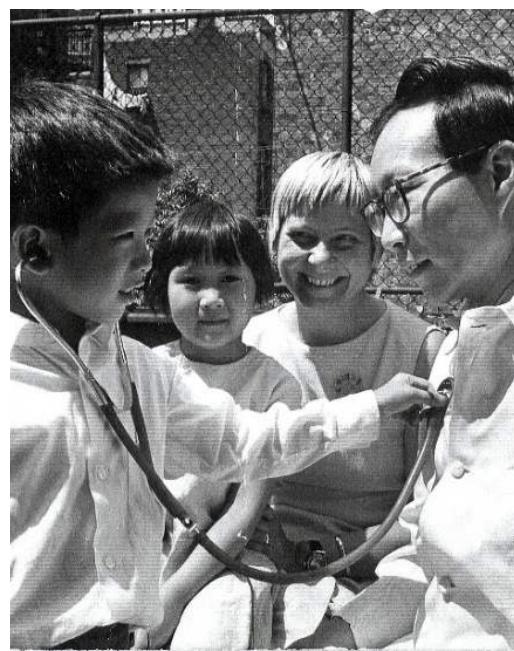


The Health Center Program:

Partnering with Communities to Build a Healthier Nation



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Partnering with Communities to Build a Healthier Nation

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- Bonnie Lefkowitz. *Community Health Centers: A Movement and the People Who Made It Happen*. Rutgers University Press, 2007.

Other resources used in the preparation of this book are listed in the bibliography at the end.

Front cover: Dr. Jack Geiger and Dr. John Hatch during construction of Tufts-Delta Health Center building, Mound Bayou, MS, 1968; Groundbreaking for Whitney M. Young Jr. Health Center, Albany, NY, 1974; Pediatrician at Tufts-Delta Health Center; HRSA headquarters at 5600 Fishers Lane, Rockville, MD; Dr. John Li from Charles B. Wang Community Health Center meets a young patient, New York City, 1971; Axis Community Health, Pleasanton, CA.

Back cover: One Health, Hardin, MT; Community Health Connection, Tulsa, OK; Examining samples in Tufts-Delta Health Center laboratory; Community Health Center, Inc., New Britain, CT; Nurses from Tufts-Delta Health Center conduct a home visit; Mobile van operated by The Wright Center, northeast PA.

All pictures at Tufts-Delta Health Center taken by Daniel Bernstein.

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HRSA Parklawn Building, 2023

Preface

Everybody in the Bureau of Primary Health Care is committed to the mission of improving the health of underserved communities. Every staff member in this bureau knows that mission and they believe in it.

—Jim Macrae, Associate Administrator, BPHC

There are no bureaus I know in the U.S. government that have done as much to serve low-income people as BPHC. It's a major success story. The program has done a phenomenal job taking care of people who otherwise would not be taken care of.

—Dr. Edward Martin, former Associate Administrator, Bureau of Community Health Services

A lot of people would come up to me and say, oh, care for poor people is poor care. But that's just not true. I've always been determined to refute that.

—Dr. Marilyn Gaston, former Associate Administrator, BPHC

The Bureau of Primary Health Care proves that government and community can come together and be trusted partners with one another.

—Gina Capra, former BPHC official

It really has made a difference in this country. When I hear that the Health Center Program takes care of 1 in 11 people in the United States, I'm amazed at the growth of the program and proud to have been a part of it for over 30 years.

—Bruce Riegel, former HRSA official

It started with a few idealistic dreamers on a mission. It started with men like Dr. Jack Geiger and Dr. Count Gibson, who had come up through the Civil Rights movement and developed an interest in community-oriented care. When President Lyndon Johnson launched his War on Poverty in 1964, it was the opportunity these dreamers needed to put their ideas into practice.

The first neighborhood health centers were established with funding from Johnson's Office of Economic Opportunity. They took root in impoverished inner cities, in isolated rural communities—places where doctors were few and the residents struggled against enormous social challenges. Soon there were more clinics, in more parts of the country, serving even more patients. The program was overseen by a dedicated group of staff in the Department of Health, Education, and Welfare, and later in the Department of Health and Human Services.

The program faced challenges, but it kept on growing and evolving. Through regular data collection and careful monitoring practices, the program was able to demonstrate the impact health centers were having. Health centers reduced infant mortality and chronic illnesses; they increased access to care and reduced wait times; and they also reduced costs. It just goes to show what a few dreamers on a mission can accomplish.

Today, the Bureau of Primary Health Care (BPHC) under the Health Resources and Services Administration (HRSA) funds nearly 1,400 health centers located in every U.S. state, territory, and the District of Columbia. Health centers provided high-quality primary health care to more than 30.5 million people at nearly 15,000 sites in 2022. They serve people experiencing homelessness, agricultural workers, residents of public housing, rural residents, veterans, students, the elderly, and anyone else who needs care.

Health centers offer medical, dental, vision, and other services, and they focus on the unique needs of each patient. They emphasize coordination among providers to ensure patients receive the best possible care. They also make use of health information technology and other quality improvement practices, for which they receive training and technical assistance from HRSA and HRSA-funded partnership organizations.

The majority of a health center's board of directors is required to be patients of the health center. This means management decisions are made by people who are part of the community and who understand its needs. Health centers are also required to provide services on a sliding fee scale, based on each patient's income and family size. Even if a patient does not have insurance or can't afford to pay, they will not be turned away.

Health centers treat chronic conditions and reduce preventable disease among populations and communities that are low-income, isolated, marginalized, and experience challenges accessing care. Because of the high-quality care they receive, health center patients make fewer trips to the emergency room and have better health outcomes.

Since its start in the 1960s, the Health Center Program has grown to become a key part of the nation's health care safety net. Health centers are also important sources of economic growth in the areas they serve. In 2022, they employed nearly 285,000 people and generated billions of dollars in economic activity.

This book is about the Health Center Program and the great things it has achieved. But it's also about the staff in the government who have made the program possible. At every phase of the program's development, hard-working project officers, policy experts, data analysts, clinical improvement managers, attorneys, and others have dedicated their careers to making sure the program is well-run and achieving its mission. You will hear their voices, as well as the words of health center directors and others who have spent decades watching the program grow and working to make it better.

The Health Center Program has come this far and accomplished this much by harnessing the talents and expertise of those in the government, alongside those in the medical professions and in the communities served by health centers. It's truly a joint achievement and a model of an effective, high-functioning government program. As Amanda Ford, Deputy Director of BPHC's Office of Policy and Program Development, puts it:

The beauty of this program is that we have a partnership with these organizations that feels supportive. Yes, we have to provide oversight and be good stewards of federal dollars. That is our role as a federal agency. But we are in it together with the health centers. We are all committed to the same mission.

The Health Center Program is a key part of our nation's infrastructure. Having a network of trusted community providers who enable people to access health care services regardless of their ability to pay is essential to delivering on our shared goal of ensuring the best possible health and well-being of everyone in our country.

–Carole Johnson, HRSA Administrator

Chapter 1: The Foundation and Early Years of the Health Center Program

Introduction

The Health Center Program as we know it today grew out of the Civil Rights movement and the War on Poverty under President Lyndon Johnson. The first neighborhood health centers were created in the mid-1960s as a demonstration project under the Office of Economic Opportunity (OEO).

Table 1: The Early Years by the Numbers

	1966	1971	1975
Health Centers	2	150	127
Funding	\$2 million	\$155.4 million	\$196.7 million

Sources: Lefkowitz, 2007; Sardell, 1988; Seacat, 1977; Zwick, 1972.

Additional health centers were added under OEO during the next few years, and similar health centers were also created under the oversight of the Department of Health, Education, and Welfare (HEW).

In the early 1970s, all of the neighborhood health centers were moved under the control of HEW, and in 1975 the Health Center Program was formally codified in law for the first time under Section 330 of the Public Health Service Act.

The War on Poverty

The Office of Economic Opportunity

In his first State of the Union address in January 1964, President Johnson called for an “unconditional war on poverty.” Congress passed and Johnson signed the Economic Opportunity Act later that year, which established the OEO within the Executive Office of the President. By administering anti-poverty programs through OEO, Johnson sought to enact innovative initiatives quickly with less chance of getting bogged down in federal bureaucracy (Mickey, 2012).

In addition to schools and jobs, OEO soon began to focus on health care after administrators realized that poor health and physical disabilities among job seekers and students prevented or limited their participation in educational and economic development programs (Schwartz, 1970). But because of a critical lack of health care staff and facilities in underserved areas, just making funds available for

medical care would not guarantee that the low-income and disadvantaged would receive the care. OEO administrators realized they would need to create new facilities to deliver care directly to these groups in their own neighborhoods.

Health Care Challenges in the Early 1960s

In the early 1960s, approximately 40 to 50 million people lived in poverty in the United States (Harrington, 1962), including about a quarter of people aged 65 or older (Congressional Research Service, 2022). The Black poverty rate was double that of whites, at around 30 percent (Department of Commerce, 1969).

The build-up of the suburbs after World War II saw the flight of young middle-class families from cities, leaving behind mostly the elderly and minorities (Stevens, 1996). Many physicians also left the cities, along with other white-collar workers. This dearth of physicians in the cities forced the remaining residents to seek health care from hospital emergency rooms, bypassing preventive health care and thereby worsening their existing conditions. From 1954 to 1964, emergency department visits increased by 16 million (an increase of 175 percent).

The U.S. hospital system at this time was in some ways extremely advanced (Stevens, 1996). A visitor might marvel at the air conditioning and artificial lighting systems, the private rooms, the adjustable electric beds, the modern diagnostic equipment. But just because high-quality care was available did not mean everyone could access it. Three-quarters of all U.S. families had some type of hospital insurance in 1963, but only slightly more than 20 percent of costs were covered. In one illustrative survey by the Health Information Foundation and the National Opinion Research Center, 25 percent of people who said they were experiencing chest pains did not seek care because they could not afford it.

Sargent Shriver, the first director of the OEO, gave an address to the American Medical Association in 1967 in which he outlined the state of public health in America:

- Half of all women giving birth in public hospitals received no prenatal care at all.
- 60 percent of children from low-income families never saw a doctor or dentist.
- The low-income had 4 times more heart disease than the rich, 6 times more mental illness, and 10 times more vision problems.
- A child from a low-income family was far more likely to die before age 1 than a rich child, and low-income people faced higher mortality rates at every phase of life.
- The rate of maternal mortality was 320 percent higher for Blacks than for whites.

Of all the forms of inequality, injustice in health is the most shocking and the most inhuman. –Dr. Martin Luther King Jr.

When attempting to access medical services, the low-income often faced barriers such as geographic distance from a hospital or clinic, patchwork services, miscommunication, unaffordable services, and racial bias (Walton, 1969). These barriers engendered feelings of isolation and frustration.

In light of such dismal health statistics, the OEO began looking to support “efforts to organize services in new ways that proved to be more effective than those available in the open health care market” (Schorr, 1988).

A Wild Man and the Civil Rights Movement

One day in January 1965, Lisbeth Schorr of OEO received a call from Dr. William Kissick, the assistant to the U.S. Surgeon General (Schorr, 1988, p. 130). “There’s a wild man in my office,” Dr. Kissick told Schorr, “and he’s got some ideas we can’t do much with over here, but I think you people in the War on Poverty would find him pretty interesting. I’m sending him right over.”

The “wild man” was Dr. H. Jack Geiger, a Harvard University professor and a fierce critic of the status quo. Dr. Geiger had spent time as a medical student in the 1950s in South Africa, working with Drs. Sidney and Emily Kark at the network of health centers they had founded to provide care to patients living in housing projects, urban slums, shack settlements, and other impoverished areas (Oltman, 2017). They taught Geiger the principles of combining clinical practice with epidemiology, environmental health, and disease prevention. The Karks were strong believers in the social, cultural, economic, and political determinants of health, and these ideas would be taken up by Geiger (Brown & Fee, 2002; Kark & Abramson, 2003).

During his time in South Africa, Geiger recruited health workers from the local community and trained them to conduct surveys of water supplies, implement environmental hygiene, and address nutrition (Oltman, 2017). The workers and residents cooperated to enhance the community from within, doing everything from planting vegetable gardens to constructing outhouses. The workers

also collected census data and information on vital statistics such as live births, infant and maternal mortality, and disease rates. By analyzing the data, health teams could anticipate disease outbreaks and develop interventions to prevent their spread in the community. Collecting and analyzing data was central to the Karks’ mission (Brown & Fee, 2002; Kark & Abramson, 2003). A staff member who served with them in the 1940s recalled how their health center’s walls were “plastered with charts.”

After leaving South Africa, Dr. Geiger completed his medical studies, received a Master’s degree in epidemiology, became involved in Physicians for Social Responsibility (a group that sought to alert the public to the growing danger of nuclear weapons), and traveled to Mississippi for Freedom Summer. He was among more than 100 health care professionals who came to Mississippi in the summer of 1964 to ensure Civil Rights workers could receive medical care.

In December 1964, Dr. Geiger attended a meeting for the out-of-state health care personnel who still remained in Mississippi to brainstorm next steps (Primary Care Development Corporation, 2017). He later recalled: “At that moment—I don’t know what took me so long—for the first time I remembered Lamontville, and Pholela, and the other communities in South Africa, and the root discipline of community-oriented primary care.” Lots of ideas were raised at the meeting, but there were still no concrete plans. “It was all just a pipe dream.”

But it wouldn’t remain a pipe dream for long. On the way back north, Dr. Geiger was traveling with Dr. Count Gibson, head of the Department of Preventive Medicine at Tufts University, when they were grounded in Atlanta overnight because of fog (Primary Care Development Corporation, 2017). They kept talking and talking about the idea of founding neighborhood clinics to serve communities like the ones they had seen in Mississippi. Finally Dr. Gibson said: “If you can get the money, Tufts will sponsor [this health center concept].”

Dr. Geiger spoke with Lisbeth Schorr, and he also spoke with Sanford Kravitz, the director of research and development at OEO (Primary Care Development Corporation, 2017). “At that point OEO



August 1964
President Lyndon Johnson signs the Economic Opportunity Act, which establishes the Office of Economic Opportunity as part of his War on Poverty.



December 1964
Returning from Mississippi, Drs. Jack Geiger and Count Gibson (pictured) discuss the idea of founding neighborhood health centers to serve impoverished communities.

had no mandate for health care,” he later recalled, “but you can do a lot of things under the rubric of ‘research and development.’”

The meeting with Kravitz went well. “I spent about two hours with him, filling pages of a yellow pad with what a community health center was and what community-oriented primary care was.” At the end of the meeting, Kravitz asked how much money Dr. Geiger was looking for. He thought for a moment, and suggested: “Well, how about \$30,000 for a feasibility study?” Kravitz said no, that wouldn’t do. Then he hastened to explain: “Because you have to take \$300,000 and do it now.”

Drs. Geiger and Gibson quickly prepared and submitted a grant proposal to OEO in February 1965 (Primary Care Development Corporation, 2017). That June, OEO approved a research and demonstration grant for the first two health centers: Columbia Point Health Center, located in a South Boston housing project, and the Tufts-Delta Health Center, located in Mound Bayou, Mississippi. Care was taken to ensure that one site was located in an urban area, the other in a rural area; one site in the north, the other in the south. When choosing the location of new health center sites, similar efforts at balancing geographic considerations, political considerations, and areas of greatest unmet need would continue during later phases of the program.

The First Neighborhood Health Centers

Columbia Point Health Center

Columbia Point is a peninsula in South Boston that juts into Dorchester Bay. In 1954, the city built a housing project for low-income people on the peninsula (Stokes et al., 1972). The land also held a garbage dump, which the residents forced the city to close in the early 1960s. The housing project housed an estimated 4,800 residents, 70 percent of whom were Black. Other residents included elderly white people. The area was one of the poorest in Boston, and it was located far away from health care services at Boston City Hospital (BCH).



February 1965

Dr. Geiger submits a proposal to OEO. In June, he receives a \$1.2 million research and development grant to launch two demonstration health centers.

Jean Hunt, a nurse who helped establish several early health centers, recalled:

There were no doctors in my neighborhood. Stuck without a car, young mothers had to take three different trains and buses to the only source of care, wrestling the baby carriage on and off each one. When you finally reached BCH, you had to wait hours in a big, cold hall on hard benches. You rarely saw the same doctor twice, but then you didn't want to because they were so rude. (Lefkowitz, 2007, p. 51)

Medical students from Tufts had conducted home surveys at Columbia Point for the school’s Department of Preventive Medicine, which showed that most residents were not receiving adequate medical care (Lefkowitz, 2007). Satisfied that this site was ideal for the new health center, Dr. Gibson and Tufts University Medical School funneled the OEO grant to build the Columbia Point Health Center. The Boston Housing Authority donated 12 apartments to be remodeled as exam rooms, waiting rooms, an emergency room, laboratories, a pharmacy, and an x-ray unit. The center opened on December 11, 1965.

The center employed internists, pediatricians, community health nurses, nursing assistants, social workers, and local community health aides (Bellin & Geiger, 1972; Ward, 2017). If patients required other specialists, the health center would arrange for such services at affiliated hospitals. Medical students from Tufts also assisted the professional staff, so that services could be provided seven days a week, day and night.

The center had a major impact on the residents’ lives and health. One resident said: “Before the health center, we used to have to call up the police when we had a sick child. It was a blessing when this opened up” (Ward, 2017). Two years after the establishment of the Columbia Point Health Center, a study found that well-child checkups had increased from 17 percent to 59 percent and polio immunizations from 78 percent to 92 percent (Bellin & Geiger, 1972). The percentage of families who postponed needed medical care declined from 23 percent to 10 percent, and the percentage who reported excessive waiting time in the doctor’s office declined from 53 percent to 20 percent. Those reporting indebtedness for medical expenses declined from 11 percent to 3 percent.



December 1965

Columbia Point Health Center opens in South Boston, offering services from a group of converted apartments in the Columbia Point Housing Project.

The premise of a successful community health center is the active involvement with its target population in ways that will change their knowledge, attitudes, and motivation.

–Dr. Jack Geiger

Community participation in center governance was a requirement of the OEO grants, so Tufts hired residents to conduct a series of meetings to gather input from the community (Stokes et al., 1972). An ad hoc committee of residents grew out of these meetings, which helped outline policies for the new health center. The committee arranged for the election of a community governing board and nominated candidates. In late 1966, residents elected 25 representatives for the Board of the Columbia Point Health Association, which would provide ongoing oversight for the health center.

In August 1966, Senator Ted Kennedy of Massachusetts (who was the brother-in-law of Sargent Shriver, the OEO director) toured Columbia Point, meeting with both staff and patients (Lefkowitz, 2007). He was particularly impressed with the wooden rocking chairs provided for mothers in the waiting room, which he thought acknowledged the patients' dignity in caring for their children. After the visit, Kennedy drafted an amendment to the Economic Opportunity Act that provided \$100 million to create 50 additional neighborhood health centers. The bill's co-sponsor was Republican Senator Orrin Hatch of Utah, initiating the program's long history of bipartisan support. The funding would later be reduced to \$51 million, but this represented the first round of dedicated funding for the neighborhood health center program (Ward, 2017).

Tufts-Delta Health Center

Poverty reigned in the Mississippi Delta in the early 1960s. Former sharecroppers and plantation workers comprised the majority of the Black community, and the area was isolated and economically undeveloped (Oltman, 2017). Residents struggled without food and jobs, their skills having been made obsolete by electrified cotton pickers, crop dusters, and national crop subsidies. The median annual

family income was \$900. Housing conditions were poor, with many sanitation challenges. Children often did not have shoes or clothes to wear to school, or good food to sustain learning. Adults, especially men, traveled north in search of work, fragmenting families and leaving the elderly alone. Most residents were illiterate, having only received an average of four years of schooling; many had never seen a doctor; and Black infant mortality was more than twice that of white infants.

Dr. Geiger was concerned that efforts to establish a neighborhood health center in Mississippi would be opposed by local leaders (Oltman, 2017). Projects funded under the Economic Opportunity Act could be vetoed by a state's governor; however, projects affiliated with a university were exempt from this veto. Thus, Dr. Geiger asked Tufts University to not only sponsor the new health center in South Boston but to also provide funds for the Mound Bayou clinic in Mississippi. After this tactic succeeded, many neighborhood health centers would partner with medical schools as part of a strategy to prevent local opposition (Mickey, 2012).

In 1966, before the Tufts-Delta Health Center (TDHC) even had a building, Dr. Geiger began recruiting staff from across the country and organizing community resources (Geiger, 2016). The first person hired was Dr. John Hatch, an assistant professor at Tufts who had grown up in the rural south and understood the challenges faced by these communities. He would help identify the health center's priorities by traveling through the area and talking with local residents about their needs. Training for health center staff began in an abandoned movie theater in early 1967, and clinical services would finally be delivered in November 1967 from a remodeled church parsonage.

