

Community health centers at the crossroads: Growth and staffing needs

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ABSTRACT

In response to increased demand for primary care services under the Affordable Care Act, the national network of community health centers (CHCs) will play an increasingly prominent role. CHCs have a broad staffing model that includes extensive use of physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs). Between 2007 and 2012, the number of PAs, NPs, and CNMs at CHCs increased by 61%, compared with 31% for physicians. However, several policy and payment issues jeopardize CHCs' ability to expand their workforce and meet the current and rising demand for care.

Keywords: physician assistants, nurse practitioners, community health centers, Affordable Care Act, access, primary care

The provisions of the Affordable Care Act (ACA) are expected to increase demand for primary care services across the United States as millions of people gain health insurance through health insurance exchanges and expansion of Medicaid and children's health insurance programs.¹ Many of these newly insured patients will be medically complicated, and the millions of patients without insurance will still need a source of high-quality care.

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The national network of community, migrant, homeless, and public housing health centers (known as community health centers [CHCs] and federally qualified health centers) is not immune to these growing demands on primary care, and will play an increasingly prominent role in meeting the needs of the newly insured and remaining uninsured alike. CHCs' unique model of care delivery uses multiple primary healthcare team members with varied skills to increase capacity, reduce barriers to care, improve patient outcomes, and control the costs of care. CHCs save the healthcare system \$24 billion annually, in part by reducing the use of EDs and inpatient care for preventable conditions.² Their broad staffing model, which includes extensive use of physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs), plays a major and growing role in the centers' ability to meet the demand for care and generate systemwide savings.

The ACA also expands CHC capacity. CHCs have long recognized the value of PAs, NPs, and CNMs in expanding their capacity to serve more complex patients, and also recognize the link between multidisciplinary healthcare teams and improved patient outcomes, reduced disparities, and lower care costs.³⁻⁶

This article describes how CHCs' growing use of PAs, NPs, and CNMs is grounded in their model of care, how they augment their capacity for primary and preventive care, and the special challenges that could inhibit their ability to apply a multidisciplinary staffing approach to meet the need for care as shaped by health reform.

A UNIQUE MODEL OF CARE

The Department of Health and Human Services' Health Resources and Services Administration administers the federal health center program and ensures that all CHCs meet the same basic program requirements set in statute and federal regulation.⁷ CHCs must be not-for-profit, serve federally designated medically underserved areas or populations, and serve all residents regardless of income or insurance status. They are also required to provide a broad range of primary and preventive clinical and nonclinical care, includ-

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ing services designed to facilitate access to care, such as translation or interpretation, case management, home visitation, transportation, and health education. Besides medical care, most CHCs provide behavioral health and dental services onsite, and many provide vision and pharmacy services.⁸ CHCs deliver these services through a multidisciplinary team of healthcare professionals, must ensure that the care delivered reflects patients' cultural preferences, and must meet other clinical performance and accountability requirements. Finally and perhaps unique among care providers, CHCs must be governed by a consumer majority board in order to ensure the community's needs and preferences are met.

These program requirements are designed to improve access to high-quality, efficient primary and preventive care in communities with few healthcare resources and high rates of health disparities. At the same time, CHCs must be customizable to a community's specific needs, preferences, and resources. They are rooted in community-oriented primary care, a population-focused, community-involved approach to care that calls for using teams of multiple healthcare professionals who can build community capacity for healthcare and broaden the delivery of comprehensive, coordinated, continuous, and accountable primary and preventive healthcare.⁹

Today, CHCs serve more than 22 million people through over 9,000 urban, suburban, and rural locations in every state and territory. CHCs' patient base is a reflection of their model of care. These patients have complex sociodemographic and clinical needs that are best managed by a diverse and integrated healthcare professional workforce.

