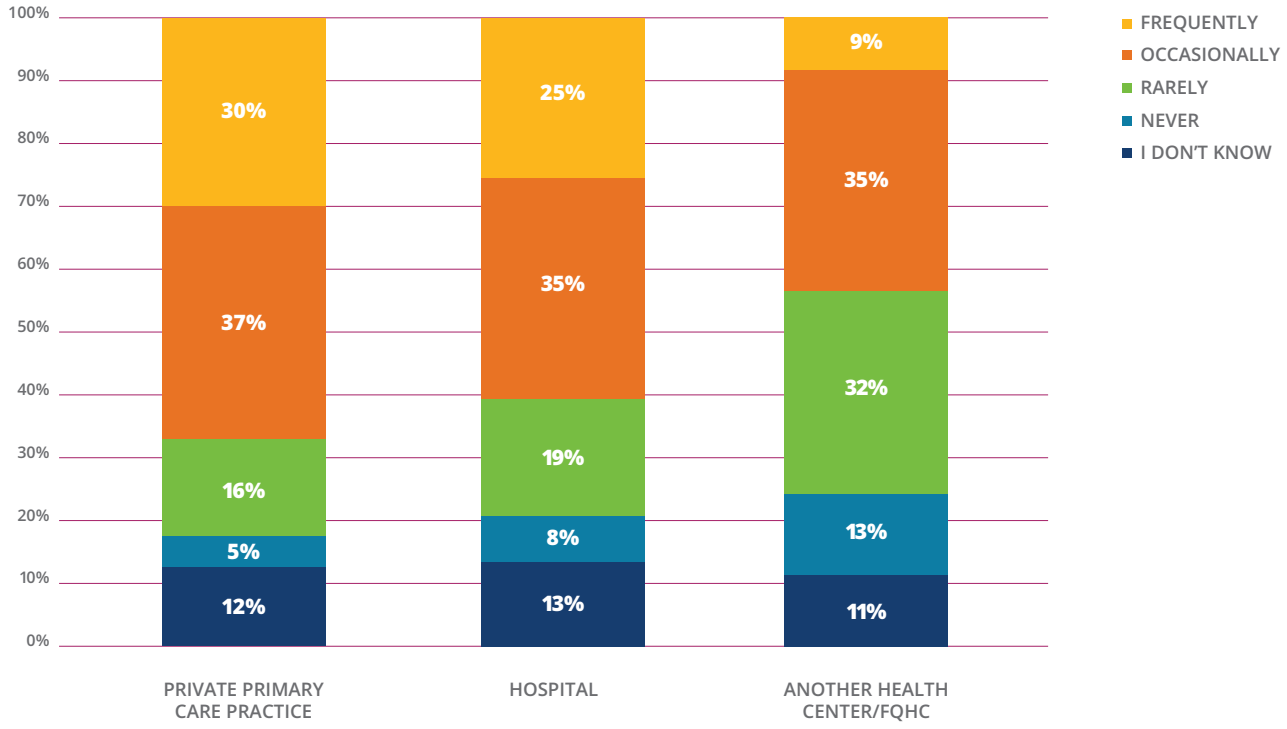


FIGURE 7 STAFF HIRED BY HEALTH CENTERS IN THE PAST TWO YEARS



Note: 18% report "None of the Above" and 6% report "Do Not Know". Totals do not equal 100% as repondents were asked to "Check all that apply."