Along with medical care, TDHC staff worked with residents to bring sanitation facilities into their communities (Geiger, 2016; Oltman, 2017). They dug wells, built outhouses, installed window screens, and fumigated houses. They also focused on preventing disease and educating patients on nutrition and hygiene.



November 1967

Tufts-Delta Health Center opens in Mound Bayou, Mississippi, offering services from a converted church parsonage. The health center would construct its own building the following year.



1970/1972

National Health Service Corps established to improve the delivery of health care in underserved areas.



Nurses at Tufts-Delta Health Center, 1968

When Dr. Hatch visited communities to talk with them about the new clinic, he often encountered residents asking for food (Oltman, 2017). TDHC devised a short-term solution where doctors would write food prescriptions that could be filled at local grocery stores. When someone from OEO complained that this was not within the scope of the health center grant, Dr. Geiger famously responded: “The last time I looked in my medical textbook, the most effective therapy for malnutrition is food” (Primary Care Development Corporation, 2017).

To address food insecurity in the long term, TDHC staff created the North Bolivar Farm Cooperative, which was owned and operated by residents (Oltman, 2017). They cultivated hundreds of acres of land, distributed food, flash-froze vegetables to store in a food locker for consumption year-round, and supported local Black farmers.

TDHC also promoted local economic development by training job applicants and developing pathways for community residents to pursue higher education (Primary Care Development Corporation, 2017). They sponsored high school equivalency courses at a local junior college and they provided pathways to higher education at Tufts, Stony Brook, Brown, and the University of Wisconsin. Many local Black high school science teachers became medical students, which had been their original career aspiration (Primary Care Development Corporation, 2017).

Coupled with other social programs such as Medicaid and food stamps, the services offered by TDHC improved the health status of the nearly 12,000 Black residents of northern Bolivar County. Incidences of miscarriages, infectious disease, and chronic illnesses such as heart disease, hypertension, and diabetes all decreased (Geiger, 2016). Infant mortality decreased by 57 percent in 1967, stemming from physicians treating infants for pneumonia and diarrhea, in addition to delivering non-medical services concerning diet, education, housing, jobs, and standard of living (Seacat, 1977).

The Health Center Program Takes Shape

Parallel Tracks, Then Consolidation

More neighborhood health centers soon followed the initial two. The underlying principles included a focus on community engagement and empowerment—with the ultimate goal of entrusting control of the health centers to the community—as well as a focus on the social determinants of health (such as housing, nutrition, and sanitation), the collection of epidemiologic data, the use of a full team of diverse staff (physicians, as well as psychologists, social workers, nurse midwives, and others), and the reduction of barriers to access and health disparities (Geiger, 2005). By 1968, there were about 40 health centers funded under OEO.

At the same time, a group of “policy entrepreneurs” in the U.S. Public Health Service (PHS) under HEW began to show interest in the burgeoning health center movement (Sardell, 1988). The PHS began in the late 18th century as the federal body responsible for providing health care to sailors—primarily in order to avoid disease outbreaks in port cities. By the 1960s, the PHS had moved into a variety of new roles involving research, regulation, sanitation, and disaster relief. In 1968 and 1969, the PHS provided grants for 24 new health centers. These PHS health centers were similar to the OEO health centers, although they focused slightly more on direct medical treatment and slightly less on addressing the social determinants of health (Lefkowitz, 2007).

Richard Nixon assumed the presidency in 1969. In the health care arena, his goal was to encourage the private sector to take over responsibilities previously handled by the federal government, and to do so more efficiently so that costs could be reduced (Sardell, 1988). Donald Rumsfeld became the new director of OEO and soon began transferring health centers from OEO to HEW. However, Rumsfeld was not opposed to the program. In fact, in his role at OEO he visited some health centers and became convinced of their value. He even suggested expanding the program to as many as 1,000 health centers, but Nixon chose instead to focus on the expansion of health maintenance organizations (HMOs) as the centerpiece of his health care agenda (Lefkowitz, 2007).

By 1973, all of the neighborhood health centers were under the jurisdiction of HEW—where the program would face the first major threat to its existence.

Block Grants: Round One

Nixon directed HEW to reduce or eliminate discretionary programs, and HEW put the neighborhood health centers on notice that they would be required to justify their existence through cost-benefit analysis (Mickey, 2012). In 1972 and again in 1973, HEW issued regulations asserting that because the health centers could collect reimbursements from Medicare, Medicaid, and private insurers, federal grant support was unnecessary and would be ending. The health centers were expected to become “self-sustaining.”

It was true that when the first health centers were created in the mid-1960s supporters expected that eventually they would be financed largely through the new Medicare and Medicaid programs.

However, this turned out not to be the case due to issues involving payment rates, eligibility rules, and covered services (Sardell, 1988). States controlled many of the parameters around Medicaid payments, and some states were unwilling to reimburse health centers. Even the states that did guarantee reimbursement often did not reimburse for outreach services, and neither Medicare nor Medicaid reimbursed for the work of non-traditional providers such as physician assistants, nurse practitioners, or family health workers (Mickey, 2012). In addition, health centers cared for many uninsured patients, for whom there was no reimbursement available. It seemed impossible that health centers could ever be “self-sustaining” under these conditions.

When the neighborhood health center program came up for renewal at the end of fiscal year 1973, Nixon proposed allowing the program to terminate (Mickey, 2012). He wanted to convert the program’s funding into block grants to the states. Supporters of the program saw this proposal as an existential threat.

New Legislative Authority

However, the health centers were not without allies. Led by Ted Kennedy (D-MA) and Jacob Javits (R-NY) in the Senate and Paul Rogers (D-FL) in the House, Congress extended funding for the neighborhood health center program (along with several other programs, including the migrant health program) for an additional year by a veto-proof margin in 1973 (Sardell, 1988).

Congress went even further the following year, passing legislation that would establish “community health centers” for the first time in law and authorize a separate source of funding for them. President Gerald Ford, who had succeeded Nixon in August 1974, “pocket-vetoed” this bill by refusing to sign it until Congress went into recess and the bill expired.

Congress passed identical legislation the following year, this time overriding Ford’s veto. The Special Health Revenue Sharing Act of 1975 became law on July 29, 1975. It formally authorized the Health Center Program through an amendment to Section 330 of the Public Health Service Act and renamed “neighborhood health centers” as “community health centers.”

The new law described how health center grants were to be awarded, what services health centers were required to provide (dividing them into “primary” and “supplemental” services), and the requirements around health center governance. A majority of the governing board at each health center was required to be patients of the health center—a crucial feature of the program that would remain consistent throughout its existence.

Workforce Challenges

Since the exodus of physicians from urban areas to the suburbs in the 1960s, health centers had sought to attract staff by linking the practice of modern medicine with social justice, making health center salaries competitive with other health care institutions, and advertising their affiliations with prestigious medical schools and teaching hospitals (Zwick, 1972). In 1972, health centers employed approximately 1,000 providers, but less than half were full-time and their turnover rate was relatively high. Health centers did employ higher percentages of young, female, and Black physicians compared with other health care settings.

Health centers tried to make up for the shortfall in doctors by employing nurse practitioners, physician assistants, counselors, and family health workers to help meet the needs of their patients (Sardell, 1983). Family health workers—or community health aides—served as a go-between for low-income families who had difficulty accessing health services. They made home visits, provided bedside care and health education, and helped families obtain housing and financial assistance.

But finding enough staff to work at health centers was a perennial challenge. A new federal effort to provide a steady stream of providers for health centers began in the early 1970s with the creation of the National Health Service Corps (NHSC).

The National Health Service Corps

The NHSC originated with the Emergency Health Personnel Act of 1970 (Rosenblatt & Moscovice, 1980). Its purpose was to “improve the delivery of health services to persons living in communities or areas of the United States where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas.” The first groups of federal health personnel reached their location assignments in the spring and summer of 1972. That same year, Congress also created a scholarship training program for the Corps. It targeted junior and senior medical students in exchange for a two-year commitment to practice medicine in rural areas.

The NHSC’s first years of operation were challenging, but when Dr. Edward Martin took over as the third NHSC director in 1974 he helped establish order and consistency (Rosenblatt & Moscovice, 1980). Recruitment and placement of providers were substantially improved, and the NHSC began to fulfill its mission of deploying health providers in areas that lacked an adequate supply.



1973

All health centers brought under the Department of Health, Education, and Welfare.



July 1975

Special Health Revenue Sharing Act formally authorizes the community health center program through an amendment to Section 330 of the Public Health Service Act.

Dr. Martin remembers:

I was running a health center in the South Bronx, the Martin Luther King Health Center. They recruited me because the National Health Service Corps was in some difficulty. At that point, the program was relatively small. It had no more than a few hundred physicians and nurses. But it was exceedingly important, because we began to put hundreds and then thousands of doctors into health centers. And the health centers were in places where it was hard to recruit doctors, to say the least. Inner cities. Isolated rural areas.

The NHSC was managed within HEW's Bureau of Community Health Services (BCHS), initially under the Health Services and Mental Health Administration, and later under the Health Services Administration (Rosenblatt & Moscovice, 1980). There were early turf battles with another HEW agency, the Health Resources Administration (HRA), which argued the NHSC should fall under their authority since they were responsible for other programs involving "medical manpower." In the end, NHSC remained with BCHS, while HRA took responsibility for defining Health Manpower Shortage Areas (HMSAs). These were areas with an identified shortage of medical providers—an important criteria for placement of NHSC assignees.

BCHS was also where the community health center program was located in HEW, as well as programs focused on maternal and child health and the migrant health program. Within a year of his arrival, Dr. Martin became the director of BCHS—and he remained in the position until 1989, overseeing the community health center program, the NHSC, and the other associated programs through years of organizational changes at the bureau and agency, significant expansion, and further challenges from a changing political landscape.

Expanding the Program

The Rural Health Initiative

In the mid-1970s, nearly one-third of Americans lived in rural areas (Sardell, 1988). This population tended to be hard to reach medically due to the high costs of serving a widely dispersed population and the reluctance of health care providers to move to rural areas. In addition, rural populations had unique public health challenges, such as higher infant mortality, sometimes up to 70 percent above the national average, as well as higher rates of chronic conditions, respiratory illnesses, and accidents. Demographically, rural populations typically had lower education and income levels, and higher numbers living in substandard housing. Nearly half lived below the poverty line.

By 1975, BCHS had come to realize that more of its resources needed to be devoted to rural areas (Sardell, 1988). More than half the medically underserved people in the country lived in rural areas, but about 85 percent of neighborhood health center funds up to that time had been directed to cities.



BCHS Director Dr. Edward Martin



1975

Rural Health Initiative begins, funding hundreds of new health centers in rural areas.



1977

Urban Health Initiative begins, funding scores of new health centers in urban areas.

The Rural Health Initiative (RHI) was intended to shift this balance. It began with funding for 47 new health centers in fiscal year 1975, and it had grown to 138 RHI projects by 1976 (Sardell, 1988). At the time, the economic situation in the country was challenging, and there was a general sense that federal resources would be very limited moving forward. RHI health centers were accordingly smaller than earlier neighborhood health centers. The goal was to open more locations, with less funding for each one, rather than a few very well-funded sites.

Under the Carter administration, RHI grew much larger. There were 262 RHI projects in 1977 and 356 in 1978 (Sardell, 1988). Because the expansion into rural areas increased the number of Congressional districts with their own health center, support across Congress was increased. The RHI also increased the number of low-income whites receiving services, which helped counter the previous view of the program as primarily catering to urban Black populations. Around the same time, Congress passed the Rural Health Clinic Services Act, which increased Medicare and Medicaid reimbursement rates and allowed payment for nurse practitioners and physician assistants at rural health centers (Lefkowitz, 2007). This improved the financial standing of health centers in rural areas, at least.

The Urban Health Initiative

Richard Bohrer, a longtime leader within BCHS and its successor organizations, describes the situation as the RHI took off: “The RHI resulted in a huge increase in the number of entities that were funded. But the administration started to receive push back, in the sense of ‘wait a minute, we don’t disagree that there’s a lot of need in rural areas, but there are also still a lot of cities that don’t have access to essential services.’ So we got approval to start a sister initiative, an urban health initiative.”

The Urban Health Initiative (UHI) followed the same principles as the RHI: many projects would be funded, each at a relatively low budget level, and efforts would be made to leverage partnerships with existing federal programs like the NHSC to contain costs (Sardell, 1988). There were 35 UHIs in 1977 and 60 in 1978.

UHI health centers provided basic medical care, not comprehensive and innovative health services (HEW BCHS, 1978). Supplemental services, were delivered through referral arrangements. This was a source of concern among longtime supporters of the program, such as Senator Ted Kennedy. In a Committee report from 1978, he praised health centers for reducing costs, but worried that they were sacrificing high-quality, comprehensive care in the process: “What part of this reduction in cost can be attributed to increased administrative efficiency, and what part results from the fact that of the 574 centers established, only 158 are providing comprehensive services—with the remaining 416 providing little more than the presence of a physician or physician’s extender and a very limited range of services?” (Sardell, 1988).

Cost-cutting and belt-tightening were the order of the day. The expansionist health policies of the 1960s had given way to the restrictive ones of the 1970s. And this would remain the case as the program entered the 1980s.

Summary

As part of the War on Poverty, the Johnson administration sought a novel method to deliver health care to those who needed it most. From two demonstration projects funded by the OEO, the neighborhood health center program grew to hundreds of health centers in the 1970s. The early health centers not only provided health care services, but sought to alleviate the conditions that cause poor health by making homes safer and more hygienic, providing jobs and training, delivering food to the needy, ensuring access to clean water, and other services. Leadership of the health centers was located in the community, with input from advisory boards.

Whether they’re in an underserved rural community, in a frontier community, or in an inner city where there’s challenges accessing care—we make sure that anyone can get high-quality, affordable health care on a sliding fee scale, and that it’s available regardless of their ability to pay.

—Jim Macrae, Associate Administrator

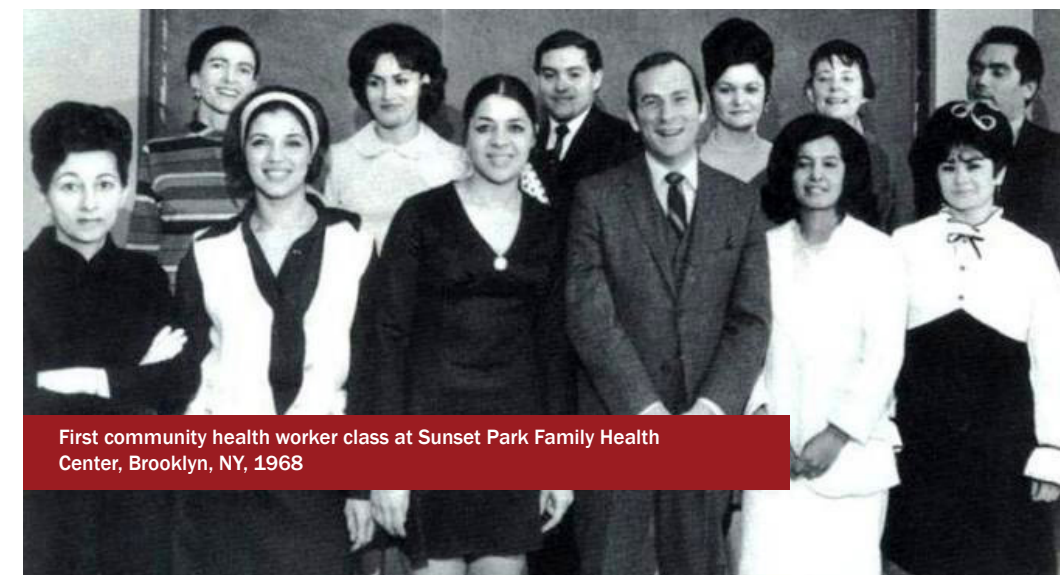
Health centers were effective right from the start. A 1971 study found the quality of care in neighborhood health centers was equal to or better than that of established health care services for adults, children, and pregnant women (Morehead et al., 1971). The centers were particularly noted for comprehensiveness in conducting routine lab work and chest x-rays, conducting prenatal workups, and adhering to prenatal visit schedules. Another study from 1965 to 1974 found that health center patients had reduced mortality rates, with the largest improvement seen in older adults (Bailey & Goodman-Bacon, 2015). This was most likely due to the health centers' focus on treating hypertension, reducing smoking rates, and improving patients' diets.

After being centralized under HEW in the early 1970s, the neighborhood health center program survived attempts to reduce or eliminate its funding during the Nixon and Ford administrations. Already enjoying broad bipartisan support in Congress, the program was formally authorized under Section 330 of the Public Health Service Act in 1975. It continued to expand in both rural and urban areas during the Carter administration, although the scope of services provided became somewhat more narrow.

By the end of the decade, health centers were facing a general imperative to cut costs. The program had a strong manager in Dr. Martin at BCHS, a slate of innovative oversight and data reporting policies (which will be discussed in the next chapter), as well as a promising source of providers sponsored by the NHSC. But the program's greatest struggle was on the horizon.



Terry and Rosie Reilly, founders of Reilly Health Services, Nampa, ID, 1970s



First community health worker class at Sunset Park Family Health Center, Brooklyn, NY, 1968

Chapter 2: The 1980s

Introduction

As the 1970s came to a close, the community health center program had been formally established under Section 330 of the Public Health Service Act. It was managed under the Department of Health, Education, and Welfare's (HEW) Bureau of Community Health Services (BCHS), which was part of the Health Services Administration (HSA). The Rural Health Initiative and Urban Health Initiative had boosted the number of community health centers significantly during the Carter administration, but the program was in for some retrenchment in the coming years.

Table 2: The 1980s by the Numbers

	1980	1985	1990
Health Centers	872	630	530
Patients	5 million	5.3 million	6 million
Funding	\$320 million	\$383 million	\$500 million

Sources: Bovbjerg & Davis, 1983; Lefkowitz, 2007; Sardell, 1988; Shin et al., 2012.

Following the election of Ronald Reagan, the community health center program faced a proposal to convert all its funding to block grants. However, this proposal was ultimately defeated and the program retained its federal funding.

Even without the block grant proposal going into effect, overall budget cuts led to increased belt-tightening and the closure of some health centers. The challenge of coping with the new specter of AIDS would place additional strain on the program, while also leading to opportunities for growth.

At the end of the decade, legislative changes would establish a new payment model for health centers and a new class of "look-alikes," which enabled the program to reach additional communities without spending additional money.

Organizational Changes

HEW became the Department of Health and Human Services (HHS) in 1979, as education was split off into its own department. On October 1, 1982, HSA merged with the Health Resources Administration to form the Health Resources and Services Administration (HRSA) under HHS

(Sardell, 1988). Shortly thereafter, BCHS became the Bureau of Health Care Delivery and Assistance (BHCDA) within HRSA. BHCDA continued to administer the community health center program, as well as the National Health Service Corps (NHSC), the migrant health program, maternal and child health, and a few smaller programs.

The new bureau continued under the leadership of Dr. Edward Martin throughout most of the decade. Dr. Martin has been described as "tough," "very bright," "demanding," and "thorough in his understanding of the political situation." He was respected for his leadership in steering the bureau through a difficult time and the steps he took to strengthen the program for the future. He "prescribed the tough medicine that hurt some centers and saved many more" (Lefkowitz, 2007, p. 142).

Regulations, Data Collection, and Regional Autonomy

Dr. Martin was instrumental in establishing data collection practices and oversight procedures for the community health center program, which became the template for later practices that the program still follows. These practices have proven essential for demonstrating the effectiveness of the program to those who would question it.

Program Regulations

In the wake of the initial health center legislation in 1975, there was a need to establish regulations that would govern how health centers were expected to function in their day-to-day operations. There was also a growing push to ensure the health centers were accountable for how they managed federal funds. As former BCHS employee John Hisle puts it: "The bureau realized: we have all these health centers, but we don't have any regulations that define what they need to do, what we need to do, and how we ought to go about doing it. Figuratively, people up until that point were flying by the seat of their pants."

Richard Bohrer, a longtime leader within BCHS and BHCDA, describes it as a "year-and-a-half (at least) journey, but a critical thing. It created a foundation that has not changed significantly from 1976 up to the present." One of the initial regulations involved the requirement for health centers to provide information on the number of patients they saw, the services they offered, their finances, and so forth. This became the Bureau Common Reporting Requirements (BCRR) (see below).

Another requirement involved the patient-majority board of directors. "Health centers didn't always like the requirement to have a majority of their board members be patients," according to Hisle, "because that meant you had to listen to people who may not have a lot of education, or medical knowledge, or management knowledge. But they had personal knowledge, and that was really invaluable to health centers. It's helped make the health centers what they are."

Bureau Common Reporting Requirements

Beginning in 1978, the BCRR required health centers to report on their number of patients, the number of visits, what services were provided at each visit, the health center's income and expenses, their workforce, and a few other things. Compared to later reporting requirements, it was minimal. (For instance, there was no reporting on clinical outcomes.) But it represented a big step for the program.

