The Composition of the Health Workforce Team Supporting Clinical Care in Community Health Centers

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I. Introduction

Federally funded Community Health Centers (CHCs) are tasked with meeting the health needs of the safety net population in the United States, including identifying and addressing social needs such as housing instability, food insecurity, financial distress. CHCs provide comprehensive primary care services to 32.5 million patients annually, many of whom are uninsured, have low incomes, or live in medically underserved areas (National Association of Community Health Centers [NACHC], 2025). With increased attention to social and health integration in the U.S. (Alley et al., 2016; NASEM, 2019), it is necessary to screen and identify the services and resources that can improve health outcomes for populations with high social risk (Alderwick & Gottlieb, 2019).

Policy Implications

- Invest in training and onboarding of enabling service personnel roles. CHCs are employing a large number of workers that serve in enabling personnel roles, training this workforce is critical.
- Include enabling service personnel in interprofessional training and work-flows. CHCs not only need to train enabling service personnel, but the broader interprofessional team on this workforce and include in clinical workflows. Develop innovative interprofessional team models that integrate enabling personnel.
- Examine workforce composition as it relates to service delivery. Future work should study the impact of enabling service personnel on patient outcomes.
- Explore state-level differences in workforce deployment and regulation (e.g., CHW certification, Medicaid billing).

Despite the growing implementation of social risk screening across healthcare settings, including CHCs, barriers persist. Common challenges include the lack of staff training, inability to incorporate screening into clinical workflows, and insufficient funding to address identified needs (Giron et al., 2024). Workforce composition represents a critical yet understudied aspect of CHCs' capacity to address social needs. The enabling service workforce at CHCs supports the clinical team in addressing patient social needs. This group includes personnel with differing roles and training backgrounds, such as case managers, patient/community education specialists, outreach workers, transportation personnel, eligibility assistance workers, interpretation personnel, and community health workers (HRSA, 2022). These team members may bring complementary skills and knowledge that collectively enhance the ways in which CHCs can identify and address patients' social needs (Drake et al., 2021; Islam et al., 2017). Yet, little is known about the composition of the workforce delivering enabling services at CHCs.

This study sought to understand the team composition of the enabling service workforce and how this impacts CHC service delivery, including the screening CHC patients for social needs. The specific research questions assessed (1) What is the composition of the enabling service workforce at CHCs? (2) Does the composition of enabling service workers vary by CHC characteristics? And, (3) Do CHCs that screen for social risk factors have different composition of enabling service team members?

II. Methods

Data were drawn from the Uniform Data System (UDS) restricted data which represents annual administrative data from all CHCs that were funded under Section 330 of the Public Service Act and operational in 2022 (*N*=1,291). Data are aggregated at the grantee (i.e., organizational) level and do not describe individual clinic site data, which limits observation of variation across the organization.

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UDS data include full-time equivalent (FTE) estimates on the enabling service workforce which included eight roles: Case Managers; Patient/Community Education Specialists; Outreach Workers; Transportation Personnel; Eligibility Assistance Workers; Interpretation Personnel; Community Health Workers; and "Other enabling service employees". Social Risk Screening. Health centers are asked two questions regarding social risk screening. 1) Does your health center collect data on individual patients' social risk factors, outside of the data countable in the UDS?; and 2) Which standardized screener(s) for social risk factors, if any, did you use during the calendar year? The UDS also contains health center organizational characteristics, including the number of clinic sites, urban/rural location, state, and total number of patients served. It also includes patient characteristics such as race/ethnicity (i.e., percent of a health center's patients who identify as Black, Asian, Hispanic, American Indian/Alaskan Native, Multiracial, and Unknown), age (i.e., percent under 18, 18-64, 65 and older), and insurance status (i.e., percent of a health center's patients who are uninsured or enrolled in Medicaid, Medicare, private insurance, or other public insurance).

Descriptive analyses were conducted to examine the proportion of CHCs with enabling service personnel and composition of enabling service personnel teams. Bivariate analyses were conducted to examine if enabling service personnel team composition varied by CHC characteristics. Finally, a multivariate logistic regression was conducted where the dependent variable was "CHC conducts social risk screening yes/no" and the main independent variables were enabling personnel composition controlling for CHC and patient-level characteristics including age, race/ethnicity, and poverty level.

III. Findings

Of the 1,291 CHCs included in the sample, the vast majority employed at least one type of enabling service personnel (99%) with on average 3.8 different types of enabling personnel on the team (SD=1.5). The most common enabling service personnel employed was a case manager (85%), followed by an eligibility assistance worker (76%). In addition to being the most commonly employed enabling personnel, case managers and eligibility assistance workers also had the largest FTE on average per CHC site (0.95, SD=1.37; 0.42, SD=0.80). Only 7 CHCs reported employing all eight enabling service personnel roles, whereas the most common were to employ three (n=309), four (n=292), or five roles (n=240) (Table 1). We examined the proportion of enabling service personnel employed per the total number of roles. For example if a CHC employed three roles the highest prevalence was case managers (94%), Eligibility assistance workers (75%), and outreach workers (53%).