FIGURE 8 WHERE HEALTH CENTER STAFF WORK AFTER LEAVING HEALTH CENTER



IMPORTANCE OF THE NATIONAL HEALTH SERVICE CORPS

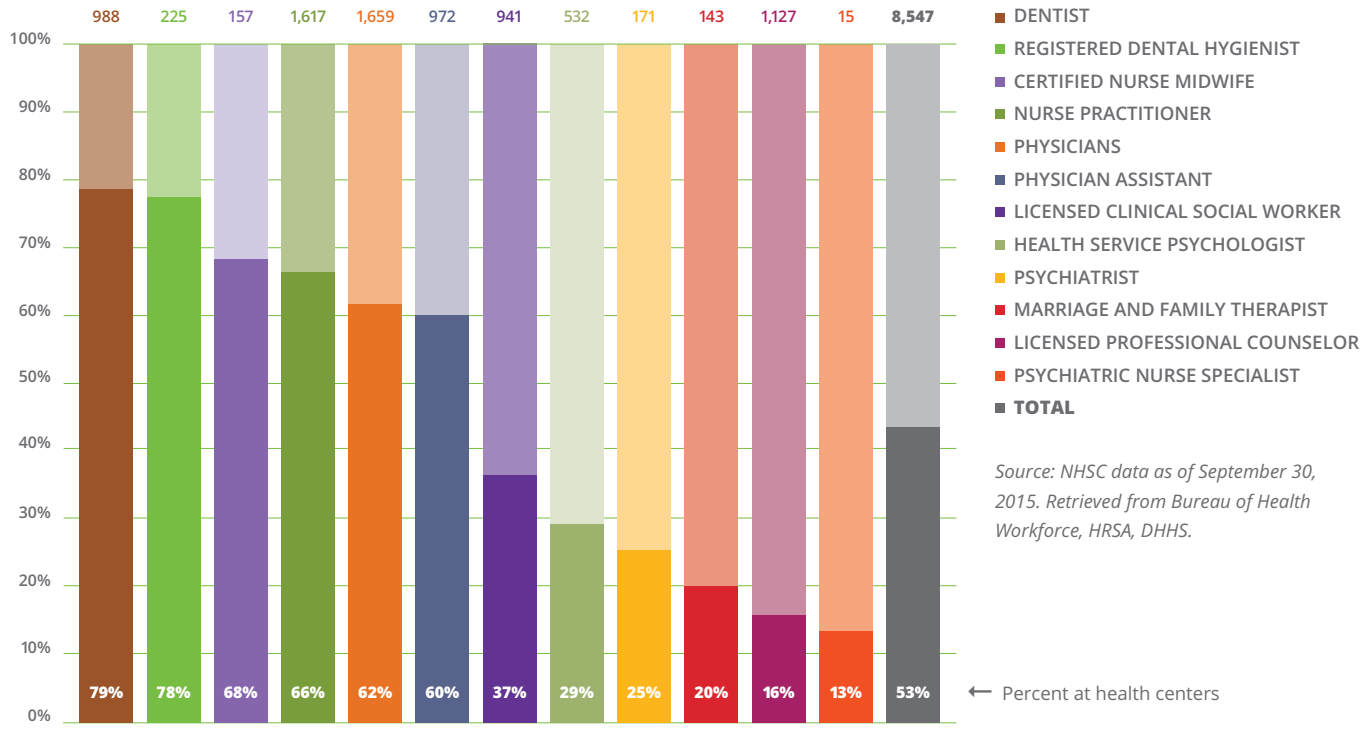
The National Health Services Corps (NHSC) provides scholarships and loan repayment to clinicians who commit to serving communities federally designated as health professions shortage areas, and in doing so serves as an essential pipeline of clinical staff to areas experiencing provider shortages. Most NHSC clinicians continue to practice in underserved communities after completing their service obligations, with more than half (55%) continuing to practice in these areas 10 years later.[10] Health centers' broad reach into underserved areas makes them ideal settings for NHSC members.

As Figure 9 shows, an analysis of NHSC data reveals that more than half of all NHSC participants are providing care at a health center. More than three-quarters of NHSC dentists and dental hygienists, as well as over 60% of NHSC certified nurse midwives, nurse practitioners, and physicians are working at a health center. While health center providers make up 53% of current NHSC participants, 61% of current NHSC vacancies are at health centers, further highlighting how important health centers find this program for their recruitment efforts.[11]

The NHSC field strength is only as vast as federal funding can support. National survey findings reveal that some health centers have given up on utilizing the NHSC because of limits in the clinician placement program's capacity. Among health centers that indicate they do not currently list positions with the NHSC, 16% report that they did not think their qualifying score was high enough to receive NHSC clinicians.