"Some of the health centers were in big trouble financially," according to Hisle. "They were losing money right and left, and they had no idea how many people they were serving, who the people were, where they were coming from, what their financial situation was, whether to charge or not charge. BCRR was a major step in creating a management structure." He adds: "Since I was one of the few people in the bureau that had an MBA in health care administration, I was tapped to help design it."

Some health centers found the change easier than others. "For some of the bigger health centers that were attached to hospitals, this was easy," according to Hisle. "But for the very small, isolated, rural health centers, the requirements could be difficult to implement."

"BCRR was not very popular with the health centers," Dr. Martin agrees. "But it turned out to be extremely important for managing the program. It helped us convince Congress that this was a well-managed program."

Ultimately it was the collection of data—first through BCRR, and later through the Uniform Data System—that allowed the bureau to show it was acting as a good steward of federal funds, to target resources where they would accomplish the most, and to offer health centers technical assistance to improve in areas where they were falling short.

"It may be mundane, it may be boring," according to Andy Jordan, who worked in BCHS in the 1970s and later would help lead NHSC, "but having data to tell your story, being able to provide information about who is getting care, what the program is doing—that's absolutely critical."

Regions vs. Headquarters

When it came to implementing the new regulations, the community health center program in the 1970s and 1980s was managed in large part at the regional level rather than the national level. This is because HSA and later HRSA had a strong network of regional offices and a smaller number of staff in the national headquarters.

Bobbi Ryder, who led a migrant health center in Michigan at the time, remembers: "The regional offices were much stronger than the central office, and there was a lot of autonomy at each of the regional offices. I was in what they called region 5. It was nice to have folks in Chicago, about two hours away from where we did business."

A bureau staffer from the time agrees: "Those of us who enjoy interacting with health centers, we really liked the regional approach. It gave us more time to visit places, because we didn't have to travel super far and we were able to get there quickly." He adds: "But those were the early days, when there weren't as large numbers. Over time it had to evolve into a much more coordinated structure."

The tension between regional and national oversight would remain a feature of the program through the early 2000s. The advantages of regional control (close contact with grantees, understanding of local issues, the ability to travel quickly to visit a grantee site) were counterbalanced by some perennial challenges (inconsistent application of rules, inconsistent funding decisions).

"In the late 1970s and early 1980s, there were hundreds of people in the regional offices involved in the day-to-day management of the program," according to Bruce Riegel, a BCHS employee at the time, "and there was a much smaller number in headquarters." Over the next 20 years, those numbers would reverse. The main reason:

There was a concern about the quality and consistency of program management. Would a health center in the Philadelphia regional office be treated the same as one in the Chicago, Seattle, or Denver offices? Was there consistency in the assistance provided, in how funds were awarded, and how performance was assessed?

In the early years funding decisions were made at the regional level, and there were even regional differences in the funding opportunity announcements and applications. This all changed in 1989, when Congress centralized the grant award process within BHCDA, leading to standard application packages, policies, review criteria, and timeframes. Congress was reacting to "concerns that regional offices were inconsistently interpreting policies, reducing funding without adequate explanation, and delaying grant awards for several weeks or months" (GAO, 1992, p. 9).

Jack Egan, who had many years of experience in HRSA at both the regional and national levels, acknowledges the improvement when most decision-making was centralized: "When the grant function was moved to the central office, all the grant decisions really became more consistent throughout the country. There was not a different protocol for Atlanta versus New York City. I think that was a major improvement."

Health center leaders across the country supported centralization of the grant program, in an effort to ensure there would be consistency of interpretation, consistency of administration, and a lot less of the adverse fallout from the inconsistent interpretations that had been somewhat rampant in the early 1980s.
—Jacqueline Leifer, NACHC attorney

Dr. David Stevens, who joined the bureau as its first Chief Medical Officer in 1988, remembers that the regional offices had their own clinical leadership who were the counterparts of those at the national level. Navigating the relationships and facilitating clear communication took a lot of time. According to Dr. Stevens: “Part of my job was to work with the 10 regional clinicians, to develop their capacity to work together and collaborate. We would have monthly conference calls and get together at meetings so we could ensure a good working relationship and learn from each other.”

Overall, feelings about the shifting balance between headquarters and the regions could be mixed. As more control and decision-making shifted to the headquarters level, health centers sometimes felt like they were losing their close connection with the people running the program. Bobbi Ryder remembers:

The health centers were used to having a working relationship with someone in the regional office, who would come to see them and establish a relationship. Now suddenly all of our relationships were by phone and fax from the central office. And those were the early days of the fax machine, so it could be pretty rough!

But everyone—whether in the health centers, in the regional offices, or at headquarters—was still focused on the same mission and committed to working together. For instance, Dr. Stevens appreciated that “the regional staff really knew the grantees. They would visit the health centers frequently, and communicate with them, and they understood the communities. I always reached out to the regions when I needed clarification about a grantee, and they called me when they needed information about something at the HRSA level. We were a team.”

Or as John Hisle puts it:

In the region, we thought we knew a heck of a lot more than the folks in Washington, D.C. And to some extent we did. But overall there was a very good relationship. We depended on each other, and we worked well together. Most of the time.

Partnership Organizations

The National Association of Neighborhood/Community Health Centers

The National Association of Neighborhood Health Centers (NANHC) was founded in 1971 by a group of health center administrators (Sardell, 1988). Its main mission at the time was to provide training for health center staff and board members. NANHC received its first training contract from the Office of Economic Opportunity later that year, and soon it had opened an office in Washington, D.C.

Providing more training for health center leadership was considered important, as many centers were perceived to be less than well-managed (Sardell, 1988). In particular, BCHS leaders were concerned that many health centers did not have adequate financial management systems in place and were therefore

not capturing all the potential reimbursement revenue they could be receiving. In addition, some health centers were seen to have excessive administrative costs or other wasteful or inefficient practices.

NANHC changed its name to the National Association of Community Health Centers (NACHC) in 1977 (NACHC, 1977). It remains a major supporter of the Health Center Program to this day, providing training and technical assistance to health centers, as well as resources, education, and coordination.

Primary Care Associations

The Health Center Program today is assisted by a network of state and regional Primary Care Associations (PCAs). Like NACHC, the PCAs provide training and technical assistance to health centers—but they do so with a focus on the local needs of their immediate area, including state regulations and policies, whereas NACHC focuses on the big picture at the national level. Every state and territory covered by the Health Center Program is supported by a PCA today, but that was not always the case.

The New York Association of Neighborhood Health Centers (also called the Association of New York Neighborhood Health Centers) was formed in 1970 for the purposes of pooling technical resources, providing training for staff and board members, and negotiating more effectively with the state of New York for higher Medicaid reimbursement rates (Sardell, 1988). They received their first funding from HEW in 1971. The Massachusetts League of Neighborhood Health Centers would receive its first batch of funding from HEW in 1973. Both of these organizations were involved in training and technical assistance for health center staff and leadership.

By the middle of the 1970s, for the purpose of receiving HEW’s training and technical assistance funds, the New York and Massachusetts organizations would become subcontractors under NANHC (Sardell, 1988). They were joined by similar regional organizations covering the rest of the country, which NANHC had created. This arrangement led to some conflict, particularly between the East Coast organizations and those representing the West and Midwest.

In the early 1980s, with funds provided by the Robert Wood Johnson Foundation, NACHC began providing technical assistance in grant writing and organizational development to health centers all across the country to assist them in founding their own state PCAs (Sardell, 1988). By 1986, there were 42 state PCAs and 9 regional ones. They received their own funding from HHS, separate from the department’s contracts with NACHC, but all the organizations worked closely together. As Dr. Martin puts it:

The bureau and NACHC and the PCAs...there are differences of opinion and there are different approaches. But in general, they all work for the same cause—that is, to assure the best care is provided to underserved populations across the country. When they all work together, it’s terribly effective. And that’s one reason the program has grown and the bureau has been so successful.

We tightened our belts and tightened our belts until there was nothing left to tighten. A lot of us thought we were going to go under.

—Bobbi Ryder, health center director

The Reagan Revolution

In his first inaugural address, President Reagan called for sharply reducing the size of the federal government. Along with many other programs, the community health center program would soon face the possibility of major changes to its funding and operations.

Block Grants: Round Two

In a February 1981 address to Congress, Reagan called for the consolidation of 88 programs into seven major block grants (Sardell, 1988). Twenty-six programs involving health services and research—including support for community health centers and migrant health centers—were to be converted into two large block grants, one focused on health services and the other on preventive health services. States would control the funding, with no federal oversight or requirements. In addition, the total amount for each block grant would be 25 percent less than the fiscal year 1981 appropriations for all the included programs.

But Congress did not fully accept the proposed budget (Sardell, 1988). Months of negotiations took place in the Senate and House of Representatives. A number of different possible compromises were considered, in which some programs would be converted to block grants while others continued as categorical federal grant programs.

The final bill, which was passed and signed into law on August 13, 1981, kept health centers as a federal grant program during fiscal year 1982 (Sardell, 1988). Then in 1983, states would be allowed to apply for block grants to take over funding of their own health centers. If they chose to do so, they would be required to maintain funding at the 1982 level, contribute some of their own funds to match the federal grant, and continue the previously established program requirements (including the patient-majority board requirement). If they chose not to take the block grant, the federal government would continue to fund and oversee the health centers.

These stipulations were unique to the primary care block grant (Sardell, 1988). At the same time, block grants were established for maternal and child health and alcohol and drug abuse services. However, migrant health centers and several other programs overseen by BCHS were retained as categorical grants.

Block Grants: The Aftermath

Only two states ended up applying for the primary care block grant: Georgia and West Virginia (Lefkowitz, 2007). Georgia's application was ruled non-compliant with the federal requirements, which left only West Virginia in the position of trying to use block grant funding to take over management of its own health centers.

NACHC and the West Virginia health centers sued the government to block the move (Lefkowitz, 2007). Local health centers testified that the proposal would harm their ability to provide care to those who needed it most. The government lost the case, and the state of West Virginia gave up its application for primary care block grant funding. West Virginia health centers—along with health centers in all other states and territories—would continue to be funded and managed at the federal level.

There were continued attempts by the Reagan administration to convert the community health center program to block grants in 1984, 1985, and 1986, which Congress rejected each time (Sardell, 1988). In 1986, Congress passed by an overwhelming margin—and Reagan signed into law—a bill to authorize funds for community and migrant health centers as separate categorical programs through fiscal year 1988.

Funding Cuts

Even without the block grant proposal going into effect, the community health center program sustained some cuts during the Reagan years, and these had impacts at the local level.

In 1981, under the last budget prepared by the Carter administration, community health centers received \$325 million (Sardell, 1988). This was reduced to \$282.2 million in 1982—and it would have been even lower if not for \$33.9 million provided in July 1982 under an urgent supplemental appropriation passed by Congress. The pattern was similar in 1983 and 1984: the Reagan administration proposed a low appropriation for the program, which was partially offset by supplemental funds provided through Congress later in the year.

By the mid-1980s, the appropriation for community health centers had risen close to \$400 million—but the cost of medical care had also increased disproportionately during these years (Sardell, 1988).

Health centers did a really courageous job being out front and saying: This is our responsibility. We've got to figure out a way to take care of these people, and also keep our staff and patients safe.
—Bruce Riegel, former HRSA official

The program was forced to reduce the amount of support it could provide, and the health centers were forced to do more with less.

Roland Gardner, former director of Beaufort-Jasper-Hampton Comprehensive Health Services, remembers the struggles of the time:

We took a huge cut—the staff of 200 had to be cut by more than one half, and doctors from 14 to 7. We went from 12 buses to 5 and we could only make one trip a day. That meant that some patients had to sit in the waiting room for hours.... We consolidated some sites in Jasper County. I insisted on closing the facilities we didn't own and keeping the ones where we had mortgage money pending. That caused a rebellion from the communities affected—150 people came to the board meeting to protest, and I was hung in effigy.... Somehow we weathered the storm and started growing back. (Lefkowitz, 2007, pp. 84–85)

Richard Bohrer recalls how the bureau tried to prioritize its reduced funding: “What we did was, we went into the orchard and we ‘pruned the trees.’ In some cases, we said to new health centers ‘you’re not really being successful in getting off the ground.’ So we eliminated some entities based on that. In other cases, we said ‘you’re in such-and-such county adjacent to so-and-so. It makes no sense to have two entities right next door.’ So there were mergers and consolidation.”

Some health centers that were doing well were encouraged to “go independent.” They received one-time phase-out funding to help them transition away from their federal grant, saving the program money in the long run. According to Bohrer, these actions reduced the overall number of grantees by a couple hundred, “but we hadn’t lost tremendous service capacity, because the ones we retained were the ones that had the capacity to continue to grow and operate successfully.”



1981
First proposal by Reagan administration to convert federal funding for health centers to block grants. Congress maintains federal funding through 1982, then allows states to choose whether to take the block grant.

The HIV/AIDS Epidemic

A New Disease

In June 1981, the Centers for Disease Control and Prevention (CDC) published a report describing a deadly type of pneumonia recently encountered in five previously healthy young men in Los Angeles (CDC, 2021). Health officials also noticed a sudden increase in a rare type of cancer—Kaposi’s sarcoma—among gay men in New York City. Alarmed by outbreaks of two rare diseases, both associated with immune suppression, among the same population but in widely separate locations, the CDC formed a task force that summer to investigate what seemed to be a new, previously unknown infectious disease. Cases were also seen in people with hemophilia and heterosexual drug users, suggesting that the new disease was bloodborne. By September 1982, scientists had confirmed the mode of transmission and named the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS).

The federal response to the HIV/AIDS epidemic was slow in coming, and when it did come, was considered “uncoordinated, insufficient and inadequate” (Lee & Arno, 1986). Health care providers became dismayed at this lack of response, prompting a number of them to establish their own guidelines for treating HIV/AIDS patients. In many cases, health centers had to scramble to figure things out on their own.

Regan Crump, who served as a nurse practitioner at South Baltimore Family Health Center in the early 1980s and later worked in HRSA, remembers the early impact of HIV/AIDS at his health center: “It wasn’t as well known. A lot of people were losing weight and staying sick with lung conditions, which we later found out was pneumocystis.” Treatment options were limited, and even conducting diagnostic tests wasn’t easy prior to the widespread availability of blood tests in the late 1980s.



1982
Health Resources Administration and Health Services Administration merge to form the Health Resources and Services Administration.

Crump recalls: “Early on, we just treated patients for the symptoms for AIDS. With more cases of wasting in 1984, we then referred to the health department or specialists. We didn’t have routine screening for AIDS at the time.” He adds that when treatment became available, it began slowly: “We had one drug, two drugs. It was a while before triple treatment came out.”

Margaret Flinter, a nurse practitioner at Community Health Center, Inc. (CHC) in Middletown, Connecticut, remembers:

It wasn't very long before the AIDS epidemic was at our doorstep. New patients appeared suddenly and died quickly. Our arsenal of treatment was pitiful. Fear was everywhere. It is hard to convey how much concern there was on the part of the health care establishment, especially dental and medical providers. Our board . . . devoted a meeting to a discussion of how we would respond. When others were refusing treatment to at-risk individuals, our board took the right course of saying we needed to act to serve everyone, and to protect everyone to the fullest extent we could. (Barber, 2022)

Even before becoming a health center in the early 1970s, CHC had started a center called TOUCH for struggling young people. As the HIV/AIDS crisis began in the 1980s, CHC opened a drop-in center called Oasis in an apartment on Main Street and a domestic violence shelter called New Horizons. “These programs recognized that people need support and community,” according to Mark Masselli, CHC founder and president, “wrapped around meeting basic needs for safety, housing, and food, in order to move forward. We built core competencies along the way, ideas that other people have adopted and enacted.” CHC also opened an AIDS outreach program in 1989.

HRSA's Initial Response

Former HRSA official Bruce Riegel remembers how the agency began to provide support and guidance for health centers as they faced the HIV/AIDS epidemic: “It was certainly a shock to everyone’s system. It was a scary time. But it was still a disease like any other disease, and health centers had a responsibility. They couldn’t be afraid to treat these people.” Health centers received guidance on the “universal precautions,” which included handwashing, wearing gloves, masks, and other protective articles, and safe needle handling and disposal. Riegel adds: “You didn’t have to go to an academic medical center to be treated if you had AIDS. There were precautions that could be taken by the health center staff to treat all patients safely.”



1983
West Virginia is only state to apply for primary care block grant. Following litigation, the state withdraws its application and returns the funding to HHS.



1986
HRSA provides its first funding to combat the AIDS epidemic.

As the federal government slowly developed a more coordinated response, and as treatment options became increasingly available, HRSA began to provide targeted funding in response to the epidemic (HRSA, n.d.). Within a few years, this would develop into the Ryan White HIV/AIDS Program (RWHAP), a critical part of the nation's public health response to the virus (see below).

- In 1986, HRSA released its first AIDS Service Demonstration Grants. This was the agency's first AIDS-specific health initiative. In its initial year, HRSA provided \$15.3 million to four of the country's hardest-hit cities: New York, San Francisco, Los Angeles, and Miami. The funding was intended to support community-based programs that emphasized case management and coordinated care.
- In 1987, soon after FDA approval of azidothymidine (AZT), the first anti-HIV drug, HRSA launched its AZT Drug Reimbursement Program. \$30 million was distributed, with the majority going to the five states with the most AIDS patients: New York, California, Texas, Florida, and New Jersey.
- In 1988, HRSA funded its first Pediatric AIDS Demonstration Grants. \$4.4 million was distributed to support projects that demonstrated effective ways to reduce mother-to-child transmission of HIV, develop services for infants and children living with HIV/AIDS, and develop programs to reduce the spread of HIV among young people.
- In 1989, HRSA provided \$20 million through the Home-Based and Community-Based Care state grant program and \$3.9 million in Low Prevalence Planning Grants to support care in parts of the country outside the large urban epicenters where the virus first emerged. HRSA also provided \$11 million directly to seven community health centers to provide HIV counseling and testing services.

The CARE Act and the Ryan White HIV/AIDS Program

Ryan White was an American teenager from the Midwest who contracted HIV in 1984 from a contaminated blood treatment for his hemophilia (HRSA, n.d.). After his diagnosis, Ryan's school barred him from attending classes, and many parents and teachers protested his attendance.

Ryan's struggle for acceptance led to media appearances and attention from celebrities and politicians. By sharing his story, he changed the public perception of those who were HIV-positive, leading to

more public support for assistance and research. Ryan had originally been given only six months to live, but he lived for five years after his diagnosis. He passed away in 1990, one month before his high school graduation. By then, more than 150,000 AIDS cases had been reported in the U.S., and more than 100,000 people had died.

Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in August 1990. The law aimed to improve the quality and availability of HIV care and treatment for low-income people with HIV. Among other things, the CARE Act established the RWHAP within HRSA.

Today, the RWHAP serves more than half of those diagnosed with HIV in the United States. It is considered the nation's safety net program for those living with the virus, providing outpatient care, treatment, and support services to low-income people with HIV. The latest RWHAP data show that 9 out of 10 people with HIV receiving medical care through the program are virally suppressed, which means they cannot sexually transmit the virus and can live longer and healthier lives.

Moving at great speed, HRSA distributed its first RWHAP grants in April 1991 (HRSA, n.d.). Agency staff worked virtually non-stop to craft funding guidelines and assist applicants to develop administrative structures as quickly as possible. "We really felt like we were doing some good," remembers Shelly Gordon, a former HRSA staffer. "We were excited about the work, so we did what we had to do. If that meant going in on Sunday or working late into the night, that's what we did."

The RWHAP received \$220.6 million in funding during its first year. This rose to \$738.5 million in 1996 and \$996.3 million in 1997, dwarfing the initial funding HRSA had been able to provide in the early years of the epidemic. In 2023, Congress appropriated nearly \$2.6 billion for the RWHAP and the work it does in the Ending the HIV Epidemic initiative.

HRSA's HIV/AIDS Bureau

Many of HRSA's initial responses to HIV were managed under BHCDA, which became the Bureau of Primary Health Care (BPHC) in 1992. Dr. Martin remembers: "In the 1980s, we picked up the issue of AIDS. But by the 1990s, AIDS was big enough and there was so much focused activity, it began to have its own critical mass and it became an organizational challenge."

Death was everywhere, and it was constant. I went to meetings time after time in which someone I had expected to see around the table had now died.

—Sheila McCarthy, former HRSA official

HRSA's activities in response to HIV/AIDS remained divided among several parts of the agency through the mid-1990s:

- BPHC handled grants for community-based early intervention services, dental reimbursement, and AIDS Education and Training Centers.
- The Bureau of Health Resources Development handled grants to cities, states, and territories for HIV-related medical care and support services.
- The Bureau of Maternal and Child Health handled grants for family-centered services and support for infants and children living with HIV.

In 1997, all the component parts of the RWHAP were finally brought together under the newly formed HIV/AIDS Bureau (HAB). This led to significant efficiencies for HRSA in administering the program and its burgeoning funding.