Size of the enabling personnel workforce employed by CHCs varied by state (Figure 1). Ranging from 6.88 FTE per CHC site (Massachusetts) to 0.81 FTE per CHC site (West Virginia). The average FTE per CHC was 2.36 (SD=2.95). Team composition also varied by rurality even when controlling for the number of CHC sites. Urban CHC were more likely to have every type of enabling personnel except for eligibility assistance workers. For example, 43.42% of urban CHCs employed CHWs as compared to only 28.52% of rural CHCs (Figure 2).

Across the 1,291 CHC organizations 73.82% (n=953) reported screening for social risk factors and of those that did screen 78.28% (n=746) used a standardized screening measure. The analysis revealed that staffing levels for certain enabling service roles were significantly associated with increased odds of screening for social risk factors. Specifically, three types of enabling service personnel were significantly associated with CHCs screening for social risks while controlling for CHC and patient characteristics: community health workers (AOR=1.99; CI= 1.25 - 3.20, p<.01), interpretation personnel (AOR=1.90; CI= 1.15 - 3.16, p<.05), and case managers (AOR=1.16, CI= 1.01 - 1.33, p<.05) (Table 2). Notably additional FTE per site for case managers was associated with close to two fold increase in the odds of screening. The proportion of patients below the poverty line was also positively associated with screening (AOR=1.14, CI= 1.02-1.27, p=0.016), suggesting that sites serving more economically disadvantaged populations may place greater emphasis on screening. However other site characteristics such as total patient volume, rural location, and patient population characteristics including percentage of patients over the age 65, and percentage of white patients were not significantly associated with screening.

IV. Conclusions

CHCs on average employ more than three different types of enabling service personnel, suggesting a growing area of the health workforce in these settings. Social risk screening at CHCs was associated with the FTE of community health workers, interpreters, and case managers, suggesting that CHCs that employ these personnel types are simultaneously building out resources and supports to address health-related social needs. As the CHC population is likely to benefit from interventions that address social needs, understanding and supporting the workforce serving in roles that address these needs is critically important.

Future work is needed to further understand facilitators and barriers to deploying the enabling service workforce in CHCs, including training and recruitment needs, potential regulation barriers, and payment issues. For example, there may be differences in community health worker employment in states with clear certification and training pathways for this role. Although CHCs are able to use funds in order to meet patient needs, understanding the multiple funding strategies for these enabling service personnel could provide clarity in how CHCs fund these roles. It is unclear what onboarding and interprofessional training occurs to support enabling service personnel in their roles at CHC, as well as what training occurs for other health professionals to understand how best to collaborate with enabling service workers. Identifying innovative models of interprofessional team development including these roles could benefit other CHCs in understanding best practices to expand care.

Although the evidence supports the delivery of interventions that address health-related social needs to improve the health and well-being of populations, little work has explored the actual workforce delivering this type of care. This study expands previous work that has examined community health worker employment at CHCs, by also examining the unique combinations of enabling service teams. Future work may examine how enabling service personnel roles may shift based on which members are present at CHCs. For example, community health workers may take on a larger role in community outreach when outreach workers are not employed at CHC. Ultimately research that examines if and how these roles impact patient health outcomes will provide evidence on the value of enabling service personnel in CHCs.

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REFERENCES

1. Alderwick, H., & Gottlieb, L. M. (2019). Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *The Milbank Quarterly*, *97*(2), 407.
2. Alley, D. E., Asomugha, C. N., Conway, P. H., & Sanghavi, D. M. (2016). Accountable Health Communities—Addressing social needs through Medicare and Medicaid. *New England Journal of Medicine, 374*(1), 8–11. https://doi.org/10.1056/NEJMp1512532
3. Drake, C., Reiter, K., Weinberger, M., et al. (2021). The direct clinic-level cost of the implementation and use of a protocol to assess and address social needs in diverse community health center primary care clinical settings. *Journal of Health Care for the Poor & Underserved,* 32(4), 1872-1888.
4. Giron, N. C., Cole, M. B., & Nguyen, K. H. (2024). Use of and barriers to adopting standardized social risk screening tools in federally qualified health centers during the first year of the COVID-19 pandemic. *Health Services Research*, 59(Suppl 1), e14232.
5. Health Resources and Services Administration (HRSA). (2022). Uniform Data System (UDS). U.S. Department of Health and Human Services. https://data.hrsa.gov/tools/data-reporting/program-data/national
6. Islam, N., Nadkarni, S. K., Zahn, D., Skillman, M., Kwon, S. C., & Trinh-Shevrin, C. (2017). Integrating community health workers within Patient Protection and Affordable Care Act implementation. *Journal of Public Health Management and Practice*, 23(4), e1-e5.
7. National Academies of Science, Engineering and Medicine. Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health (NASEM). (2019). https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health
8. National Association of Community Health Centers (NACHC). (2025). America's Health Centers: By the Numbers. NACHC. https://www.nachc.org/resource/americas-health-centers-by-the-numbers/