While the NHSC loan repayment and scholarship program is the largest federal program routing clinicians to underserved areas, some health centers also rely on other federal placement programs, such as the NURSE Corps and J-1 Visa Waivers, and many rely on state initiatives to fill critical workforce gaps. Without these important programs, health center vacancy rates would be much higher.

FIGURE 9 TOTAL NHSC PARTICIPANTS BY PROVIDER TYPE, AND PERCENTAGE OF PARTICIPANTS AT HEALTH CENTERS



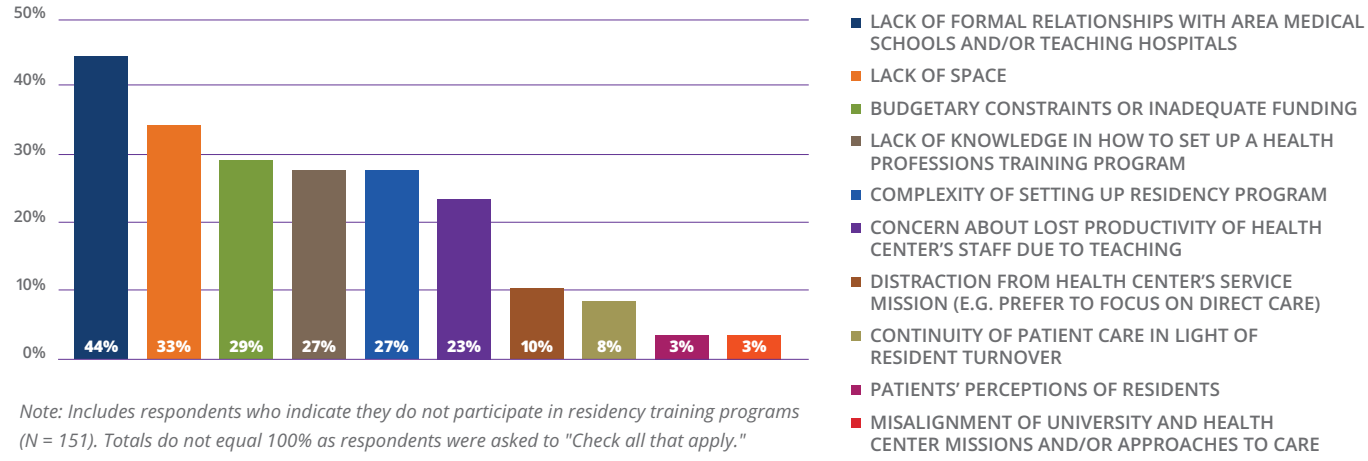
Source: NHSC data as of September 30, 2015. Retrieved from Bureau of Health Workforce, HRSA, DHHS.

HEALTH PROFESSIONS EDUCATION AND TRAINING IN HEALTH CENTERS

Health centers are active participants in the education and training of the next generation of primary care providers. Nearly all health centers are participating in some kind of education or training—for students, residents, or both. They also play a large role in employing providers who have trained in the unique health center setting. Family physician and nurse practitioner are the provider types most commonly trained at health centers today. Despite this, a number of key barriers prevent more health centers from participating in residency training programs. Lack of formal relationships with area medical schools and/or teaching hospitals, lack of space, and budgetary constraints or inadequate funding are the most commonly cited reasons for not participating in such programs (Figure 10).