New Reimbursement Rates and a New Category of Health Centers

Throughout the 1980s, many health centers continued to struggle to collect sufficient reimbursements from Medicare and Medicaid. The Rural Health Clinic Services Act of 1977 had increased reimbursement rates in rural areas, but health centers in urban or suburban areas were still subject to state limitations on payment rates and eligibility criteria.

Health centers took a major step towards fiscal solvency at the end of the decade when a new reimbursement category was created: Federally Qualified Health Centers (FQHC). By meeting the FQHC designation, all health centers became eligible for higher reimbursement rates from Medicare and Medicaid. Along with this new designation came a new category of health center—the “look-alike.” In subsequent decades, the payment method for FQHCs would be modified on several occasions. The Prospective Payment System (PPS) would result in higher overall payments to health centers, while disincentivizing unnecessary treatments.



1989/1990
Federally Qualified Health Center designation created for Medicaid and then for Medicare.

Federally Qualified Health Centers

The FQHC designation was created for Medicaid in the Omnibus Budget Reconciliation Act of 1989 and for Medicare in the Omnibus Budget Reconciliation Act of 1990. All existing and future HRSA-funded health centers, no matter their location, now became eligible for cost-related reimbursement rates (Lefkowitz, 2007). Services provided by physicians, as well as physician assistants, nurse practitioners, certified nurse midwives, clinical psychologists, and clinical social workers, were all covered.

As Tonya Bowers, BPHC's Deputy Associate Administrator, puts it:

The FQHC designation was really important because it ensured that health centers were paid a reasonable amount for a visit. Health centers are required to provide a lot of services that aren't billable. The FQHC designation created a floor for them to get paid at least a reasonable amount, an amount that would cover the cost of the care they provided.

Over the next few years, Medicaid and Medicare reimbursements began to replace federal grants as the largest source of income for most health centers (Lefkowitz, 2007). In 1990, federal grants accounted for more than 40 percent of health center revenues. By 1998, the percentage was down to 26 percent. Today, the percentage is around 19 percent.

(Note: In addition to community health centers, the FQHC designation also applies to rural health clinics and tribal health centers, which are not managed by HRSA and are not part of the Health Center Program. For this reason, while some people use the terms “FQHC” and “health center” interchangeably, HRSA does not. The agency prefers terms like “HRSA-funded health center” in order to be clear about which entities are being described.)

Look-Alikes

The FQHC designation included a brand new category: entities that met all the requirements of the health centers funded by HRSA under Section 330 of the Public Health Service Act, but that didn't receive funding from HRSA. These are known as Health Center Program look-alikes. Look-alikes are eligible for FQHC reimbursement rates, along with some other benefits that health centers receive, such as placement of NHSC providers. However, they do not receive direct grant funding from HRSA.

The FQHC designation enabled health centers to plan their financial futures with some assurance of funding beyond just what the grants provided. But it also increased the level of complexity, because now they had to deal with CMS.
—David Benor, OGC attorney advising HRSA

As a former BPHC leader puts it: “If you look like, walk like, and act like a Section 330-funded entity, this allows you the opportunity to get FQHC reimbursement.” In addition, because look-alikes are expected to meet all the requirements of a funded health center—such as the patient-majority board of directors, required and additional services, sliding fees, etc.—they often have an easier time applying to become HRSA-funded health centers when new grant opportunities become available. They have a “step up, because they’ve already done some of the homework.”

Dr. David Stevens describes the look-alike category as “sort of a training ground for organizations that maybe have the right vision, are in the right place, but just need to mature a little and develop their capacity. Then they can subsequently apply for funding.”

The Prospective Payment System

In 2000, the FQHC payment method for Medicaid was changed from a retroactive cost-based system to the PPS. Under PPS, FQHCs are paid a predetermined rate that covers all services provided during a single visit (MacPac, 2017). This is different from a fee-for-service system, in which a screening by a nurse, an exam by a physician, and lab tests conducted the same day would all be billed separately. These services are all covered by a single encounter fee under PPS. The PPS structure was designed to provide financial security to FQHCs and reduce the incentive to deliver unnecessary services, which can occur in a volume-based fee-for-service system that reimburses providers for each individual service (Chapman & Pellón, 2022).

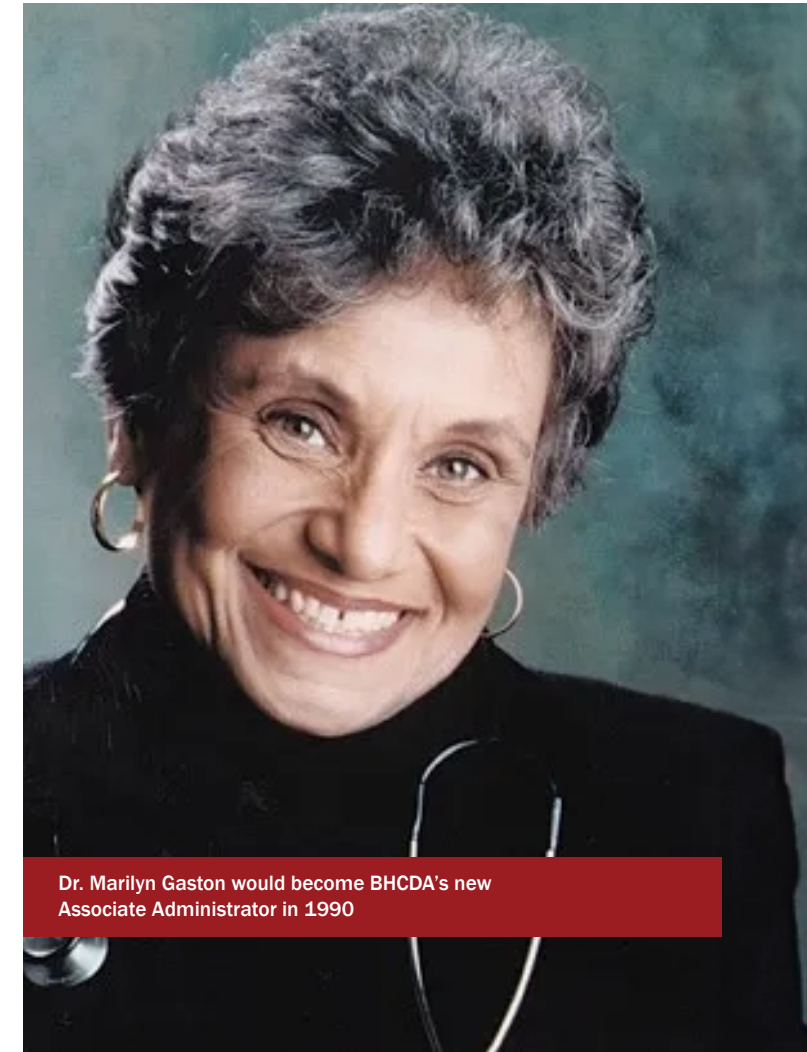
PPS rates for Medicaid are set at the state level for each FQHC based on its historic costs, and states have some flexibility in determining what services are covered (MacPac, 2017). States may also implement an alternative payment method, if it pays the same or more than the PPS.

After passage of the Affordable Care Act, the FQHC payment method for Medicare also transitioned to PPS in 2014. Rates are set at the national level, with adjustments made based on the location where services are furnished.

Summary

In many ways the 1980s were the decade that saw the health center movement come of age. The heady idealism of the 1960s and the rapid growth and organizational shifts of the 1970s gave way to a more stable paradigm. Few new health centers were funded, but the existing ones began to mature and strengthen, developing more savvy leadership and more sophisticated management structures.

Within HRSA, the new home of the community health center program, data collection procedures under the BCRR and the program’s first regulations began to lay the groundwork for the sophisticated compliance management procedures that define the program to this day. By documenting the program’s successes and proactively addressing any problems, HRSA was able to show that federal funds were being managed effectively. This paid big dividends when the program faced questions or threats.



Dr. Marilyn Gaston would become BHCD's new Associate Administrator in 1990

Chapter 3: The 1990s

Introduction

The community health center program entered the 1990s on an upward trajectory. The new FQHC designation enabled health centers to count on a more stable source of funding from Medicare and Medicaid, leaving them less reliant on fluctuations in government appropriations. In addition, several new federal benefits would soon be introduced that allowed health centers to conserve their resources and focus on expanding their services.

Table 3: The 1990s by the Numbers

	1990	1995	2000
Health Centers	530	694	722
Patients	6 million	7.7 million	9.6 million
Funding	\$500 million	\$756 million	\$1 billion

Sources: Shin et al., 2012; Taylor, 2004

The program would make strides to improve the quality of care provided by health centers as the decade went on, and the program would implement new oversight and data collection practices. Perhaps most significantly, the previously separate migrant health program, along with programs for people experiencing homelessness and residents of public housing, would be merged with community health centers to form the Health Center Program we know today.

The Bureau of Health Care Delivery and Assistance (BHCDA) would experience some internal changes as the decade went on, with programs shifting to other parts of HRSA—but first, it was in for new leadership and a new name.

Leadership and Organizational Changes

In 1990, BHCDA received a new director: Dr. Marilyn Gaston. She would remain the director of the Health Center Program until her retirement in 2002. Dr. Gaston has been described as “a wonder,” “one of those people you could follow anywhere,” and “one of the most dynamic leaders the bureau has ever had.”

Growing up in an impoverished neighborhood in Cincinnati, Ohio, Dr. Gaston was inspired to become a doctor after witnessing her mother’s struggles to receive health care (Maryland Women’s Hall of Fame, n.d.). She was one of only six women, and the only Black woman, in her medical school class.

After earning her degree, she rejected an offer to practice medicine in a middle-class neighborhood. Instead, she chose to help found a community health center in the low-income neighborhood of Lincoln Heights, Ohio. In the 1980s, while working at the National Institutes of Health (NIH), she was noted for her work on sickle cell disease in infants. When she came to BHCDA, she was the first Black woman to direct a Public Health Service bureau in the U.S. government, and only the second to achieve the rank of rear admiral in the Public Health Service Commissioned Corps and serve as the Assistant Surgeon General.

Becoming the Bureau of Primary Health Care

Soon after her arrival, Dr. Gaston decided the bureau needed a new name:

We were called the Bureau of Health Care Delivery and Assistance. And at that time we had a lot of different programs delivering different kinds of services, not just the health centers. But I wanted our name to include something about primary care. That’s the kind of focus I wanted us to have.

Rather than just pick the new name herself, Dr. Gaston opened it up to employees:

It was important to me to always have the staff involved, not just decisions being made at the director’s level. So we had a contest to pick the new name, and the winner got free parking for a month. The staff got really involved. They suggested a lot of different names. And in the end, they chose the name that I wanted all along: the Bureau of Primary Health Care. So that’s how it happened.

BHCDA became BPHC in 1992.

Dr. Gaston saw her approach as distinct from her predecessors in the way she wanted to prioritize the bureau’s mission of caring for those who needed it the most:

I found the bureau being managed as a business, to the bottom line.... I appreciated this discipline and structure. It worked.... But I felt I brought something different and wanted to see something added. I was about people’s health. I brought a clinical perspective. I added “and improve health outcomes” to the mission. I called the centers, “healing centers.” I put primary care in the name of the bureau to have a broader view than [just] programs and centers. (Scanlon, 2003, p. 20)

She also worked to strengthen the bureau internally, encouraging collaboration and trust. “I really pushed the staff to start working together,” she says. “It wasn’t that way when I came.” She wanted everyone to contribute to the mission of the program and to feel ownership of the results. She explains her philosophy as “everybody had leadership potential, everybody had qualities they could use to advance the mission and the goals of the program.” In addition to overseeing the change to the bureau’s name, she put in place a new motto: “The people we serve, the people we are.”

The ability to get access to affordable drugs for their patients was really important for health centers. They could take the savings and reinvest that into care.

—Tonya Bowers, Deputy Associate Administrator

Pieces Break Off

BHCDA had administered HRSA's maternal and child health activities since 1982. With the creation of HRSA's Maternal and Child Health Bureau in 1990, all of the agency's activities involving maternal and child health were consolidated and BHCDA no longer had significant involvement in this area.

As discussed in chapter 2, some HIV/AIDS activities were managed within BHCDA and BPHC until the formation of HRSA's HIV/AIDS Bureau in 1997.

Oversight of the National Health Service Corps (NHSC) remained with BPHC until 2002, when it was transferred to HRSA's Bureau of Health Professions. NHSC would be transferred to the Bureau of Clinician Recruitment and Service in 2007, which merged with the Bureau of Health Professions in 2014 to form today's Bureau of Health Workforce.

BPHC also had oversight of the determination of Health Professional Shortage Areas and Medically Underserved Areas/Populations, until this responsibility too was transferred to the Bureau of Health Professions in 2002.

There were a number of other programs and initiatives managed at BHCDA and later BPHC throughout the 1980s and 1990s. For instance, BPHC had oversight of HRSA's Black Lung Clinics Program (to treat coal miners), National Hansen's Disease Program, and Lower Extremity Amputation Prevention (LEAP) Program. Over time these were transferred to other parts of HRSA, leaving BPHC to focus on health centers.

As Angela Damiano-Holder, BPHC's Executive Officer, puts it:

When I started three decades ago, this bureau's functions and responsibilities encompassed a lot more of HRSA's mission. We not only administered and managed the Health Center Program, but we handled grants management, the health care workforce programs, shortage designations, the 340B Drug Pricing Program, and other things like black lung and Hansen's disease. Over time, many of those functions were realigned to other parts of the agency. Now BPHC's primary focus is the administration and oversight of the Health Center Program.

The 340B Drug Pricing Program

In 1992, Congress created a new program under Section 340B of the Public Health Service Act. In exchange for having their products covered by Medicaid and Medicare Part B, pharmaceutical companies were required to provide discounts on outpatient drugs purchased by health centers and other safety net providers. Health centers could then pass these savings on to patients or reinvest the money into expanded services. Participating entities were required to meet various requirements and re-register for the program on an annual basis.

"The 340B Program is a lifesaver for us to this day," according to Roland Gardner, former director



1992
HRSA's Bureau of Health Care Delivery and Assistance renamed the Bureau of Primary Health Care.



1992
Creation of 340B Drug Pricing Program, which provides low-cost prescription drugs for health centers and other safety net providers.

FTCA helped us quite a bit. We used to spend \$1.2 million for malpractice coverage for our providers. \$1.2 million just to cover my doctors! Now we could put that \$1.2 million toward expanding services. We could hire more doctors, more staff. We could provide more mental health and social services.

***—Roland Gardner,
former health center
director***

of Beaufort-Jasper-Hampton Comprehensive Health Services. “When you look at the cost of pharmaceuticals, being able to buy those through the 340B Program has been a lifesaver. Instead of spending \$8 or \$9 for some pills, if you can get them for \$1.50—those savings go a long way. You can use those dollars to expand your services.”

The Federal Tort Claims Act

Congress enacted the Federal Tort Claims Act (FTCA) in 1946. This law allows citizens to sue the federal government for acts or omissions committed by federal employees in the course of doing their jobs. Claims can be brought for injury or death, as well as damages or loss of property.

Through the Federally Supported Health Centers Assistance Acts of 1992 and 1995, FTCA coverage was extended to health centers and their staff (HRSA, 2022; HRSA, 2023a). The law provides that covered individuals (i.e., employees, officers, governing board members, and certain individual contractors) of FTCA-covered health centers may be treated as Public Health Service employees for the purpose of medical malpractice liability coverage. As Public Health Service employees, any liability they incur is covered by the U.S. government, and the health centers are not financially liable for any claims that arise.

This means that health centers that receive FTCA coverage do not need to pay for medical malpractice insurance, which results in significant savings, and they are immune from civil lawsuits. In the event of a claim, the U.S. Department of Justice defends the health center.

Rachel Gonzales-Hanson, CEO of Community Health Development, Inc. and later an executive at the National Association of Community Health Centers (NACHC), emphasizes the importance of FTCA coverage for certain types of care in particular:

FTCA was huge for health centers, because it allowed us to save so much money. We were able to use the savings to provide more services, pay staff better wages, and cover other important expenses. It especially made a difference to those that were providing obstetrical care, because the cost of malpractice coverage for OB care was going through the roof. Some health centers had planned to stop providing OB care, which would have been super detrimental to the communities we were serving.

Health centers must re-apply each year for FTCA coverage from HRSA. Look-alikes are not eligible for FTCA coverage. However, in 1996 free clinics became eligible for FTCA coverage (even if they are not HRSA-funded health centers), and funds to support this coverage were appropriated to BPHC starting in 2004. In 2016, volunteer health professionals also became eligible for coverage alongside health center employees.

An important element of BPHC’s FTCA Program is ensuring that health centers protect patient safety and reduce the risk of adverse events that could result in malpractice claims or other litigation. With this in mind, BPHC provides extensive training and technical assistance—both directly and through partnership organizations—to make sure health centers are taking proper measures to avoid medical mistakes. This is good for patients, of course, and also good for the federal government as the provider of liability coverage. As BPHC staffer Timothy Montgomery puts it: “Every dollar that has to go to a claim is one less dollar we can send out to health centers. We want to make sure health centers have high-quality care, because you are less likely to have a tort claim in that situation.”

The effort has shown results. According to Dr. Suma Nair, former director of BPHC’s Office of Quality Improvement:

When we look at our medical malpractice claims experience, compared to national averages, we perform far better. Even with more clinically and socially complex patient populations, we have a lot less claims.

Taken together, programs like 340B and FTCA enabled health centers to stretch their resources further and expand their services, even if federal appropriations for health centers were not rising in the 1990s as quickly as some might have wished. Coupled with the new FQHC reimbursement rates, these programs enabled health centers to become more financially secure than they had been in a long time. Former BPHC official Richard Bohrer sums it up:

Whether you're talking about the first Bush administration or the Clinton administration, there were no major funding initiatives for health centers. So why did the health centers grow? FQHC, 340B, and FTCA. Over a decade when, if you look at the grant funding, it increased only slightly, those were the three biggest drivers.

The Health Centers Consolidation Act of 1996

Funding for community health centers was first authorized in 1975 under Section 330 of the Public Health Service Act. Funding for migrant health centers was originally authorized by the Migrant Health Act in 1962. Funding for health centers serving people experiencing homelessness was authorized through the McKinney-Vento Homeless Assistance Act of 1987, and funding for health centers serving residents of public housing was authorized by the Disadvantaged Minority Health Improvement Act of 1990.

Within BPHC, these four types of health center were managed by different people within different offices, leading to inconsistencies. A BPHC staffer from the time remembers: “Everyone was well-intentioned, but there were disparities in how the programs were handled. Health care for the homeless and public housing were treated differently from community and migrant health centers, just because they were in different divisions and different people were managing them.”

In 1996, Congress consolidated all four of these programs under Section 330 of the Public Health Service Act:

- Section 330: Community health centers serving a general underserved population.
- Section 330(g): Health centers serving migratory and seasonal agricultural workers.
- Section 330(h): Health centers serving people experiencing homelessness.
- Section 330(i): Health centers serving residents of public housing.

All four types of health center were henceforth treated the same—funded and managed together under BPHC, subject to the same program requirements and oversight activities, eligible for FQHC

reimbursement rates, 340B drug pricing, FTCA coverage, and so forth. Some organizations received funding under multiple categories, depending on their local need and the number of people in each group they proposed to serve—but they were able to apply for the different types of funding using a common application.

This led to obvious efficiencies in bureau management. As Tonya Bowers explains it: “When I started, the program was organized by population type, because there were different statutes that applied to each population. In 1996, when they consolidated all of those pieces into one statute, we were able to really start organizing ourselves by function.”

Consolidation also led to efficiencies on the health center side, as Gonzales-Hanson recalls:

I was so glad that happened! If a health center had different funding sources, even though they were all under the bureau, we basically had to write four or five different grant applications in one year. Even though all the money came from the same place. It was so tedious and inefficient! We kept saying, can't we just consolidate it so that it's one grant, one grant period, for all the funding coming from that one source?

The consolidation did lead to some challenges. For starters, the three categories of “special population” health centers were required by law to continue to receive funding in approximately the same proportion every year. Over time, this has meant that additional funds cannot be provided to one group at the expense of another, which limits the bureau’s ability to undertake certain kinds of initiatives—although it also safeguards each category, ensuring that none can be sharply reduced.

In a way, the consolidation both protected and limited the bureau’s ability to support these special populations. As the longtime director of the National Center for Farmworker Health, Bobbi Ryder sees at as “both a blessing and a curse”:

The blessing was that suddenly, instead of being scrutinized individually every time it was up for reauthorization and appropriation, migrant health just became one element in the bigger community health center world. When the community health center appropriation went up, the migrant health center appropriation went up correspondingly. Like they say, a rising tide floats all boats.



1992/1995

Federal Tort Claims Act coverage extended to health centers, allowing them to receive medical malpractice liability coverage from the federal government.