APPENDIX

Table 1. Prevalence of Enabling Service Roles by Count of Total Number of Roles in a FQHC

	Count of Enabling Service Roles in the FQHC								
	0	1	2	3	4	5	6	7	8
n	*10*	*84*	*178*	*309*	*292*	*240*	*128*	*43*	*7*
Enabling Service Role	%	%	%	%	%	%	%	%	%
Case Managers	0.00	0.32	0.69	0.88	0.94	0.94	1.00	1.00	1.00
Patient/Community Education Specialists	0.00	0.07	0.08	0.25	0.54	0.83	0.89	0.95	1.00
Outreach Workers	0.00	0.18	0.37	0.53	0.76	0.88	0.89	1.00	1.00
Transportation Personnel	0.00	0.01	0.08	0.13	0.23	0.43	0.59	0.93	1.00
Eligibility Assistance Workers	0.00	0.35	0.56	0.75	0.78	0.91	0.98	1.00	1.00
Interpretation Personnel	0.00	0.00	0.07	0.13	0.29	0.36	0.59	0.79	1.00
Community Health Workers	0.00	0.04	0.13	0.26	0.36	0.50	0.80	0.93	1.00
Other Enabling Services	0.00	0.04	0.02	0.07	0.09	0.15	0.26	0.40	1.00

Figure 1. Full Time Equivalent of Enabling Personnel Workforce Employed by CHCs by State