Compared with the US population, CHC patients are disproportionately poor, uninsured, or publicly insured (Figure 1). Minorities also are disproportionately represented among CHC patients: Health centers serve one in three minority patients who fall below the federally defined poverty level, and one in seven of all US rural residents.⁸

Compared with patients of other providers, CHC patients are more likely to have chronic conditions that require ongoing care.¹⁰ In fact, the number of patients with chronic conditions is rising at a faster rate than that of the number of total patients at CHCs: from 2001 to 2012, total patients increased 105%, but patients with a primary diagnosis of diabetes increased 245% and patients with a primary

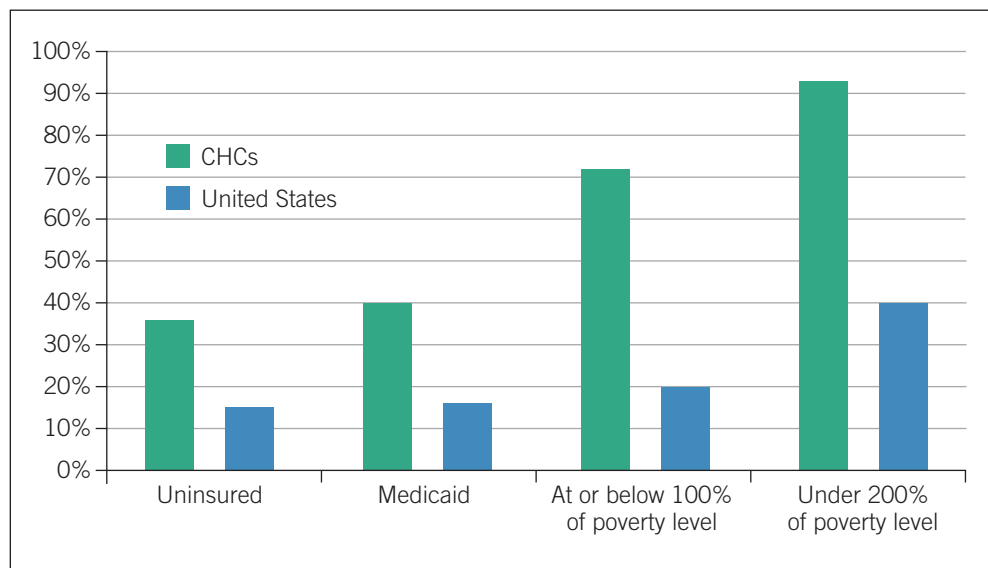


FIGURE 1. CHC patients by insurance and income compared with the general population, 2012.^{11,20,22} In 2012, the federal poverty level was \$23,050 or less for a family of four.

diagnosis of hypertension increased 293%. More than 25% of all current patients have diabetes, cardiovascular disease, asthma, depression, cancer, or HIV.⁸

A CHANGING WORKFORCE

As of 2012, PAs, NPs, and CNMs made up 14% of all provider staff full-time equivalents (FTEs) at CHCs (Table 1). This is similar to the rate they represented in 2007 (13%), yet over this time period the proportion of all medical encounters provided by PAs, NPs, and CNMs increased from 29% to 36%.¹¹

CHC data show the increasing trend of hiring PAs, NPs, and CNMs, including hiring PAs, NPs, and CNMs at a faster rate than that of physicians. From 2007 to 2012, the total number of PA, NP, and CNM FTEs employed by CHCs increased by 61% compared with an increase of 31% for physician FTEs (Figure 2).¹¹ CHCs now hire more than 7 PAs, NPs, and CNMs for every 10 physicians, with the ratio of PA, NP, and CNM FTEs to physician FTEs increasing rapidly over the past 5 years (Figure 3).¹¹ Following this trend, demand for PAs, NPs, and CNMs at CHCs nationally will continue to increase in order to meet the diverse needs of their communities. Across individual CHCs, however, staffing decisions will vary according to each community's preferences and circumstances.

PAs, NPs, and CNMs fill an important role at CHCs looking to expand their capacity to provide face-to-face clinical visits as well as other forms of services. In fact, all three provider types alone contribute more to patient health education than physicians.¹² Given the distinct roles these PAs, NPs, and CNMs serve to meet the varied needs of their patient population, it is not surprising that CHCs are twice as likely to hire PAs, NPs, and CNMs (88%) compared with other practices (44%).¹³ And CHCs

TABLE 1. CHC medical staff and encounters, 2012²⁰

	Number of FTEs (n=53,063)	Number of encounters (n=59,846,057)
Physicians	10,445 (20%)	35,453,435 (59%)
PAs, NPs, and CNMs	7,555 (14%)	21,228,864 (36%)
Nurses	12,551 (24%)	3,163,758 (5%)
Other medical personnel	19,666 (37%)	n/a
Laboratory and radiograph personnel	2,846 (5%)	n/a

hire more of these providers on average compared with other primary care practices.¹³