1995

BPHC launches Models That Work campaign to highlight health centers that are achieving particular success and to publicize their methods so that others can create similar programs.

UDS has been a game changer, helping us tell the story of the program and the impact it has, showing the impact of the investments we have made in health centers and what they've been able to deliver for communities across this country.

—Amanda Ford, Deputy Director, Office of Policy and Program Development

But at the same time, we lost the separate focus. The money kept going up, but we lost some of the administrative attention. There wasn't adequate accountability to ensure that the funds for migrant health centers were really being used to serve migrant farm workers. It was easy for health centers to spend more time focusing on the other groups, who were maybe easier to take care of and who brought in more insurance reimbursement, rather than extending the additional effort to reach out to serve farm workers and really serve them appropriately.

The Loan Guarantee Program

The Health Centers Consolidation Act of 1996 also authorized a new federal program to guarantee up to 80 percent of the principal and interest on loans taken out by health centers for capital projects. Gonzales-Hanson describes the concept:

The idea was, we could apply for a loan for capital to build a new building or buy equipment—which health centers didn't always have access to, especially in rural areas—and the feds would work with the bank to handle the guarantee part. In essence, the bank knew they would be covered whether the health center was able to pay off the loan or not. The feds were like a co-signer, and that made a big difference.

Of course there was a lot of responsibility on the part of the health center to ensure a good business plan and a well-managed project. If the program was to be successful, it was incumbent on health centers to pay back the loans so the feds did not have to actually cover them.

Due to credit or collateral shortfalls, many health centers have trouble getting affordable loans for building or renovation projects (Capital Link, 2023). A loan guarantee can enhance the health center's credit profile, reducing the lender's risk and allowing them to provide a loan with more favorable terms. For some health centers, a loan guarantee could mean the difference between a lender's "yes" or "no." For others, the guarantee may result in a lower interest rate, a longer fixed-rate term, or a higher loan-to-value ratio.

While it was first funded in 1997, the Loan Guarantee Program took some time to make an impact. Additional funding was allocated in 2018, and BPHC has continued to work to raise awareness of the program.

"It's not something that's really widely known," according to Matt Kozar, director of the division that runs the program. "But when we got the new funding and authority in 2018, we started rethinking the program—how to streamline it, how to promote it much more than we had ever done before. There's a lot more lending authority than was there before, so we're trying to get both health centers and lenders aware of the program and how they can take advantage of it."

An example of a successful use of the Loan Guarantee Program is PrairieStar Health Center, located in rural Kansas (Primary Care Development Corporation, 2020). In 2010, they wanted to construct a new building that would double the size of their facility. But they needed to borrow \$3.3 million to finance the work. None of the five local banks they approached was willing to provide them with a loan of that size. But after getting a loan guarantee through BPHC's program, PrairieStar was able to obtain long-term financing for the total amount, with a better interest rate, a better loan term, and lower closing costs than they had been previously offered. When PrairieStar needed to expand again a few years later, the same bank financed the loan—this time without the need for a loan guarantee.

Developing the Uniform Data System

Since the creation of the Bureau Common Reporting Requirements (BCRR) in the 1970s, a key aspect of the Health Center Program has always been the collection of grantee data. In 1996, BCRR was replaced with the Uniform Data System (UDS). The UDS is a standardized reporting system used by all HRSA-funded health centers (and by all look-alikes since 2011). Health centers are required to report each year on a core set of information, so that BPHC can ensure they are in compliance with program requirements and can assess the impact of the program.

In its early years, the UDS collected data on the services each health center delivered, the different types of providers they employed, the number of encounters each provider handled, financial information about the health centers' costs and revenues, demographic information about the total patient population (age, gender, race/ethnicity, language), patient income and insurance coverage information, and "selected diagnoses and services rendered." This provided raw totals for certain diseases or conditions, but no indication of clinical outcomes.

The UDS has undergone a variety of technical changes through the years. "Prior to 2000, we were collecting it on paper," Angela Damiano-Holder recalls. "I took over the management of BPHC's UDS data collection efforts in late 1999, and we worked with the contractor John Snow, Inc. to convert it

I've seen the UDS shift from collecting mostly output data to collecting outcome data. It's made a big difference in what we can do.

—Diana Koorkanian-Sauders, BPHC contractor

to electronic reporting.” The initial method of “electronic submission” was simply an email address to which health centers were directed to send the file. Even after shifting to an electronic report, health centers were still asked to submit a paper copy to their respective HRSA regional office through 2002.

Beginning with the 2005 UDS reporting cycle, health centers received “custom software” to help them compile their report. This software enabled them to submit their report via File Transfer Protocol (FTP), or they could still use the UDS email address. Beginning with the 2008 UDS reporting cycle, health centers began using an online system connected to HRSA’s Electronic Handbooks to submit their data. In the years since then, BPHC has continued to work to refine the UDS reporting methods available to health centers, with the goal of making the process as seamless and efficient as possible.

The UDS has grown significantly over time, particularly in the area of clinical quality. BPHC started collecting data on quality of care and health outcomes for the first time in the 2008 reporting cycle. The first quality measures were early entry into prenatal care, childhood immunizations, and pap tests. Outcome data were collected on low birthweight infants, hypertension control, and diabetes control.

“The quality measure data were based on a sample of medical charts,” recalls Dr. Nair. “Each health center pulled about 70 charts and extracted the clinical data and metrics. And we started with a small set of measures.”

It became possible for health centers to provide aggregated data on all their patients—not just samples—once electronic health records were in use almost everywhere, and over time many more measures have been added. BPHC has been able to analyze and use this clinical data to provide targeted technical assistance and to assess the progress of program initiatives focused on diabetes, cardiovascular health, HIV, and others. Dr. Nair describes the impact:

We started looking at trends over time, and we noticed that what we select to focus on in the UDS really matters. Every time we added a new UDS clinical quality measure, we could see the impact it had on the health centers. During the baseline year it might be hard for them to collect the data. But then every year subsequently, they were making improvements. At the national level we were seeing some significant improvements. And this was really quite inspiring. When you think about things like cancer screenings—if you're screening thousands more people, especially with the population we serve, how many more cancers are you uncovering early, and as a result how many lives are saved?

Initially, UDS data were shared publicly only at the national level. State and regional summary reports were provided directly to grantees and their state and regional Primary Care Associations (PCAs), but not shared more broadly. Packages of data could also be released under certain conditions to researchers or other specialty users. Beginning in 2002, the state and regional reports were posted online along with the national data.

Data at the health center level was posted publicly for the first time beginning with the 2011 UDS reporting cycle. “I think that was a good thing,” Bobbi Ryder recalls, “because transparency is always good.” Dr. Nair describes how sharing the data led to improvements in quality:

Health centers actually asked us to share the data. They were like, “I’m reporting my quality measures to you, I know how I’m doing, but I don’t know if that’s good, bad, or indifferent because I have nothing to compare it to.” So once we started sharing the data, they could see how they compared with other health centers that were similar—small, large, rural, serving



1996

Health Centers Consolidation Act combines community health centers, migrant health centers, health centers for people experiencing homelessness, and health centers for residents of public housing under Section 330 of the Public Health Service Act.



1996

Health centers begin submitting annual data reports through the Uniform Data System.

individuals experiencing homelessness, etc. And that really changed the game in terms of quality improvement. They were motivated to compete, but it also led to peer-to-peer learning and sharing, and it had a really positive impact on quality.

Specialized tools and methods to analyze and present UDS data were also developed. For instance, in 2014 BPHC launched the UDS Mapper. This was an online mapping tool that existing health centers, PCAs, project officers, prospective health centers, researchers, or anyone else could use to visualize the services provided in each zip code and the level of unmet need. Gina Capra, a former BPHC official who is now at NACHC, praises the “sophistication” of the bureau in embracing tools like this: “It was great. It was like, we have all this data, let’s make it available for our own staff and others to use. And let’s make it available not in a stereotypical government way, but in a really nice, interactive way.”

Health Center Controlled Networks

Health information technology was an exciting new tool in the 1990s. Technology could be used for managing patient data, tracking the incidences of particular diseases, tracking prescriptions, coordinating care among providers, as well as administrative and financial management (Gaylin et al., 2005). It could improve efficiencies and quality of care, and it made data reporting much easier (see above). But the new electronic systems were expensive, and the process of acquiring and implementing them posed significant technical challenges, which health center leadership, staff, and providers were often not equipped to meet.

In 1994, a group of health centers realized that by joining together into a network they could obtain the advantages of a large health system in implementing new electronic systems, as well as other financial and organizational improvements (Health Choice Network, n.d.). Health Choice Network became the first example of what would eventually be called a Health Center Controlled Network (HCCN). The original members of Health Choice Network were all located in Florida, but in the early 2000s they were joined by additional health centers in New Mexico and Utah. Today, the network has grown to include 35 health centers spread across 10 states and territories.

Because health centers may provide a more comprehensive array of services than traditional medical clinics, and because they are required to meet federal reporting requirements, early off-the-shelf electronic health record (EHR) systems were often not suitable for their needs (Moiduddin & Gaylin, 2007; Oregon Health and Science University, 2011). A customized EHR would be much more expensive, but this cost could be shared across the members of a network.

BPHC sponsored a number of initiatives through the 1990s and 2000s that helped expand access to health information technology. One was the Integrated Services Development Initiative (ISDI), which began in 1994 with a focus on developing integrated networks of health centers to provide managed care. By the late 1990s, the focus had widened to also developing shared capabilities involving administration, financial management, clinical quality, and information systems. Under the Shared Integrated Management Information System (SIMIS) initiative, which began in 1998, health centers were encouraged to join together in networks to achieve economies of scale in implementing new technology systems. Between 2001 and 2003, the bureau’s Electronic Medical Record Project worked to analyze the current market for EHRs, to identify the needs of providers and organizations through a series of interviews, and ultimately to develop a set of specifications for the “gold standard” EHRs that health centers could obtain.

HCCNs have received funding under various names. HRSA awarded \$31.4 million in 2007, followed by \$18.9 million in 2008, and \$27.8 million in 2009 to support the Electronic Health Record Implementation Initiative, as well as the Health Information Technology Innovation Initiative and Health Information Technology Planning Grants. In 2010, HRSA awarded \$83.9 million in funding from the American Recovery and Reinvestment Act to 45 HCCNs to support new and enhanced EHRs as well as health information technology innovation.

Today HRSA provides funding to 49 HCCNs. The HCCNs use this funding to provide specialized training and technical assistance to their participating health centers, which encompass 84 percent of all HRSA-supported health centers and look-alikes. Tracey Orloff, director of the division that oversees HCCN funding, sums up their importance: “In this day and age, if you are not electronic, you are not providing the best possible care. We knew that years ago, and we started giving money to health centers and networks to stay ahead of the curve. Health information technology has kept this program modernized.”



1998

BPHC launches Health Disparities Collaboratives, with the goal of improving clinical quality and reducing health disparities.



1998

BPHC launches 100% Access/0 Health Disparities initiative, setting an ambitious goal to eliminate health disparities and provide 100 percent access to care.

Models That Work

Over time, the Health Center Program has devoted more effort to leveraging knowledge and strategies developed at one health center in order for other health centers to benefit. In 1995, BPHC launched the Models That Work campaign to highlight health centers that were achieving particular success in reducing barriers to care and to publicize their methods so that other health centers could create similar programs (Crump et al., 1999).

Dr. Gaston recalls it as one of her signature initiatives:

That one was close to my heart. I was out a lot, visiting health centers across the country. We really needed to know exactly what was going on, what was working, what wasn't working, what we needed to do to try to improve access, and build more health centers, and address specific populations, like the homeless or students in schools.

BPHC collaborated with 39 cosponsoring partners and external stakeholders, including state and federal agencies, community-based organizations, foundations, and businesses, to select winners through a national competition. The criteria included:

- Responsiveness to the needs of the community;
- Innovative program design;
- Collaboration and coordination with partners;
- Measurable outcomes; and
- Potential for replication or adaptation at other health centers.

The bureau worked to publicize the winning models in several ways:

- Published a free Compendium with descriptions of each winner;
- Created an online database with information about the winning programs;
- Distributed a packet of articles on the winning programs, as well as videos; and
- Shared Strategy Transfer Guides created by the winners, explaining how they developed, financed, organized, and implemented their programs.

One of the 1995 winners was the East Side Health Coalition, located in East St. Louis, Illinois (Crump et al., 1999). The city had a low immunization rate for 2-year-olds of just 20 percent. The coalition was formed by a local health center, the local health department, a local foundation, and a regional hospital to help address this problem. They created an immunization registry and worked on information sharing among local health care organizations. Within three years, the immunization rate for 2-year-olds in the city had reached 82 percent.

The Sunset Park Family Health Center Network in Brooklyn, New York was a 1998 winner (Crump et al., 1999). They identified and enrolled 500 children who had previously been uninsured into Child Health Plus, the state's child health insurance program for low-income families. They also sponsored

a School Health Outreach Project that served 11,000 children at 11 school-based sites. The program increased immunization rates, reduced hospitalizations and emergency room use, and improved the management of chronic childhood conditions such as asthma.

Models That Work selected 5 winners in 1995; 5 winners and 10 special honorees in 1996; 3 winners and 3 special honorees in 1998; and 4 winners and 2 special honorees in 2000.

Health Disparities Collaboratives

In 1998, the bureau launched a new effort to eliminate health disparities among the populations served by health centers. BPHC worked with PCAs, National Clinical Networks, the Institute for Healthcare Improvement, other HHS components (NIH, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration), and many other partners to develop and implement the Health Disparities Collaboratives. A former BPHC leader describes them as “a systematic way of looking at quality, a systematic approach to looking at health disparities and trying to figure out how to address them.”

Participating health centers selected a multi-disciplinary team that would dedicate time each week to training and discussion, including time away from the health center to attend learning sessions and a national forum dedicated to the subject of the collaborative. Health centers could learn from each other and from experts in the field.

BPHC Chief Medical Officer Dr. David Stevens, who was involved in launching the initiative, describes them as “a collaboration with the quality improvement infrastructure of the United States. That included the Institute for Healthcare Improvement, and other organizations outside the government.” The key was bringing all parties into the same discussion:

In the bureau we had all these metrics we were collecting. But how do you analyze them? How do you use them to foster improvement? For the first time, we worked to create a learning system. Health centers formed teams, and reported on their outcomes, and presented to each other what exactly they had done and what they had learned. And they also were able to participate in didactic sessions about quality improvement and measurement. There were specific clinical-oriented discussions about how to improve care.

The first collaborative focused on improving diabetes outcomes. Later collaboratives focused on cardiovascular disease, asthma, cancer, depression, perinatal safety, and oral health. Approximately 800 health centers participated in collaboratives during the course of the program, which transitioned into other knowledge-sharing and quality improvement initiatives after 2008.

Studies documented numerous process improvements, gains in clinical workforce morale, and cost savings that resulted from the Health Disparities Collaboratives (Stevens, 2016). There were improvements in diabetes, asthma, and depression outcomes, as well as long-term savings for the care of patients with diabetes. The cost to HRSA was only a fraction of one percent of the Health Center Program's total budget, since the participating health centers contributed most of the resources and staff time.

It was a principle-driven initiative. We felt that nothing less than 100 percent access for the population served in those communities was okay, and no level of disparities—not 30 percent differential, not 20 percent, not 10 percent—no level of disparities was acceptable.

—Regan Crump, former HRSA official

Rachel Gonzales-Hanson is still enthusiastic about the Health Disparities Collaboratives:

Love, love, love that! Those collaboratives were wonderful, because they started to help the health centers really focus on transitioning to “care teams.” It wasn’t just the clinical staff that were necessary for improving quality. It was everybody that worked at the health center, regardless of their position—even if they worked in registration, or outreach, or the promotores (community health workers)—everybody needed to be part of the care team.

An Ambitious Goal: 100% Access/0 Health Disparities

In 1998, a group of senior leaders within BPHC announced a new vision for the bureau: 100 percent of the people in America should have access to high-quality health care, and there should not be persistent gaps between those who were wealthy and those who were low-income, those who had insurance and those who didn’t (Scanlon, 2003).

“We wanted all of our programs to deliver 100 percent access, and we wanted zero health disparities,” Dr. Gaston says simply. “Meaning that the health outcomes in our programs were the same as everybody else’s.”

“It was kind of a rallying cry for all of us involved in the health center movement,” according to Joseph Pierle, CEO of the Missouri Primary Care Association. “We were going to work within our respective states and our communities to make sure that all people had access to health care, and also to work hand-in-hand to reduce the disparities that impact many individuals across America.”

At the time, the Health Center Program was achieving perhaps 10-20 percent access among the uninsured and underserved (Scanlon, 2003). The goal seemed impossible, but those involved felt passionately committed. Regan Crump, one of the original planners, recalls: “I never had to be convinced. 100 percent is such a moral imperative that we don’t have to agree that ‘it can be done.’ It was about: ‘It must be done’” (p. 13).

Part of the Clinton administration’s stated mission for HHS was to “reduce health status disparities.” But Dr. Gaston recalls feeling: “That is not good enough. There is no urgency or call to action in *reduce*. I had

the bureau push *eliminate*.... When people would complain that eliminate is too bold, too unrealistic, I would ask, “What is the level of disparity you are willing to live with?” (Scanlon, 2003, p. 21).

A core group of BPHC leaders began to develop a plan to achieve this audacious goal. They hoped to enroll 500 communities across the nation into the campaign within three years. Each of these communities would be provided with financial and technical assistance to increase access to care. Communities that had shown success would be identified and their leaders would be enrolled in the campaign as models, teachers, and advocates.

BPHC official Charles Van Anden developed a 10-step scale that would be used to assess progress (Scanlon, 2003). The steps ranged from initial discussions and commitments within a participating community, to alignment of community assets and construction of new service delivery systems, to establishing continual improvement standards and sharing the results with other communities.

Two early models for the initiative were Buncombe County, North Carolina, and Hillsborough County, Florida (Scanlon, 2003). In Buncombe County, physicians and other providers had “self-organized” into an integrated delivery system, which included a physician-led charity care program that provided services for the uninsured and individuals living in poverty. The Buncombe County Medical Society signed a cooperative agreement with BPHC, and by 2001 they were working with 50 communities around the country to help replicate their model.

I remember some officials were skeptical about it. You couldn’t have 100 percent access, that was an impossible goal. BPHC leadership said, “Well, who would you like us to eliminate from having access?” That was a reminder to me of why we put all our blood, sweat, and tears into this program.
—Charles Van Anden, former BPHC official

In Hillsborough County, proceeds from a new sales tax were used to fund a comprehensive, coordinated managed care network run by the county government. This replaced the county's previous system, which was fragmented, short-term, and emergency-driven. The new program was providing services to 34,000 people by 1998, out of an estimated 39,000 residents in need of services. One of the lessons BPHC leadership took from the Hillsborough County experience was the importance of creating buy-in at the local level. Because the Hillsborough County commissioners were committed to expanding access to health care—in part as a means of reducing health care costs for the county government—they were able to implement their innovative model.

The BPHC team accomplished a lot in a few years. By the end of 2001, dozens of benchmark communities had been identified, and successful projects were being replicated in scores of other places (Scanlon, 2003). More than 600 communities had enrolled as participants in the campaign and were tracking their progress on the 10-step scale. But the incoming Bush administration had different goals for the Health Center Program (see chapter 4). A new HRSA Administrator was soon in place, and Dr. Gaston retired from the bureau.

In the end, what impact did the 100% Access/0 Health Disparities initiative have? Tonya Bowers calls the initiative “important, and before its time.” She adds that it “really did lay out so much that’s at the center of what we’re doing in the Health Center Program today. We’re still working to eliminate those disparities and ensure that everyone has equal access to care.”

Dr. Gaston sees the legacy of the initiative continuing more broadly:

It generated a lot of interest and enthusiasm, and not just within our communities and our health centers, but also with other programs. There were foundations that saw what we were doing, and they thought it was a good idea, and they started funding their own programs to do it. It really began to spread across the country, and I think it's still viable. There are still programs out there where that's their goal: to make sure that everybody in a certain area is taken care of and eliminating the disparities. And I think we have to keep insisting. I think our goal still has to be to get 100 percent of our people access to care.

Summary

In March 2000, the U.S. General Accounting Office (now the U.S. Government Accountability Office) conducted a study on the performance of health centers (GAO, 2000). The number of HRSA-funded health centers had remained roughly stable for several years, although they were serving more patients and providing care at a greater number of locations. HRSA estimated that about half of the health centers had some operational or financial problems, and about 10 percent were struggling to maintain operations. Federal funding had gone up by the end of the decade, but health centers were now getting a majority of their funds from Medicaid payments. The study found that health centers that formed partnerships and networks and participated in managed care were the most likely to be successful.