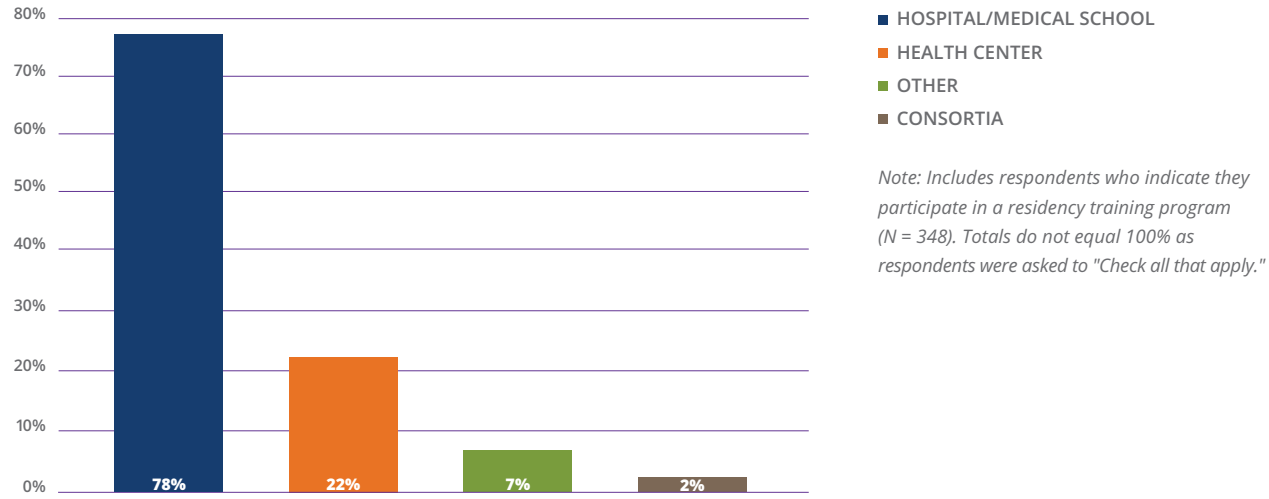
While local hospitals and/or medical schools are by far the most likely entities to hold the accreditation for the residency programs in which health centers are participating, more than 1 in 5 (22%) health centers report that they now hold the accreditation for their own residency programs (Figure 11).

FIGURE 10 — PERCENT OF HEALTH CENTERS REPORTING KEY BARRIERS TO PARTICIPATING IN RESIDENCY TRAINING PROGRAMS



Note: Includes respondents who indicate they do not participate in residency training programs (N = 151). Totals do not equal 100% as respondents were asked to "Check all that apply."

FIGURE 11 — ORGANIZATIONS HOLDING THE ACCREDITATION FOR HEALTH CENTERS' RESIDENCY TRAINING PROGRAMS



Note: Includes respondents who indicate they participate in a residency training program (N = 348). Totals do not equal 100% as respondents were asked to "Check all that apply."

POLICY IMPLICATIONS

Over the past 50 years, health centers have grown from two small demonstration grantees to become the largest primary care network in the United States, thanks to strong support from Congress and both Democratic and Republican Presidents. That growth has led to a remarkable expansion of access to primary care.

Yet the full potential of health centers' historic growth continues to go unrealized, due primarily to the challenges they face in training, recruiting and retaining a qualified, culturally competent, mission-driven, and dynamic clinical workforce. Vacancies on a health center's clinical staff can have a ripple effect, leading to productivity challenges and an inability to meet surging demand, both major barriers to patient growth. Indeed, with 95% of health centers reporting at least one clinical vacancy, they themselves collectively report that **2 million additional people** could be served if these vacancies were filled. Yet despite these challenges, health centers have proven themselves as innovators in addressing costly chronic illness and addressing the root causes of poor health. Health centers are reaching beyond the walls of traditional medicine and partnering with other organizations to apply bold community-based solutions to treat population health. They are starting food banks and community gardens, providing housing and job training, and integrating behavioral or oral health with primary care. In doing so, health centers both empower patients to effectively manage their health and help reduce health care costs.

When it comes to the workforce challenges faced across the health care system, and particularly those faced by health centers, there is no single silver bullet within federal policy to solve this complex crisis immediately. Rather, America's Community Health Centers are embracing a platform of policy and systems solutions that together can help move our system toward one that emphasizes access to high-quality primary care for all Americans, and especially for the underserved:

- ❑ Recruitment and retention incentives like the National Health Service Corps and other programs must be grown, strengthened, and made to work for all Community Health Centers.
- ❑ Training and education of all primary care team members must continue to move towards the community settings where they will be providing care upon completion of their program. And, health centers should have a prominent place in any reform of our current health professions education and training system.
- ❑ Innovative care models must be embraced and incentivized with a focus on team-based approaches and greater use of technology to bridge gaps in care.