FUNCTIONING AS PATIENT-CENTERED MEDICAL HOMES

Every CHC is moving to achieve the triple aim—improve the health of the populations served, improve the patient experience, and bend the cost curve. To accomplish this, CHCs are transforming into patient-centered medical homes (PCMH), which includes the integration of behavioral and oral health. Key tenets of the PCMH include everyone working at the top of their training, licensure, or certification; working in care teams; and being responsible for a panel of patients. As primary care providers on PCMH care teams, health center PAs, NPs, and CNMs may have their own panel of patients or be on a team that is responsible for a panel of patients. As CHCs serve increasing numbers of patients, the need for PAs, NPs, and CNMs to practice at the top of their profession increases. For example, by assuring PAs, NPs, and CNMs are practicing at the top of their profession, other team members can provide case management and care coordination services.

To function successfully as a PCMH, care team members need to be trained interprofessionally and/or in the team approach to care. Many CHC care team members are learning the PCMH team approach to service delivery with the assistance of practice transformation coaches. And several training programs are reaching the next generation of PAs, NPs, and CNMs. For example, for 35 years, the University of Utah PA program has placed PA students in clinical rotations in Utah CHCs. Utah CHCs have used this training opportunity to create workforce pathways that assure a steady source of PAs. Duke University in Durham, N.C., and A.T. Still University with campuses in Kirksville, Mo., and Mesa, Ariz., have similar PA training programs. Middletown, Conn., Community Health Centers, Inc., developed an NP residency program to train licensed NPs in CHCs. These examples serve as case studies of mutually beneficial relationships between training institutions and CHCs in need of clinicians.

THREATS TO CHC CAPACITY

Several policy and payment issues threaten the current and future capacity of CHCs and may inhibit their ability to hire PAs, NPs, and CNMs or use them at their full skill set. Pending cuts to federal health center grant funding are the most threatening to CHC capacity, specifically their ability to retain current staff and hire new staff. These funds are the CHCs' second-largest source of revenue after Medicaid reimbursement, and are critical to bringing primary care infrastructure to underserved areas, caring for the uninsured, and covering services not reimbursed by insurance.

The ACA created the Health Center Trust Fund, providing \$9.5 billion in CHC operation costs between fiscal years 2011 and 2015, on top of existing discretionary spending. During fiscal year 2015, the trust fund accounts for 70% of CHCs' total federal health center grant funding. Continued funding for the trust fund is uncertain and a major

cause for concern. The recently passed federal budget for fiscal year 2015 fully funds the trust fund, but beyond this year, Congress will need to address the shortfall in federal funding created by the expiration of mandatory funding. Federal health center grant funds only cover about half of the cost of treating the uninsured.¹⁴ Cutting total federal funding by 70% would reduce health centers' operational capacity, potentially leading