In some ways the 1990s were a quiet time for the Health Center Program, compared with what came before and what would come after. But the events of the 1990s strengthened the program and prepared it for future success. The new FQHC payment method established health centers on a firmer financial footing, even as ongoing changes to the health care industry would continue to pose challenges. New federal benefits like the 340B Drug Pricing Program and FTCA coverage allowed health centers to stretch their resources further, while HCCNs and other collaborative efforts allowed them to learn from and assist one another in improving quality. The launch of the UDS created the foundation for future efforts to improve clinical quality, while also strengthening BPHC's ability to document the accomplishments of the program and target areas for improvement.

The consolidation of community health centers, migrant health centers, health care for the homeless health centers, and public housing primary care health centers under a single program created efficiencies and helped to simplify the focus of the program. The Loan Guarantee Program represented an initial effort by HRSA to support capital improvement projects at health centers—a goal that would gain momentum in subsequent years and become far more extensive.

With the 100% Access/0 Health Disparities initiative, the bureau took a step back to its roots in the idealism of the 1960s. The goal of providing universal access to health care and eliminating health disparities was audacious—perhaps impossible—but by setting this marker, BPHC declared that it was not interested in playing a minor role in the health care challenges of the coming century. The Health Center Program intended to be a key player and to do big things.



Allen County Health Partners, Lima, OH, 1990s

Chapter 4: The 2000s

Introduction

The 2000s were a period of sustained growth for the Health Center Program. This was also a decade that brought major changes to the way the Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care (BPHC) managed the awarding and oversight of their grants, as well as the way BPHC monitored health centers' compliance with program requirements. New electronic systems changed the way of doing business for almost everyone, and health centers were called upon to take a more prominent role in disaster response and recovery.

Table 4: The 2000s by the Numbers

	2001	2005	2008
Health Centers	~770	~1,000	~1,080
Sites	~3,320	~3,750	~7,350
Patients	10.3 million	14.1 million	17.1 million
Funding	\$1.2 billion	\$1.7 billion	\$2.1 billion

Sources: Shin et al., 2012; UDS

The Health Center Growth Initiative

In 2001, soon after coming to office, President George W. Bush proposed an expansion of the Health Center Program. His Health Center Growth Initiative set a goal of adding or expanding 1,200 health center sites in the nation's most underserved areas over 5 years, providing health care services to an additional 6 million people. The initiative funded two types of grants: New Access Point (NAP) awards, which were for newly funded health center sites, and Expanded Medical Capacity (EMC) awards, which were available to existing health centers for the expansion of services at existing sites.

By 2007, 716 NAP awards had been issued along with 520 EMC awards (HHS BPHC, 2008). The total number of patients treated at health centers increased by nearly 5.8 million between 2001 and 2007. Federal funding for the Health Center Program nearly doubled, from \$1.2 billion in 2001 to just under \$2 billion in 2007.

Former BPHC official Richard Bohrer recalls: "Bush supported the program because it was community-directed. It was a series of local businesses. And he had seen them in Texas. They were reaching people with real needs, and they were serving them very well."

Organizational Changes

During the 2000s, there were major changes in the way work was done within BPHC. Project officers were relocated from the HRSA regional offices to the bureau's headquarters in Maryland. New electronic systems made it possible to gather, store, and process information at a rate never before imagined.

In 2005, BPHC staff moved from a building in Bethesda, Maryland to join the rest of HRSA in the "Parklawn Building" at 5600 Fishers Lane in Rockville, Maryland. There were about 150 employees working on the Health Center Program at that time, plus another 350 working on the National Hansen's Disease Program and other initiatives that would eventually be moved out of BPHC.

Following the retirement of Dr. Marilyn Gaston, the bureau had several new directors, including Dr. Sam Shekar, Michelle Snyder, and Jim Macrae, who would play a major role in its future development. The bureau also began to provide dedicated funding to new partnership organizations to assist health centers with training and technical assistance, and the bureau instituted new oversight procedures. All of these changes would position the program for the larger role it was soon to play in the nation's health care system.

Project Officer Centralization

As discussed in chapter 2, there had long been a tension within the Health Center Program between management at the regional level and oversight at HRSA's national headquarters. Grant-making decisions had already shifted to headquarters in 1989, along with policy making, data collection, and partnership activities. But hundreds of project officers were still stationed in the regional offices, where they performed day-to-day oversight duties for the program. Because they lived near the health centers, they could travel to visit them quickly, and they had a sense of the local issues the health centers were facing. But all of this changed in the 2000s.

In July 2003, at the direction of the new HRSA Administrator, Dr. Elizabeth M. Duke, and implemented by BPHC's new Associate Administrator, Dr. Shekar, project officer responsibilities for the Health Center Program were transferred from HRSA's 10 regional offices to the headquarters office. This meant that many staff had to be trained to take on completely new duties. "It was a very trying time," according to Nedria "Von" Bailey, a longtime BPHC employee. "We tried to keep it positive, but people were nervous."

Charles Van Anden, who worked in the headquarters office, recalls the change being "difficult for the people out in the regions." But he believes: "Ultimately, it was a good thing. It led to a leveling of how the program was managed, how things were communicated, how oversight was performed." A member of the BPHC leadership team at the time suggests another benefit: "Having everybody in a central location really allowed more cross-fertilization of thoughts and ideas."

The centralization of the project officer role from the field into headquarters really altered the approach used to provide oversight. It increased standardization—having a team of folks who are working not just in the same place, but with the same guidance and structure and directors. That was a key milestone in our ability to provide oversight.

—Amanda Ford, Deputy Director, Office of Policy and Program Development

James W. Hunt, Jr., former CEO of the Massachusetts League of Community Health Centers, feels the change was positive in the end: “We really loved the regional focus of the program, the direction we got, the people we worked with. But we understood it was inconsistent across the country. Centralizing the project officer assignments and the attention from the headquarters has really worked. We came around to support it over the long run.”

Electronification

In the mid-2000s, as was the case in many organizations, BPHC began to shift from a largely paper-based office to an electronic one. The change was gradual and not without hiccups, but it would eventually impact virtually every aspect of the program.

A BPHC staffer who started in 2001 remembers:

In my early years, it was very manual. Everything we did was on paper. We had big three-ring binders. Depending on how long a grantee had been associated with the program, they could have three or four binders. When we wanted to find something, we had to look through the binders, and it could take a long time.

Gina Capra, a former BPHC official who is now at the National Association of Community Health Centers (NACHC), says: “I remember when we had to pack up our grant files in Boston and ship them to the Parklawn building in Rockville. Then the people in Rockville were saying, oh my gosh, the floor is caving in with all these boxes.”

HRSA launched its Electronic Handbooks (EHBs) system in 2004. The EHBs started out as a tool for new or existing health centers to submit grant applications electronically. (The system was developed as part of the Bush administration’s “E-Government Initiative,” which required grant-making agencies to provide for electronic creation and submission of applications.) Soon the EHBs were also used by project officers to manage their work, and over time many additional modules have been added to the system, until almost every aspect of the agency’s work with grantees is handled there.

Prospective health centers submit their application packages through the EHBs, and then grant reviewers conduct their assessments and document their scores in the system. Notices of award are sent out through the system, as well as other communications over the duration of the funding period.

Health centers submit their Uniform Data System (UDS) data through the EHBs, and request changes in their scope of project, and file required progress reports. BPHC staff plan their health center site visits through the EHBs, and file site visit reports, and document any problems that were identified and any conditions placed on the grant. The system contains financial audit information, and capital development records, and Federal Tort Claims Act deeming applications, and so much more.



2001
Bush administration launches Health Center Growth Initiative.



2003
Project officer responsibilities relocated from HRSA regional offices to headquarters office.

It was a really important change, moving the work to an electronic platform. Finally everyone was working in a system—rather than just pieces of paper and post-it notes and files about each grantee that are off in a drawer somewhere. Anyone could go in the system and get access to the same information.

—Margaret Davis, former BPHC official

Capra describes how workflows in the system enabled tremendous improvements in efficiency:

The old pass-the-paper from person one to their supervisor, and then to their supervisor, to sign off on a health center's request to add a site to their scope of project...that all got electrified. It got put into workflow queues, which meant it could not get lost. And there was coverage if something happened to one person. It did not sit on my desk because I was out for a week. That was a major step forward.

Shifting more work into the EHBs—in conjunction with the hundreds of new project officers who were now based in the headquarters office—led to an increased emphasis on clear, well-defined procedures. “There was an effort to standardize workflows,” according to Dr. Suma Nair, former director of BPHC’s Office of Quality Improvement. “Along with the technology, we had to develop the business processes and the standard operating procedures to make everything run smoothly.”

The shift uncovered some aspects of the program that needed to be managed better. Dr. Nair describes “scope reconciliation efforts”—attempts by BPHC to improve data quality related to health centers’ documented sites and services.

As with any electrification process, the more you get into the nitty-gritty, the more you discover there's a lot of clean up, a lot of data definitions and processes we need to make more standardized. We need to make sure everybody understands the policy, and the policy is being implemented consistently. Electrification helped us re-engineer and review a lot of what we were doing.

The EHBs enabled more accountability. Margaret Davis, a former BPHC official who now works at NACHC, talks about the importance of dashboards in the system: “You could see all grantee submissions and the status of everything in the project officer’s queue. It became a great tool for managing the staff and the workload.” Dr. Nair describes the performance management possibilities:

You could say, hey, I'm going to run a report on the 20 staff in my division and see how my people are doing. If they're 80 percent on time, and their application reviews are high-quality, that's going to result in a high rating when it comes time for performance evaluations.



BPHC Associate Administrators Dr. Sam Shekar, Michelle Snyder, and Jim Macrae

The system developed gradually over time, and it continues to evolve today. Efficient use of the EHBs and other electronic systems has enabled the Health Center Program to move nimbly and effectively when faced with a variety of challenges. This electronic infrastructure has been critical to the program’s success.

New Leadership

The departure of Dr. Gaston left big shoes to fill for the next director of BPHC. Dr. Shekar became the new Associate Administrator in 2002. Like Dr. Gaston, he was a rear admiral in the Public Health Service Commissioned Corps and he also served as the Assistant Surgeon General. Dr. Shekar previously led HRSA’s Bureau of Health Professions and HRSA’s Office of Field Operations. During his time leading the Health Center Program, Dr. Shekar oversaw the centralization of project officer duties within the headquarters office, which represented a major shift in how the program was managed, as well as the launch of the EHBs. Dr. Shekar would go on to serve as a director at NIH and later become the Chief Medical Officer at Northrop Grumman.

In 2005, Michelle Snyder became BPHC's new Associate Administrator. She previously led HRSA's Healthcare Systems Bureau, after spending a number of years as the Chief Financial Officer at the Centers for Medicare & Medicaid Services (CMS). During her time leading the Health Center Program, Snyder spearheaded the bureau's response to Hurricane Katrina. She left BPHC in 2006 to ultimately return to CMS.

BPHC's next director, Jim Macrae, first arrived at the bureau in 1992. He served in a variety of capacities, eventually becoming the director of the Office of State and National Partnerships. He was part of the team dedicated to the 100% Access/0 Health Disparities initiative under Dr. Gaston.

He left the Health Center Program in 2000 to serve as the leader of HRSA's Office of Field Operations, and then HRSA's Office of Performance Review (OPR), which provided oversight of HRSA programs in the regional offices (including site visits—see below). In the spring of 2006, he returned to BPHC as the bureau's new Associate Administrator.

Macrae has been described as “a terrific manager,” “open-minded,” “very smart,” a person with “such enthusiasm and a real can-do attitude,” and someone who has “been around the program forever and really knows it well.”

One of the hallmarks of Macrae's leadership has been innovation. He has pushed the bureau to always be thinking ahead, always asking if there's a better way to accomplish its goals. The director of one of the Primary Care Associations (PCAs) describes Macrae as someone who “embraces the good and the bad. He believes strongly in performance improvement, and he's constantly working to provide the best possible customer service. He's always seeking input from the field, as well as internally among his BPHC colleagues.”

This focus on innovation has resulted both in changes to the way BPHC oversees its grantees, as well as changes within the bureau itself. Under Macrae's leadership, the bureau has worked through several rounds of strategic planning and re-engineering, which have resulted in several large-scale transformations and reorganizations, as well as the hiring of many new staff.

In 2020, Macrae would lead the bureau through the challenges of the COVID-19 pandemic (see chapter 5). During this time of crisis, Macrae would be called on to act as a conduit for critical information between his staff, HRSA leadership, the Department, the White House COVID-19 Task Force, the

health centers, the PCAs, and organizations like NACHC. His “Today with Macrae” webcasts (first monthly, then biweekly) became essential viewing for health centers and other stakeholders as they struggled to make sense of the pandemic and to understand what would happen next.

Health Center Oversight Changes

A series of General Accounting Office/Government Accountability Office (GAO) reports during the 1990s and 2000s, along with the new possibilities introduced by electronic management systems, as well as new leadership in the bureau, together prompted several significant changes in how BPHC provided oversight of health centers. The site visit process, which had been somewhat ad hoc through most of the program's history, evolved into something far more standardized. The period of performance for health center grants was adjusted, and health centers were expected to re-compete for funding. Automatic renewal of most grants was no longer assumed.

Operational Site Visits

For a number of years, BPHC had conducted what were known as Primary Care Effectiveness Reviews (PCERs) to provide periodic on-site monitoring of health center operations (GAO, 2005). PCERs occurred every 3 to 5 years, usually when a grant period was about to expire. During PCER visits, a team of reviewers (usually contractors) assessed the health center's strengths and weaknesses in administration, governance, clinical and financial operations, and management information systems.

Beginning in 2004, this process was shifted out of the bureau and managed at the HRSA level through OPR (GAO, 2005). The goal was to reduce the burden on grantees by consolidating on-site monitoring for multiple HRSA programs (e.g., the Health Center Program, the Ryan White HIV/AIDS Program) under a single visit. OPR reviews occurred in the middle of a grantee's project period—in the second year for a new grantee, or in the third or fourth year for an existing grantee. The reviews were generally conducted by HRSA staff from the regional offices. Following the site visit, the team would prepare a report describing its findings and identifying any actions the health center needed to take to ensure compliance with program requirements.



2004
HRSA launches the Electronic Handbooks, which health centers use to submit grant applications electronically. Over time the system expands to encompass almost every aspect of the program.



2004
BPHC issues the first Service Area Competition funding opportunity.

In 2010, BPHC took back the responsibility for conducting site visits at health centers (GAO, 2012). The assigned project officer would conduct an initial site visit within 90-120 days of funding being awarded to a new grantee, and consultants would conduct operational assessment visits at existing grantees “as needed.” These visits would be used to assess the health center’s compliance with the 19 program requirements (see chapter 5). If any problems were identified, follow-up visits would be scheduled to assess the health center’s progress in addressing the problems. There were also “targeted technical assistance” site visits, which would be scheduled to help a health center improve its performance in an identified area.

Following the site visit, the consultant and project officer—if applicable—would prepare separate reports documenting any areas of non-compliance and recommendations for improvement (GAO, 2012). Compared with the OPR reviews, BPHC’s site visits placed a greater emphasis on compliance with Health Center Program requirements. However, the schedule was irregular, the bureau did not have strong internal processes for tracking when site visits occurred and what their findings were, and consultants and project officers did not always apply consistent standards when assessing compliance.

BPHC developed a Health Center Site Visit Guide in 2010 to assist the site visit teams. This document contained chapters for each of the 19 program requirements, with lists of questions the site visit team should ask the health center. But it was less detailed and less user friendly than the Site Visit Protocol the bureau would later develop (see chapter 5).

In subsequent years, the process evolved to become more standardized. Health centers (and look-alikes) were to receive an operational site visit (OSV) at least once every three years, generally midway through their project period (or designation period). Records about planned or completed visits were all entered in the EHBs, along with records about any findings of non-compliance and corrective measures. It became possible for the bureau to make far more sophisticated assessments of overall compliance across the program and identify areas where health centers needed more assistance.

Katie Ballengee, today a BPHC deputy office director, remembers one of her first jobs at the bureau: working on upgrades to the EHBs to enable the system to track site visits.

Before, there was no centralized way of tracking when a health center had their last visit. I literally interviewed current project officers and asked, when did you last visit this health center? Then I wrote it down and created an Excel file so we could start tracking when the visits were actually occurring. There was nothing centralized before that time.

Roland Gardner, former director of Beaufort-Jasper-Hampton Comprehensive Health Services, admits to some frustration with the expanded OSV process and the increased expectations for demonstrating compliance:

At first I swore at it, I didn't like it. It was a headache. I said, why are we doing this every three years? But it ended up saving a lot of us, because we could show that what we're doing is meeting the requirements, and we're continuing to improve. It really made us better.

James W. Hunt, Jr., former CEO of the Massachusetts League of Community Health Centers, sees the OSV process as a way for health centers to demonstrate their success:

I think the OSVs have provided a great opportunity for health centers to showcase their best practices, and also to be measured against standards that have been created for all health centers across the country. In Massachusetts, when a health center achieves 100 percent compliance in its OSV, there's always a cheer from all their colleagues across the commonwealth.

Service Area Competition

HRSA’s process for awarding grants to health centers has changed through the years, including how competitive the application process is and how long awardees can expect to receive funds before they must reapply.

As noted in chapter 2, the responsibility for awarding grants was moved out of the HRSA regional offices and centralized within the Bureau of Health Care Delivery and Assistance (BHCDA) in 1989, in response to concerns about inconsistency and delays. At this stage, most grants were provided for 3-year project periods, but grantees had to apply separately for each year’s funding “using a scaled-down version of a grant application” (GAO, 1992, p. 9).

Bureau policy called for new grants to be awarded competitively, but a GAO report in 1992 found that “BHCDA has not awarded grants competitively.... Instead, it has restricted grant awards to existing health center grantees” (p. 3). To determine the amount of a grant, the bureau was simply starting with the previous award and adding a cost-of-living increase. There were also questions raised about potential bias in the selection process.

The bureau argued that while they supported competition in theory, it was difficult to achieve in practice because “nurturing a center and developing an infrastructure to support service delivery may take years” (p. 3). The bureau also argued that competition “was not always in the best interest of either the patient or the public. For example, turnover among primary care providers may increase the likelihood of poor health outcomes among populations already at high risk or may be costly given start-up costs of new centers” (p. 14). The bureau expressed an intention to seek approval from HHS to award non-competitive grants to most health centers.

A report by the HHS Office of the Inspector General (OIG) from 1996 states that when their project period ended, health centers would submit an application for project period renewal, and in most cases “renewal is automatic” (p. 24). Only if the grantee had shown serious administrative problems or deficiencies in delivering services—or if another organization wished to compete—would BPHC staff conduct a site visit and perhaps consider the possibility of discontinuing funding. The prospect of competition in this scenario seems to be regarded as rare and unlikely.

Over time, however—as the program grew larger, as more organizations around the country became interested in potentially becoming health centers (including the new class of Health Center Program look-alikes), and as oversight of federal spending became more acute—the bureau moved away from non-competitive grants.

BPHC introduced the Service Area Competition (SAC) for the first time in 2004. When an existing health center's project period was ending, the current health center would have to compete against any other organization(s) that proposed to serve the same area. (Although the name SAC was new in 2004, these same characteristics had also existed in a generically titled funding opportunity for Community and Migrant Health Center project period renewal during 2003.)

In 2005, with the Health Center Growth Initiative in full swing, BPHC was providing NAP funding with a 3-year project period for new health centers, while existing health centers could receive SAC funding for up to 5 years at a time before having to re-compete (GAO, 2005). For each year of the project period, health centers were expected to document their activities through a non-competing continuation application in order to continue to receive funds.

The SAC application has become an essential safeguard for the program and an important way to ensure the program's funds are being used effectively. Existing health centers must compete against other local health care providers—including potentially other health centers—to prove they can make the best use of federal funds to continue to serve patients in their service area.

In recent years, some of the details around project periods have continued to change. The standard project period for a SAC award is now 3 years, with budget period progress reports expected prior to the second and third year. The Bipartisan Budget Act of 2018 further required HRSA to award only a 1-year project period to any health center that has shown a history of non-compliance with program requirements. If a health center is awarded two consecutive 1-year project periods, and their next SAC application would also result in a 1-year project period, they cannot receive additional SAC funding. The service area must be advertised and awarded to an organization that is able to provide care in compliance with Health Center Program requirements.

Through its current oversight practices, HRSA balances support and enforcement—enabling health centers to grow, mature, and overcome their challenges, while also ensuring that federal funds are used appropriately and care is provided to those who truly need it.

Supporting Communities and People in Need

National Cooperative Agreements

In addition to NACHC and the state and regional PCAs, BPHC has had ongoing relationships with a variety of other national organizations that focus on the needs of health centers and their patients. Many of these organizations are focused on the “special populations” defined in the Health Center Program statute—migratory and seasonal agricultural workers, people experiencing homelessness, and residents of public housing—as well as other underserved groups and high-need communities.