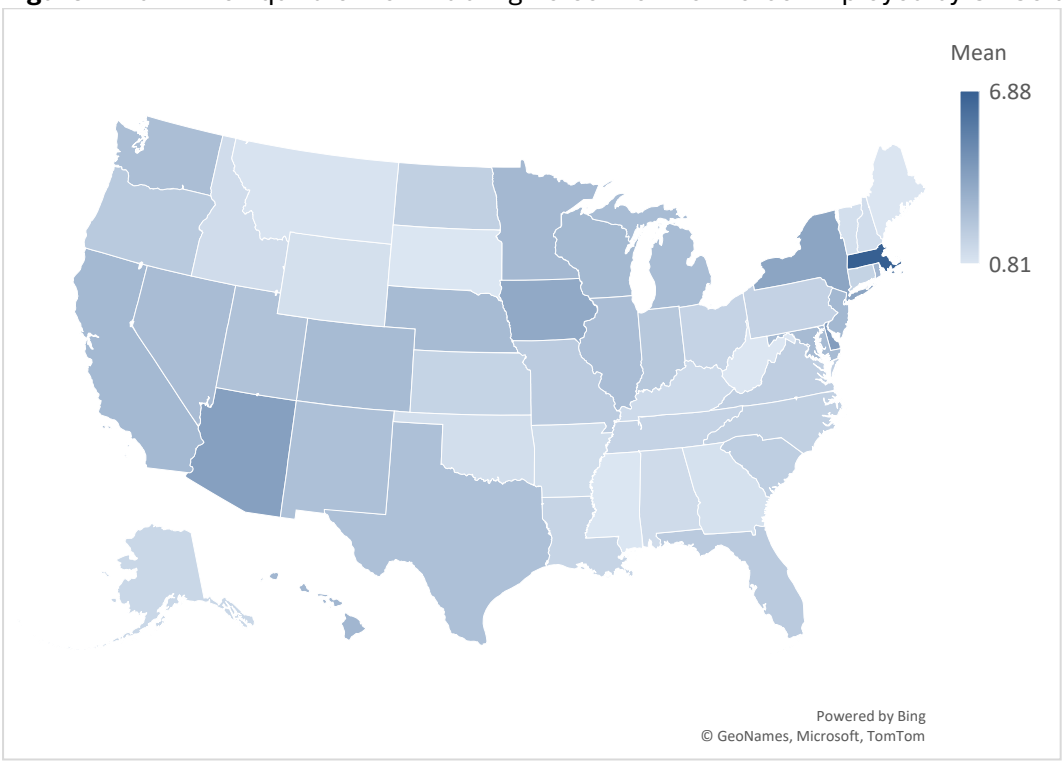
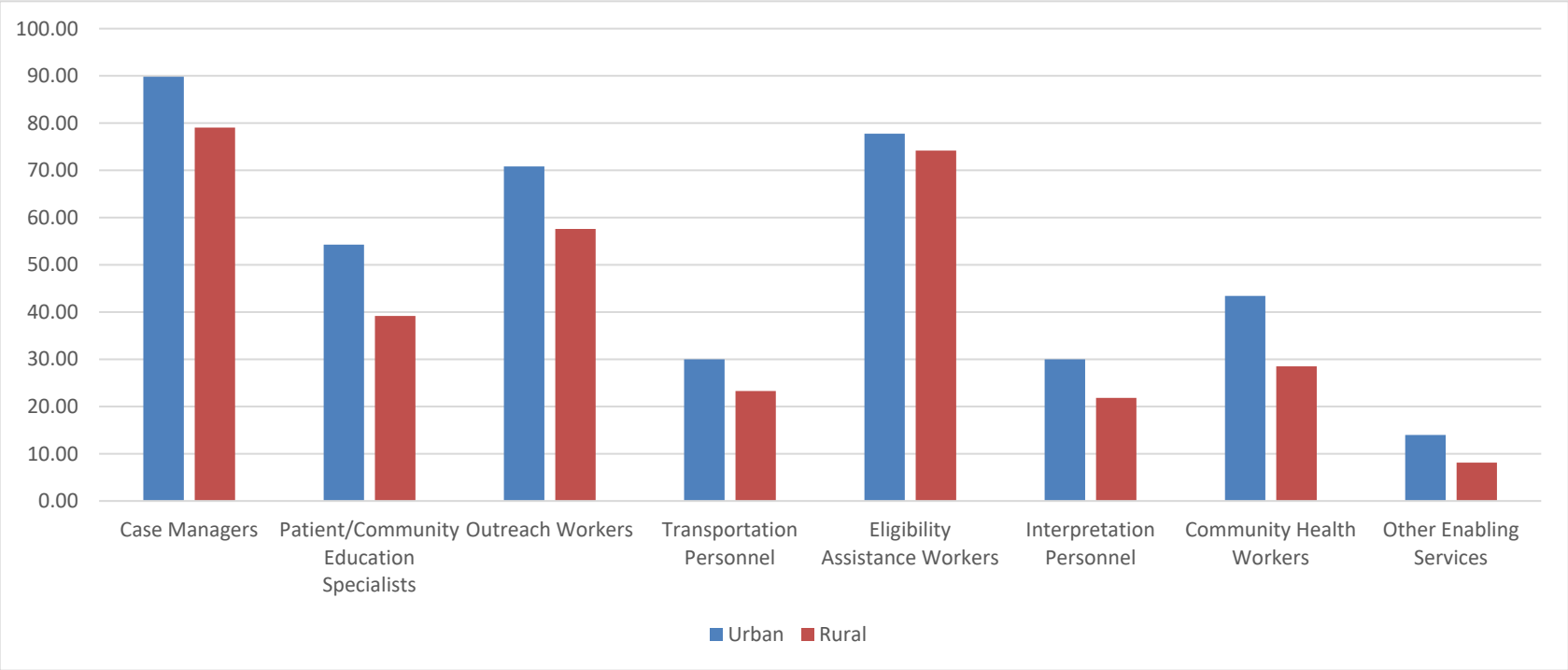


Figure 2. Enabling Personnel Workforce at CHCs by Rurality



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Table 2. Association of Enabling Service Worker FTE per Clinic to CHCs Screening for Social Needs

	Odds Ratio	95% Conf. Interval	p-value
FTE per Clinic			
Case Managers	1.16	1.01 - 1.33	0.044
Patient/Community Education Specialists	1.20	0.90 - 1.64	0.262
Outreach Workers	0.90	0.69 - 1.16	0.405
Transportation Personnel	1.08	0.74 - 1.57	0.703
Eligibility Assistance Workers	0.89	0.70 - 1.12	0.326
Interpretation Personnel	1.90	1.15 - 3.16	0.013
Community Health Workers	1.99	1.25 - 3.20	0.004
Other Enabling Service Worker	0.85	0.55 - 1.32	0.477
CHC Characteristics			
Number of Patients (Per 5,000 patients)	0.95	0.87 - 1.04	0.235
Rural CHC (Compared to Urban CHC)	0.98	0.73 - 1.31	0.885
Number of Patients Over Age 65 (Per 5,000 Patients)	1.36	0.82 - 2.26	0.238
Number of White Patients (Per 5,000 patients)	1.03	0.94 - 1.12	0.549
Number of patients below the federal poverty line (Per 5,000 Patients)	1.14	1.02 - 1.27	0.016

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