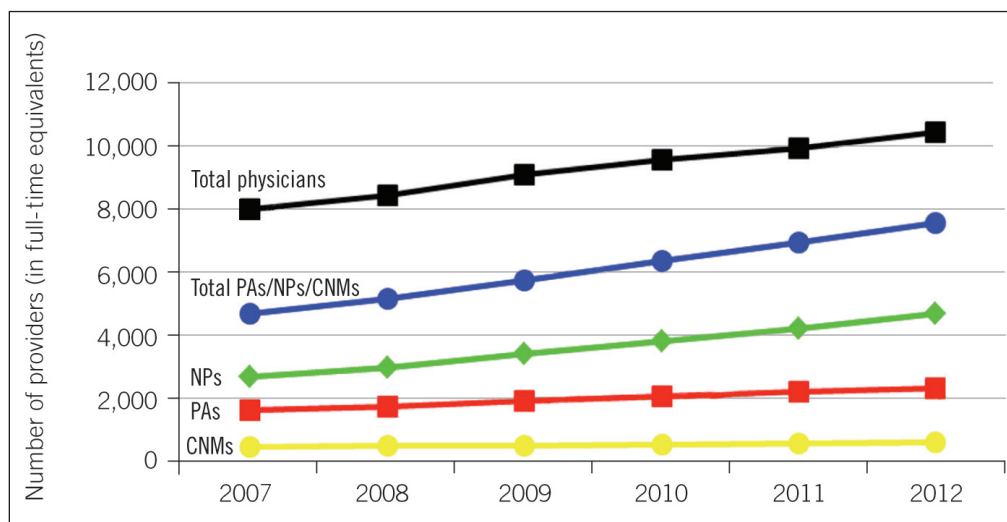


FIGURE 2. PAs, NPs, CNMs, and physicians employed by CHCs (FTEs), 2007-2012¹¹

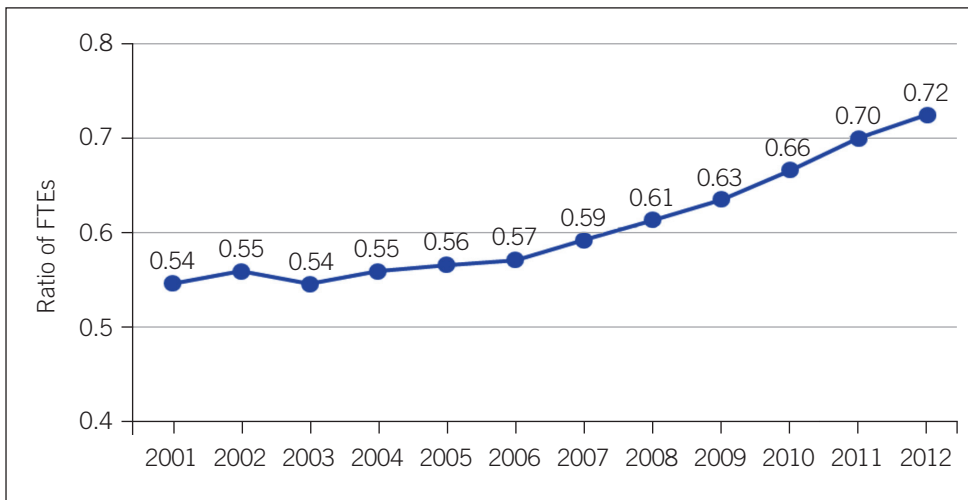


FIGURE 3. Ratio of PAs, NPs, and CNMs to physicians at CHCs, 2001-2012¹¹

to CHCs closing, layoffs of providers and staff, and most importantly, a loss of access to primary and preventive care for millions of patients who often have nowhere else to turn for care. This would occur as the demand for CHCs' comprehensive care continues to rise. Evidence from Massachusetts' health insurance expansions, which are similar to those included in the ACA, suggests that CHC use will increase after implementation and that the uninsured, who already disproportionately rely on CHCs, will become even more reliant on them.¹⁵

An influx of patients with Medicaid and private insurance would not make up for these revenue losses, particularly given chronic underpayment in per-patient Medicaid and privately insured costs.^{13,16} Even as CHCs' payer mix is expected to serve more patients with insurance, they will continue to serve larger concentrations of uninsured patients who have few or no other options for care. As many as 43% of the uninsured patients served by CHCs could remain uninsured due to many states' decisions not to expand Medicaid.¹⁷ Adequate third-party reimbursement also supports CHCs' staffing model by covering the costs of care, yet it does not have the same effect that federal health center funding does in terms of physically placing new CHCs in underserved areas that do not have CHCs.

Also facing a looming funding shortfall is the National Health Service Corps (NHSC), a federally administered program that places healthcare providers in documented healthcare professional shortage areas through loan repayment incentives. The NHSC reduces provider shortages in many underserved communities. At present, 6% of clinicians in the NHSC are PAs, 15% are NPs, and 2% are CNMs.¹⁸ Many former PAs, NPs, and CNMs who participated in the NHSC continue to practice in underserved areas 10 years after their service commitment ends (42% for PAs, and 60% for NPs and CNMs).¹⁹ Unless Congress prevents the NHSC funding shortfall from occurring at

the end of fiscal year 2015, underserved communities across the nation, including those served by CHCs, will lose access to needed primary care workforce.

CONCLUSION

The ACA aspires to make primary and preventive care more accessible in part by expanding insurance coverage and CHCs as a reliable source of care for complex, underserved, and uninsured and insured patients. Because of their unique and comprehensive model of care, CHCs con-

tinually change their mix of providers to meet community-specific healthcare needs and PCMH transformation goals. CHCs heavily rely on PAs, NPs, and CNMs to perform essential clinical and preventive care services, and reliance on these essential providers will only increase as CHCs work to meet current and future capacity needs. However, the gaps left from the end of the Health Center Trust Fund after fiscal year 2015 and cuts to NHSC funding will need to be filled and sustained in order to maintain capacity and meet rising demand for care. **JAAPA**

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