Beginning in 2006, a new category of funding was provided under the name National Cooperative Agreements (NCA). Some examples of organizations supported with NCA funding include: the Association of Asian Pacific Community Health Organizations, Capital Link, Farmworker Justice, the Institute for Healthcare Improvement, the National Assembly on School-Based Health Care, the National Health Care for the Homeless Council, the National Network for Oral Health Access, the National Rural Health Association, and a number of others. HRSA provided NCA funding to support these organizations in providing training and technical assistance at health centers.

In 2019, National Training and Technical Assistance Partnership (NTTAP) funding took the place of NCA funding. Most of the NTTAPs were the same as the NCAs, and the purpose of the partnerships remained the same. NTTAPs continue to assist BPHC by using their unique subject matter expertise to develop and deliver training and technical assistance for potential and existing health centers. This includes learning collaboratives, webinars, live training sessions, learning modules, articles, newsletters, toolkits, and fact sheets.

Health Center Patient Survey

In 2009, BPHC began conducting a survey of health center patients. Further iterations of the Health Center Patient Survey (HCPS) were conducted in 2014 and 2022.

The idea for the survey grew out of earlier efforts by health centers to survey their own patients. Around 1999, health centers and BPHC began to discuss the possibility of a standardized, national-

***The SAC is a good way to keep grantees honest. It allows them to see that others in the community who are providing the same or similar services might be interested in serving that area. So it's your responsibility to be 100 percent compliant at all times.
—A BPHC leader***

level approach, which could provide more representative data for the program as a whole. BPHC asked health centers to share their own survey tools, and more than 300 were submitted. A task force of BPHC staff, health care professionals, and patients was formed to review the survey tools and develop criteria for a new standardized tool.

The HCPS collects information about patients' sociodemographic characteristics, health conditions, health behaviors, access to and use of health care services, and satisfaction with the care they received at HRSA-supported health centers (HRSA, 2023b). The survey consists of in-person, one-on-one interviews with patients who are selected to be representative of the Health Center Program's total patient population.

As a former BPHC leader puts it:

Health centers exist to improve the health of individuals and their communities, and we need to know at the end of the day, do the patients feel satisfied? What kind of experience and understanding do the patients have about their own care? And it's not only important for the program to know. It's good feedback for the health center boards. They can gather their own data personally, but it's nice for them to see whether that is consistent with the national picture.

The HCPS provides crucial empirical evidence that informs HRSA's policy, funding, and planning decisions. It also has served as a rich source of data for a variety of health care researchers, in government, academia, and the private sector. The most recent data, from 2022, will be critical for understanding the impact of the COVID-19 pandemic on the country's medically underserved populations, and it will also provide useful information that will enable HRSA to better prepare for future public health emergencies.

Hurricane Katrina

In August 2005, a devastating hurricane struck the Gulf Coast of the United States. Hurricane Katrina caused widespread flooding throughout the city of New Orleans and surrounding areas, while also

causing significant damage in other parts of Louisiana, Mississippi, and Alabama. Thousands of people were killed, and tens of thousands were displaced. The storm caused as much as \$190 billion in damage.

Like so many others, health centers were affected. "I can remember going down to Alabama after Katrina, and the health center I was visiting was just totally washed out," Gina Capra recalls.

On the lawn in front, they had put up tarps and spread all their paper records out to dry in the sun. They were figuring out how to get their medicines from the hospital and how to preserve them with a backup generator. I'll tell you, health centers have an important role to play in natural disasters. People depend on their health centers to be there, especially in an emergency.

Longtime contractor Diana Koorkanian-Sauders describes the Health Center Program's experience responding to Hurricane Katrina as "the beginning of BPHC's more structured response to national emergencies." The experience would repeat in years to come: Superstorm Sandy in New York and New Jersey; the water crisis in Flint, Michigan; wildfires in California; Hurricane Maria in Puerto Rico. Each time, health centers were asked to play a role in providing much-needed services under the most challenging conditions.

Today, health centers are seen as a key part of the response to natural disasters (and some manmade disasters) wherever they occur. As James W. Hunt, Jr. puts it:

Health centers have been encouraged by the bureau and positioned by the bureau to step in where the systems have failed. For instance, after Hurricane Katrina, the bureau made sure that health centers were enabled to step out of their lane and provide vital emergency and access services to patients in Alabama, Mississippi, and especially Louisiana during a real crisis period. The bureau and the health centers have been seen as at the ready—ready to jump in, to provide services, to collect data. They make a huge impact.

This would become more apparent than ever with the arrival of the COVID-19 pandemic (see chapter 5).



2009
First Health Center Patient Survey.



2009
American Recovery and Reinvestment Act provides \$500 million to expand health center services and \$1.5 billion for capital development at health centers.

The American Recovery and Reinvestment Act

In 2008, the United States suffered its worst economic downturn since the Great Depression of the 1930s. During what became known as the Great Recession, the nation's unemployment rate doubled, home prices fell roughly 30 percent, and the stock market declined by as much as half. In response, Congress passed the American Recovery and Reinvestment Act (ARRA) and President Barack Obama signed it into law in February 2009.

The total budget for the Health Center Program in 2009 was \$2 billion. ARRA provided an additional \$2 billion for the program, spread out over 2009 and 2010 (Shin et al., 2012).

- \$500 million was provided to expand services.
- \$1.5 billion was provided for capital development, including construction or renovation of buildings, the purchase of equipment, and investments in health information technology.

The bulk of the service expansion funding was awarded at record speed. In March 2009, \$155 million in NAP funding was issued to create 126 new health center sites, with awards going to organizations that had submitted highly rated but unfunded applications during the 2008 NAP funding opportunity (Shin et al., 2010). Later that same month, nearly \$338 million was awarded to all existing health centers to expand services—in the process creating many new jobs for providers and staff at the health centers.

More than \$851 million of the capital funding was distributed almost as quickly. Every Health Center Program grantee received a one-time award in June 2009 for construction, renovation, repair, equipment purchases, and/or health information technology (Shin et al., 2010). Then in December 2009, nearly \$509 million in capital funds was awarded competitively to 85 health centers. Finally, around \$125 million would be provided for health information technology development, with \$88 million of it going to HCCNs.

Outside of BPHC, ARRA also provided \$500 million to support the primary care workforce, including \$300 million for the National Health Service Corps (Shin et al., 2010). Additional funding was also provided to states to support health information technology adoption by certain Medicaid providers—many of which were health centers.

Changes to the Bureau

All the new funding required a lot of new staff to manage it. At the end of 2008, BPHC had about 150 full-time employees working on the Health Center Program—along with 80 staff working on the National Hansen's Disease Program. By the end of 2012, the bureau had about 300 full-time employees, and this did not include anyone working on Hansen's disease (which had transferred to HRSA's new Healthcare Systems Bureau) or any other initiatives. The staff devoted to overseeing the Health Center Program had doubled in just a few years.

BPHC's way of doing business had also changed. Angela Damiano-Holder reflects on the impact of the new funding and the urgency everyone felt to get it into the hands of health centers immediately:

ARRA changed everything about how we work in this bureau. It changed the volume, the pace, the process, the expectation. We had such a surge of money, like we never had before. And it was not just the surge of money, but the expectation of how quickly we had to expedite those funds—developing criteria, application systems, our ability to document, track, and monitor, our oversight abilities, building a whole infrastructure around it. We learned what we could really do as an organization, and we did it. And then it became an expectation. We could never go back to “normal” after that. We constantly had to operate at that speed, at that level.

When the ARRA dollars came, we could get the resources out so quickly because we had the technological ability, and health centers had some familiarity with using the electronic systems for a couple years. So rather than taking 6 months to put out our Recovery dollars, we were able to do them in 2 or 3 months. That was unprecedented. I think we were one of the first programs to put that significant volume of ARRA dollars out to so many communities across the country.

—Dr. Suma Nair, former director, Office of Quality Improvement

When I came here in 1980, we were in double-wide trailers. We were in surplus health department buildings. It was not until 30 years later, when we got the capital money, that we could actually build new facilities.
—Roland Gardner, former health center director

The scramble to distribute ARRA funding as quickly as possible, along with the associated reporting and monitoring requirements that followed, would change the bureau. Another big change was the inclusion of funding for capital projects, which had not been provided through the Health Center Program at that scale before.

Capital Improvement Funding

In the early years of the program, health centers were prohibited from using Section 330 funds for construction or renovation. This was done to ensure the maximum amount of funding would be devoted to providing services. But the result was that many health centers were forced to make due with outdated or poor quality physical facilities (Lefkowitz, 2007).

The Loan Guarantee Program, launched in 1997, was an attempt to leverage federal support to enable health centers to undertake construction projects. But ARRA was the first time a large amount of dedicated funding was provided for these projects—and it wouldn't be the last time.

BPHC's ability to fund capital improvement projects would prove transformative for health centers, helping them undertake much-needed expansions and build new facilities all across the country. This in turn allowed more people to get access to care, including expanded access to new services.

Funding for capital projects is different in many ways from funding for service delivery. There are requirements involving the National Historic Preservation Act and the National Environmental Policy Act. There are nuances involving what types of equipment or facilities may be covered, and timelines for construction, and architectural design requirements. Matt Kozar describes how BPHC had to ramp up its in-house knowledge in order to manage this new type of funding:

The bureau at that point did not have many individuals with experience awarding construction grants. So that's where myself and some of the staff that had experience with another HRSA program lent our guidance and perspectives to get the funding awarded. Once the funding was awarded, some of us transitioned to BPHC to support them in administering and overseeing the construction grants. The capital funding branch was born from that. We had to develop new ways to perform reviews, and collect data, and use that to understand how the construction process was going, so we would be able to answer questions.

Just a year later, another infusion of capital improvement funding would be provided to health centers through the Affordable Care Act (ACA). This would be followed by additional capital funding

for hurricane and disaster relief, as well as significant funding for capital development during the COVID-19 crisis. Kozar describes how the work done after ARRA to develop BPHC's capacity to manage these projects would prove critical in future years:

The work we had done was really important when the Affordable Care Act was enacted in 2010, because the bureau got another \$1.5 billion in capital funding, and also got increasing amounts of funding to support the overall expansion of the program. We had created this infrastructure within the operations of the program to support getting the new money out to health centers. And we had learned to think more creatively about how awards could be made, and what kinds of needs they could address.

Impacts of ARRA on Health Centers

In one study of the economic impact of ARRA funding on health centers, researchers estimated that every \$1 million invested in health centers yielded an average of \$1.7 million in new economic activity (Shin et al., 2010). The bureau's investments were targeted towards parts of the country hardest hit by the recession, maximizing the effectiveness of the investments.

In another study, researchers conducted interviews with health care safety net providers in several communities around the country (Felland et al., 2010). One Cleveland health center reported being able to hire a full-time nurse, a half-time physician, and a clerical person. Another Cleveland health center

For the first time there was a recognition that health centers were important economic engines, as well as health care providers. By virtue of being in economically distressed communities, health centers were a major employer and could help create economic growth.
—Jana Eubank, Executive Director, Texas Association of Community Health Centers

added a part-time dentist and a full-time dental assistant. These staffing increases provided jobs for local providers, while at the same time enabling the health centers to provide services to many more patients.

NAP funding enabled clinics in Cleveland and Phoenix to become HRSA-funded health centers for the first time (Felland et al., 2010). With the funding they received from HRSA, as well as the enhanced Medicaid reimbursement rates they became eligible to receive, they were able to reduce patient fees, increase the number of uninsured patients they could treat, and increase their staff and services.

The increased capital funding also had a big impact. A health center director in northern New Jersey said: “The stimulus package was a godsend in the sense that it allowed us to get at least a good portion of those items from our ‘if only we had dollars we could repave the parking lot or redo our roof list’” (Felland et al., 2010, p. 4).

In the end, ARRA funding supported a total of 127 new health center sites and more than 2,600 capital improvement projects. 2010 UDS data showed that health centers were serving an additional 2.3 million patients compared with 2008, an increase of 14 percent. Overall, health centers were serving more than 7.3 million patients without insurance, an increase of nearly 12 percent since 2008. But increases in this category would change in coming years, as the provisions of the ACA began to take effect and more Americans gained insurance.

For the Health Center Program, passage of the ACA in 2010 would amplify many of the changes first begun under ARRA—expanded services, new access points, capital funding, as well as increases in bureau staff, heavier workloads, an increased focus on measuring quality and impact, and a much higher profile for the important work health centers were doing all over the country.

Summary

The 2000s were a period of major expansion for the Health Center Program, beginning with the Bush administration’s Health Center Growth Initiative and ending with the rapid delivery of funds for expansion and construction under ARRA to combat an urgent financial collapse. In some ways, this was only a preview of the growth to come in the following decade, as first the ACA and later COVID-19 spurred even higher levels of funding and ever larger numbers of patients.

The bureau worked throughout the 2000s to refine its procedures for monitoring and providing oversight of health centers, creating OSVs, SACs, and a growing stable of policy guidance documents (see chapter 5). Along the way, increasingly sophisticated electronic systems allowed the bureau to work more efficiently and enhanced its ability to collect and analyze data. The workforce grew rapidly, and nearly all staff were now located in the HRSA headquarters.

The Health Center Program moved into the 2010s on a mission to show that what it had accomplished with ARRA funding was just a taste of what the program could do.



Parklawn Building, pre-renovation

Chapter 5: The 2010s and Beyond

Introduction

At the start of the 2010s, the Affordable Care Act (ACA) resulted in major changes to the nation's health care system, which affected the Health Center Program in a variety of ways. Most immediately, with the additional funding provided by the ACA as well as continued bipartisan support in Congress, the Health Center Program would continue to expand greatly.

The 2010s would also see major developments in the way the Health Center Program conducted

Table 5: The 2010s by the Numbers

	2010	2016	2022
Health Centers	~1,100	~1,400	~1,400
Sites	8,100	10,400	~15,000
Patients	19.5 million	25.9 million	30.5 million
Funding	\$2.2 billion	\$5.1 billion	\$5.5 billion

Source: UDS

oversight of its awardees, including the new Compliance Manual and Site Visit Protocol, as well as efforts to recognize the highest-performing health centers and foster innovations that could be shared throughout the health center universe. As the decade came to a close, BPHC underwent a strategic planning initiative and reorganization that resulted in major changes to the way work is divided among staff and the way health centers interact with the bureau.

As the 2020s began, the COVID-19 pandemic placed the nation's health care system under unprecedented strain. Health centers were called on to play a central role in responding to the pandemic, providing testing, treatment, and ultimately vaccines to millions of the nation's most at-risk individuals. In the process, the Health Center Program would be transformed yet again.

The Affordable Care Act

At the very start of the Obama administration, the American Recovery and Reinvestment Act (ARRA) had resulted in a significant expansion of the Health Center Program (see chapter 4). BPHC received \$500 million to support new health center sites and \$1.5 billion for capital improvement projects. But another big change was coming.

The ACA was signed into law in March 2010. It led to further expansion of the program, including a brand new funding mechanism, and it also led to major changes in the nation's health care landscape—including the populations served by health centers.

Impacts of ACA on the Health Center Program

Increased Access, Increased Services

The ACA led to a lot more patients visiting health centers. Between 2009 and 2014, when the law was fully implemented, visits went up by 22 percent. One of the goals of the law was to expand insurance coverage for uninsured Americans, and the impact it had was apparent at health centers. The proportion of patients with Medicaid went up by 10 percentage points, while the proportion who were uninsured went down by 9 percentage points.

The ACA also provided more than \$1.6 billion for further capital investments at health centers, continuing the expansion begun with ARRA capital funding. Health centers were able to use these investments, along with the additional operating funds allocated for the Health Center Program (see below), as well as the increased revenue from Medicaid reimbursement due to so many patients who were newly covered, to expand the range of services they provided in the wake of the ACA.

Health centers were able to accommodate the increase in patient visits and services in part because of an increase in staffing. Between 2009 and 2014, total employees at health centers increased by 38 percent, with particularly large increases in dental providers (69 percent), mental health providers

There was the American Recovery Act, which at the time we thought was a once in a lifetime expansion of the Health Center Program. And then one year later was the Affordable Care Act, which was the second once in a lifetime opportunity to expand the program. The Bureau of Primary Health Care really began to grow.

—Gina Capra, former BPHC official

(73 percent), and pharmacy personnel (48 percent). This increase was likely due in part to another aspect of the ACA: a large increase in funding for the National Health Service Corps (NHSC).

The ACA permanently authorized the NHSC, and it provided mandatory funding through the same mechanism as the Health Center Program (see below). The NHSC budget increased from \$141 million in 2010 to around \$300 million for each of the subsequent years.

In addition, the ACA created the Teaching Health Center Graduate Medical Education program to alleviate the ongoing shortage of primary care providers in rural or otherwise underserved areas. This program funds the training of physicians and dentists at health centers and other community-based settings. Studies have shown that residents trained at health centers or in similar settings are more likely to continue practicing in underserved areas (Chen et al., 2012). There were 11 teaching health centers in the inaugural cohort, and this has risen to 81 program participants as of the 2023–2024 academic year.

Jana Eubank, Executive Director of the Texas Association of Community Health Centers, highlights the importance of this program for providing a pipeline of future providers:

After the ACA, that was the first time that health centers were acknowledged as having an important teaching role, which would ultimately create the pipeline that we needed to have adequate physicians staffing the health centers. Workforce has always been one of our vulnerabilities. One of our long-term strategies needs to be growing our own.

Mandatory Funding

The ACA permanently authorized the Health Center Program (before, the program had required periodic renewal by Congress), and it established a new source of mandatory funding: the Community Health Center Fund (CHCF). The CHCF was intended to provide a more stable source of funding for the Health Center Program. More stable funding levels would allow health centers to plan more effectively from year to year.

The CHCF initially provided \$11 billion for the Health Center Program spread out over 5 years. Combined with the program's annual discretionary appropriation, this led to increases in BPHC's total budget throughout the Obama administration. While the total budget for the program was around \$2 billion at the end of the George W. Bush administration, it increased to the \$3 billion range in the

first years after passage of the ACA, and the total had reached \$5 billion by 2015. The CHCF has been extended by Congress for subsequent 2- or 3-year increments several times. It continues to provide approximately two-thirds of the Health Center Program's operating budget.

Since the CHCF must be renewed periodically, it has led on several occasions to concerns about a "fiscal cliff." If the period of authorized mandatory funding ends without Congress having renewed the CHCF, a large portion of the Health Center Program's budget will abruptly disappear, leaving only the discretionary funds. As Sara Rosenbaum, a longtime expert on the health center movement, explains:

The CHCF is a reliable way of getting funding, but it also means that at the end of the funding period, instead of being able to assume a baseline of current funding plus or minus whatever it's going to be, you're suddenly faced with a potential drop to zero.

Outreach and Enrollment Assistance

One of the key elements of the ACA was an expansion of Medicaid eligibility, along with tax credits for the purchase of private insurance and creation of a health insurance marketplace. When these options became available, health centers were called upon to help enroll eligible patients in Medicaid and to help share information about the marketplace.

In 2013, \$150 million was awarded to all HRSA-funded health centers to help enroll the uninsured in new health insurance plans. Health centers were expected to hire thousands of outreach and eligibility assistance workers and to hold community events and provide educational materials. "Health centers work in communities across the country," HRSA Administrator Mary Wakefield said at the time, "giving them a unique opportunity to reach the uninsured in their communities and help connect them with the benefits of health insurance coverage under the health care law."

According to Jana Eubank:

That was the first time we had been acknowledged as a key player in outreach and enrollment. Health centers really led the way nationally to enroll currently uninsured people into Medicaid and the health insurance marketplace.

The ACA made a huge difference for the program. There were many people who had previously been uninsured, and suddenly they were insured. And the law provided a lot more resources for health centers in order for them to become health homes, provide additional services, and see more people.
—Tonya Bowers, Deputy Associate Administrator

Assessing Compliance with Program Requirements

The Health Center Program achieved a major milestone in 2017 with the release of the Compliance Manual. This document enabled BPHC to provide better oversight of health centers, with greater consistency and predictability. It also enabled health centers to understand more clearly what was expected of them. By understanding the requirements and seeing exactly how HRSA would assess their compliance, health centers were able to proactively identify and rectify problems more quickly, often without having to go through HRSA's progressive action process.

Health Center Program Expectations

From the earliest years of the program, there had been a perennial challenge documenting exactly what was required of health centers and how they could show they were doing it. The statute governing the Health Center Program was first passed in 1975, followed by a major revision in 1996, and additional changes were made in 2002 and 2018. For the first decades of the program's existence, when oversight was largely maintained at the regional level, interpretation of the statute was in the hands of individual project officers and regional leadership. This led to a frustrating level of inconsistency.

An important effort at bringing all the requirements together in one convenient place was made in 1996 with the first version of the Health Center Program Expectations. The Program Expectations were revised into their most enduring form in 1998, issued as Policy Information Notice 98-23.

Dr. David Stevens, BPHC's Chief Medical Officer at the time, was involved in creating the document. He describes it as an effort to document not just what was required, but what was helpful to foster a strong organization. "We used the word 'must' when it was a regulation or a law, but we would use 'should' for anything that was a best practice. We wanted them to see these were excellent practices that organizations should try to adapt to their program."