Solving America's primary care workforce challenges will not happen overnight. Yet around the country, Community Health Centers are leading the way with innovative solutions in the face of major challenges. Policies at all levels should reward, replicate, and strengthen these efforts. The health of millions depends on it.

METHODS

NACHC fielded an online survey to all federally-funded health centers between November 2015 and January 2016 to assess their current clinical vacancies, staffing priorities, perceptions of recruitment and retention challenges, and participation in programs that place or train clinicians in underserved areas. Some questions had been previously used in or adopted from a prior validated instrument, and the full survey instrument was reviewed by a national expert panel made up of academics, health center leaders, and other subject matter experts. Most surveys were completed by the health center CEO or Director of Human Resources. The final survey sample (N=499, 39% response rate) is representative of health centers nationally along key characteristics such as size (total patients), patient mix (percent with Medicaid and percent uninsured), geography (urban/rural location), and costs of care. Findings reflect a given point in time and therefore health centers' priorities could change given capacity-building funding opportunities. Some vacancies reflect existing positions rather than new positions; therefore, NACHC extrapolated findings to estimate the number of new patients that could be reached nationally if all new positions were filled. This was done by applying the proportions of health centers with any clinical vacancies and any new positions (95% and 66%, respectively) to the total number of federally-funded health center organizations nationally (nearly 1,300), and multiplying that by the average number of patients reached, as reported by survey respondents.

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[1]NACHC, 2015. Includes all patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2015. Bureau of Primary Health Care, HRSA, DHHS. 2000 and 2014 Uniform Data System.

[2]NACHC. Health Centers Disproportionately Serve Patients with Costly Chronic Conditions. Snapshot. May 2014. Available at http://www.nachc.com/client/documents/High_Cost_Conditions_2014.pdf.

[3]Mukamel DB, White LM, Nocon RS, et al. Comparing the cost of caring for Medicare beneficiaries in federally funded health centers to other care settings. Health Serv Res. 2015 July. Sharma R, Lebrun-Harris LA, Ngo-Metzger Q. Costs and clinical quality among Medicare beneficiaries: Associations with health center penetration of low-income residents. Medicare Medicaid Res Rev. 2014 Sep 8;4(3). Ku, L et al. Using primary care to bend the curve: Estimating the impact of a health center expansion on health care costs. Policy Research Brief No. 14. Sept 2009. Geiger Gibson/RCHN Community Health Foundation Collaborative at The George Washington University. NACHC. Health Centers Provide Cost Effective Care. Fact Sheet. August 2015. Available at http://www.nachc.com/client/documents/Cost%20Effectiveness_FS_2015.pdf. NACHC. Studies of Health Center Cost Effectiveness. October 2014. Available at http://www.nachc.com/client/documents/HC_Cost_Effectiveness_1014.pdf.

[4]Bureau of Primary Health Care, HRSA, DHHS. 2005 and 2014 Uniform Data System.

[5]Proser M, Bysshe T, Weaver D, Yee R. Community health centers at the crossroads. JAAPA. April 2015. 28(4). 49-53.

[6]NACHC. Assessment of Primary Care Teams in Federally Qualified Health Centers. December 2014. Available at http://www.nachc.com/Patient%20Centered%20Medical%20Home.cfm.

[7]Bureau of Primary Health Care, HRSA, DHHS. 2014 Uniform Data System.

[8]The term family physician is used to refer collectively to general/family physicians.

[9]AMN Healthcare. 2013 Clinical Workforce Survey: A National Survey of Hospital Executives Examining Clinical Workforce Issues in the Era of Health Reform. 2013. Available at http://www.amnhealthcare.com/uploadedFiles/MainSite/Content/Healthcare_Industry_Insights/Industry_Research/executivesurvey13.pdf.

[10]HRSA, DHHS. NHSC Clinician Retention: A Story of Dedication and Commitment. December 2012. Available at http://nhsc.hrsa.gov/currentmembers/membersites/retainproviders/retentionbrief.pdf.

[11]NHSC data as of September 30, 2015. Retrieved from Bureau of Health Workforce, HRSA, DHHS.

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