Not everyone found it entirely user-friendly. "The Program Expectations were really vague," Bobbi Ryder, a health center director in the early 1980s and later the director of the National Center for Farmworker Health, recalls. "Let me tell you, as a parent, there's a lot of difference between a rule and an expectation. When they moved away from almost 80 pages of expectations to just 3 1/2 pages of requirements, my life got a lot easier."

The Summary of Program Requirements

In 2007, BPHC took a step towards concision with the Summary of Program Requirements. This was an attempt to capture and summarize what was truly required of health centers. While the Health Center Program Expectations was a nearly 80-page document, the Summary of Program Requirements was just a few pages long. It consisted of a numbered list of requirements, with a few sentences about each one. Early iterations contained up to 28 items, but this was soon condensed to 19. (For many years, the "19 program requirements" was familiar shorthand at the bureau and health centers.)

According to Amanda Ford, Deputy Director of BPHC's Office of Policy and Program Development:

The Summary of Program Requirements was a significant attempt at helping both internal and external stakeholders understand what was required of health centers. Previously there were a lot of "shoulds" versus "musts." They were not catalogued in a very systematic way. They didn't really define what it meant to be a health center.

But a brief summary could not accommodate all the details necessary for ensuring compliance. Throughout the 1990s and 2000s, a significant body of separate policy and guidance documents accumulated. Policy Information Notices (PINs) provided detailed information about policies and procedures that health centers were required to follow. Program Assistance Letters (PALs) summarized or explained important topics and provided recommendations.

Eventually there were dozens of PINs and PALs. Certain PINs would remain in use for many years (such as PIN 98-23, the Health Center Program Expectations, which was still being cited as bureau policy until 2011). Others would be re-issued regularly—sometimes on an annual basis—with each new version superseding its predecessor. Over time, it became increasingly difficult to determine what the latest guidance was on any given topic.

The Health Center Program Compliance Manual

The need was clear for a new resource that would pull everything together into one place and make it as user-friendly as possible. But it didn't happen overnight. "When it came out in 2017, the Compliance Manual was the product of more than a decade of work," according to Diana Koorkanian-Sauders, a longtime contractor in BPHC's Policy Division.



2010

Affordable Care Act provides \$1.6 billion for capital development at health centers. It also creates the Community Health Center Fund, which provides mandatory funding for the program.



2011

First Grantee Satisfaction Survey.

We had to really sit down with the Health Center Program statute, and the regulations, and analyze and operationalize them for the modern health center world. We were working off regulations that were written in the 1970s, consolidated in the mid-1990s. I can't say enough about it. It was a huge milestone.

The Compliance Manual provides a step-by-step guide for health centers to understand exactly what they need to do in order to remain in good standing with the Health Center Program. Each chapter describes exactly what is required in a particular area, the legal basis for the requirements, and what a health center must do to demonstrate compliance. It also notes some areas where health centers have discretion, and it provides some suggestions for best practices that are not strictly required. But these are kept brief, so that the focus remains squarely on what is truly a requirement. The Compliance Manual replaced almost all the PINs and PALs, becoming the unified source of policy guidance for the program.

The Site Visit Protocol

The Compliance Manual was followed one year later by the first edition of the Site Visit Protocol (SVP). Aligned with the chapters and sections of the Compliance Manual, the SVP provides the precise methodology for HRSA staff and consultants to follow when conducting operational site visits (OSVs) at health centers.

Amanda Ford describes what it was like to conduct a site visit before the SVP: “We were showing up, we were evaluating, we were engaging with the health center board and learning about what they were doing. But there was this range of variability depending on who went, and their experience, and other factors.” The SVP made the process much clearer and more consistent.

Quality Improvement Efforts

The 2010s saw continuing efforts by BPHC to ensure that health centers were providing truly high-quality care. One way of doing this was to encourage and assist health centers to receive accreditation, particularly recognition as Patient-Centered Medical Homes (PCMH). BPHC also instituted the Quality Improvement Awards (QIAs) to incentivize improvement, before transitioning into a new class of awards intended to foster quality improvement innovations.

Accreditation Initiative

HRSA contracts with three organizations to work with health centers in gaining and retaining accreditation and/or recognition:

- The Joint Commission
- The Accreditation Association for Ambulatory Health Care
- The National Committee for Quality Assurance

For ambulatory health care accreditation, a health center must meet standards of quality for care delivery and patient safety. This accreditation functions as a “stamp of approval,” according to Dr. Suma Nair, former director of BPHC’s Office of Quality Improvement. “We think it’s really important for health centers to show they can meet the standards of these independent accrediting organizations.”

Health centers began to seek ambulatory health care accreditation from what was then called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the 1990s. In 2000, approximately 18 percent of health centers (200) were accredited by JCAHO. By 2005 the number had risen to nearly 30 percent (300) (GAO, 2005). The number today is around 23 percent (318), in part because the bureau has begun to place greater emphasis on PCMH recognition.

For PCMH recognition, a health center must demonstrate a commitment to patient-centered care and meet standards for care coordination and ongoing quality improvement. The PCMH model places the focus on the patient, with awareness of their unique needs, culture, values, and preferences. It emphasizes the relationships forged between providers, patients, and their families as they work in partnership to support the patient’s needs. It also emphasizes care coordination: the team of physicians, nurses, pharmacists, therapists, nutritionists, social workers, and so forth who care for a patient are expected to work together to ensure the patient receives comprehensive care. The PCMH model has been shown to yield better care for chronic illness, better preventive care, improved patient safety, increased patient and provider satisfaction, and cost savings for the health center.

BPHC started to promote the PCMH model in 2010. According to Dr. Nair, “All the early research showed that staff liked it better, patients liked it better, it was better for cost and health outcomes. So we started investing in that.” At first only about 1 percent of health centers had received PCMH recognition, and the process was considered difficult. Health centers needed to retrain their staff, update their procedures, and then provide a lot of documentation and data to qualify.

When the Compliance Manual was issued, that was transformative. Not just in terms of identifying what the statutes said, what the requirements were, but also how BPHC would assess health centers’ ability to demonstrate compliance. Everyone could read the same words. It allowed everyone to operate from the same page—the project officers, the program staff, and the health centers themselves. It outlined exactly what we would expect when we came to see if they were in compliance.

—Amanda Ford, Deputy Director, Office of Policy and Program Development

Accreditation lets health centers demonstrate that they are providing the same quality of care as hospitals or other organizations. It helps to show the value of the program, because our health centers really are providing such high-quality care.

—Tonya Bowers, Deputy Associate Administrator

Dr. Nair recalls:

So we thought, if we believe in this and this is good, what can we do to scale and spread adoption? We started with incentives to help cover the cost of a health center going through the PCMH transformation process. Our contract support helped pay for their surveys and technical assistance. Then we did small grants, like \$25,000 or \$35,000, to give a little more assistance.

Next we thought, we need to leverage our strategic partners. A lot of this change was being driven at the state level, so we partnered with our Primary Care Associations, gave them some additional resources, and made one of their objectives to help their health centers become Patient-Centered Medical Homes. We asked them to bring all of the right points of contact from the state together to have a learning community, to support health centers with this transition.

As a result, the number of health centers that had achieved PCMH recognition rose from 1 percent in 2010 to around 70 percent by 2016. The number was 78 percent in 2023.

Quality Improvement Awards

Along with all the major funding for service expansion, capital development, etc., the ACA provided \$36.3 million to recognize health center quality improvement achievements (Jin et al., 2022). The first QIAs were given to 1,113 health centers in 2014. This was the first time funding was provided to health centers for meeting quality metrics.

The categories included use of electronic health records, exceeding national averages for various clinical benchmarks, overall clinical quality, and improvement in clinical quality measures over the previous year. Assessment was made based on the previous year's Uniform Data System (UDS) report. Virtually every health center received some recognition, particularly in the improvement category. But those that showed the highest performance (particularly the National Quality Leaders, who surpassed national benchmarks) received the most funding. Thus, almost every health center could expect some recognition, even if just for relative improvement over the previous year, while the overall top performers received more support (Jin et al., 2022).

Another round of QIAs was given in 2015, with \$63.3 million in additional funding from the ACA awarded to 1,153 health centers. A new "Access Enhancers" category was added for health centers that increased their total number of patients and the number of patients receiving comprehensive services, and a new "Value Award" was given to health centers that improved their cost efficiency. Further rounds of QIAs followed through 2020, with total amounts over \$100 million each year. Additional categories were added in subsequent years for advancing the use of health information technology, addressing health disparities, and achieving PCMH recognition.

The QIAs were popular with health centers, because of the financial support they provided but also because of the encouragement and recognition they conferred. Bobbi Ryder remembers "the pride I saw in the eyes of medical directors when they would receive those awards." James W. Hunt, Jr., former CEO of the Massachusetts League of Community Health Centers, describes how important the QIAs were for morale: "At a lot of health centers, their quality awards from the bureau would be featured in the lobby or somewhere prominent. Sometimes there would be copies at the desks of individual staff or providers."



2014
First Quality Improvement Awards recognize health centers for high achievement or improvement over time.



2017
BPHC issues the Health Center Program Compliance Manual, which documents exactly what health centers must do to remain in compliance with program requirements.

I think a real hallmark of Jim Macrae's leadership is getting feedback. "How are we doing?" Sometimes it's painful to hear. But it's extremely important for both internal and external improvement.

—A former BPHC official

In the wake of the COVID-19 pandemic, BPHC transitioned away from the QIAs to develop new initiatives to recognize and incentivize quality improvement. According to Amanda Ford:

Health centers really loved the QIAs. They were getting recognized for doing great things. But we weren't really spurring innovation. The awards were retrospective. And then with COVID, we knew the data would be impacted, and we wanted to think about a different way to use our resources that would advance the program.

In 2022, BPHC launched the Quality Improvement Fund (QIF), which provides health centers with funding to develop, test, and disseminate innovative solutions for addressing emergent public health challenges. The first QIF award (\$55 million to 29 health centers) focused on Optimizing Virtual Care. Recipients were committed to improving the use of health information technology and virtual care models—a critical priority in the wake of COVID-19. The 2023 QIF award (\$67 million to 36 health centers) focused on maternal health. Recipients were committed to reducing maternal mortality and morbidity, as well as racial and ethnic maternal health disparities.

The key to the QIF is learning lessons from health centers that have directly experienced and overcome challenges, then sharing those lessons widely. Similar to the Models That Work initiative in the 1990s, the QIF is designed to support innovative solutions developed by particular health centers and then help adapt and bring them to scale across the entire health center universe.

BPHC also transitioned its recognition efforts, creating the Community Health Quality Recognition (CHQR) badges to recognize health centers that have made notable improvements in areas such as access, quality, health equity, and health information technology, based on UDS reporting. These badges can be posted at the health center or on the health center's website, signifying HRSA's recognition of the health center's achievement in providing high-quality care. But CHQR badges don't come with additional financial support.

Grantee Satisfaction Survey

Beginning in 2011, BPHC began conducting a survey of grantees to gain a better understanding of their experiences interacting with the bureau and its technical assistance partners. The survey asked about their level of satisfaction with the grant application process, the Health Center Program's guidelines and policies, the Federal Tort Claims Act (FTCA) program, and technical assistance

they had received from the bureau, Health Center Controlled Networks, or National Cooperative Agreement partners.

In 2012, the survey expanded to become an annual HRSA-wide initiative to assess satisfaction among all HRSA grantees (HRSA, 2023d). The survey provides information that is incorporated into HRSA's efforts to improve grants management procedures and customer service. It assists HRSA in its efforts to gauge, understand, and effectively respond to the needs and concerns of its customers, and provides indicators regarding the best areas to dedicate resources to improve customer service, support continuous quality improvement efforts, strengthen partnerships, and improve the efficiency, quality, and timeliness of business processes.

Tonya Bowers remembers: "The first time we did that survey, it was exciting. It was our first time getting that real pulse check from our grantees about what we were doing well and where there was room for improvement." Another BPHC leader describes the survey as a great opportunity for "real-time feedback that enables us to course-correct, if needed, to improve our processes."

Tess Kuenning, CEO of Bi-State Primary Care Association, describes the grantee survey as an example of BPHC's continual efforts to improve: "An exemplary attribute of any strong organization, and one that the bureau regularly embodies, is to ask itself: if something isn't working, is there a better way to go about it? They collect the data, they analyze it closely, and they identify process improvements."

Strategic Planning and Reorganization

BPHC has undergone many reorganizations through the years. New branches, divisions, and offices have come and gone. New strategies for merging or dividing managerial responsibilities from programmatic work have been tried. In 2015, as the result of a strategic planning initiative called BPHC 2.0, the Office of Strategic Business Operations was created, bringing together communications, information technology, and staff training and development in a new office that was dedicated to supporting staff in the other parts of the bureau so they could perform their work with maximum efficiency. BPHC grew quite a bit at this time: from around 300 full-time employees in 2015 to more than 400 in 2017.

Beginning in October 2018, BPHC embarked on a new effort to think about where the bureau and the Health Center Program should be in a few years. What did health centers need in order to truly become leaders in primary health care? What should BPHC's compliance monitoring processes

Having the project officer be the one person a health center could go to for everything was both good and bad. Some health centers felt like everything rode on that project officer's shoulders and their relationship with that project officer. If the project officer was someone the health center didn't get along with, they could really struggle.

—Katie Ballengee, Deputy Director, Office of Health Center Investment Oversight

look like? Should the bureau structure be changed again? Would BPHC need new technologies or capabilities to achieve its goals? Staff and leadership held brainstorming sessions, formed working groups, and gradually assembled a list of proposed strategic shifts.

The initiative was ultimately known as “BPHC REACH” (Reaching for Excellence, Advancing Community Health), and it was making headway in early 2020 when the COVID-19 pandemic began. But bureau leadership believed the initiative was too important to sideline or suspend. Even as the response to COVID-19 dominated the bureau's work, staff and leadership continued to invest time and effort in reimagining how the Health Center Program could be improved for future success. Health centers were also involved, providing feedback and helping to pilot new ideas as they were developed.

Some of the changes that emerged from BPHC REACH included a new division focused on innovation, a new division focused on leveraging all types of data, and a new Chief Data Officer. But perhaps the largest change was a reorganization of the bureau's two large offices tasked with oversight and grants management.

The program had always relied on project officers who worked with particular health centers and provided most of the input and oversight for those health centers. The project officers were organized according to geography. In the most recent structure, one office handled all the health centers in the north, the other managed health centers in the south. In August 2021, this entire structure was changed. New offices of Health Center Investment Oversight and Health Center Program Monitoring were created, and the former project officers were reassigned to new roles.

Rather than acting as generalists, the former project officers now became specialists in one type of funding or one area of monitoring. This meant they could really focus and become experts, rather than trying to maintain a little bit of knowledge about every aspect of the program. They could ultimately provide better customer service to health centers, and the program could leverage their talents and expertise to work towards higher goals like improving health outcomes and reducing health disparities.

The Opioid Epidemic

Health centers have been increasingly called on to respond to public health crises. A notable crisis of the 2010s was the rise in opioid overdose deaths. In response to this crisis, HRSA awarded several rounds of funding to health centers for the expansion of substance use disorder (SUD) and mental health services: \$94 million in 2016, \$200 million in 2017, and \$352 million in 2018. This funding enabled health centers to increase the number of patients screened and treated for SUD, provide training and educational resources for providers, and expand access to medications for opioid use disorder (MOUD).

The number of health center patients receiving MOUD increased from just 39,000 in 2016 to nearly 194,000 in 2022, with more than 10,300 health center providers eligible to prescribe the treatment.

By integrating screening and treatment for mental health and SUD with their other services, including safe and effective pain management, health centers are able to offer higher-quality care for those struggling with opioid use disorder or other behavioral health challenges. However, health centers are currently only able to meet an estimated 27 percent of the need for mental health services and 6 percent of the need for SUD services among their patients.



Matt Kozar, Jessamy Taylor, Tonya Bowers, and Jim Macrae at BPHC REACH planning session, 2019

I believe substance use disorder requires BPHC's attention. The overdose crisis in our country right now is staggering. There's a real role for BPHC here, particularly in providing medications for opioid use disorder.
—Dr. Barbara DiPietro, Senior Policy Director, National Health Care for the Homeless Council

COVID-19

In early 2020, reports began circulating of a highly contagious new infectious disease that was spreading in certain parts of the world. Within a short period of time, COVID-19 would become the biggest global health crisis since the influenza pandemic of 1918, resulting in more than 770 million confirmed cases and nearly 7 million deaths worldwide as of late 2023.

The impact on HRSA, BPHC, and the Health Center Program would be immense. Congress would authorize billions of dollars to be distributed to health centers at lightning speed to help them endure the emergency and respond to the virus, while continuing to provide essential primary care. Entire new programs would be launched by HRSA, with new logistical challenges the agency had never before experienced.

The Health Center Program would prove to be one of the central planks in the nation's response to COVID-19, providing essential care for individuals and communities most at risk from the disease, and the work undertaken by HRSA and BPHC staff would save many lives. But all of that still lay ahead in mid-March 2020, when the most pressing challenge was simply to understand what was happening.

The command meetings started because Jim was being bombarded with information from the White House and the Department, and he wanted to get it out to a wide array of individuals. We didn't have time for it to filter down through the typical chain of command.
—Matt Kozar, BPHC official

The Initial COVID-19 Response

On March 16, 2020, BPHC staff—along with HRSA staff and most other employees throughout the U.S. government, as well as schools, private businesses, and many others—began operating under “maximum telework flexibility.” Suddenly everyone was working from home, 100 percent of the time, for the foreseeable future. At a time when rapid information-sharing and decision-making were of the utmost importance, BPHC staff were unable to meet in person. At the same time, the need for clear communication was greater than ever.

In the first days of the response, BPHC leadership began holding multiple calls each day with office directors and other key staff from throughout the bureau. By mid-April 2020, 40 staff from throughout the bureau had been organized into six teams, each tasked with addressing a different aspect of BPHC's COVID-19 response. These teams reported on their activities to BPHC leadership at twice-daily Incident Command calls.

Meanwhile, others in the bureau labored to take up the slack for colleagues who were now entirely focused on COVID-19, as the need for ensuring that health centers could provide high-quality primary health care had not gone away during the pandemic—in fact it was more important than ever. The pace of work was quick, the pressure was intense, and staff burnout was an ever-present risk. BPHC worked to increase its staffing capacity—growing from about 430 full-time employees at the start of the pandemic to more than 480 by the summer of 2021, and surpassing 520 in the fall of 2023.

BPHC's communications staff coordinated frequent updates to the website and released a steady stream of email bulletins for health centers and other external stakeholders. They also developed a



2018

BPHC issues the Site Visit Protocol, which documents exactly what will be reviewed during an operational site visit.

The COVID-19 public health emergency has really been a test of our mettle. It has really shown us how we can be agile and work at a heightened pace.

—Ernia Hughes, Director, Office of Health Center Investment Oversight

rapidly growing set of FAQs, with answers to health centers' many urgent questions: Would BPHC still be conducting scheduled site visits? What would happen to health centers whose funding was due to expire? Where could health centers obtain personal protective equipment (PPE) for their staff? What were the rules around transitioning from in-person services to telehealth?

To better understand what was happening at the health centers, BPHC launched a voluntary weekly survey in April 2020. Health centers were asked to report on the number of tests they had provided, the percentage of virtual visits, the number of site closures, staff who tested positive, and their need for additional PPE or other supplies.

In the early months of the pandemic, this survey provided a critical window on the impact COVID-19 was having on health care facilities across the country. Other parts of the government requested frequent updates from HRSA based on the data from the health center survey. To meet the high level of external interest, HRSA developed online dashboards that conveyed the latest survey data on health center operations, testing, and eventually vaccinations, at the national level or by state. This all required significant expansion of BPHC's data processing staff and capabilities.

Because of the sudden drop in patient visits, health centers were facing the prospect of acute financial shortfalls in the spring of 2020. HRSA was able to blunt the impact of these shortfalls by rapidly distributing emergency funds. The first round of emergency supplemental funding for all health centers was released on March 24, totaling \$100 million. A second round was released on April 8, totaling \$1.3 billion. This was soon followed by a third round—which went to both health centers and, for the very first time, look-alikes—totaling \$600 million.

To put these amounts in perspective, the original total appropriation for the Health Center Program in fiscal year 2020 had been \$5.6 billion. During the first few months of the pandemic, HRSA distributed an additional \$2 billion to health centers. The money was distributed as quickly as possible, so that health centers could immediately put it to use. BPHC also leveraged grant flexibilities to extend the health centers' award periods of performance by an additional year, so they would not have to worry about applying for continued funding during the crisis.

At the same time, other parts of HRSA were using emergency funding and any flexibilities they could identify to support their own programs. In April 2020, the Ryan White HIV/AIDS Program awarded \$90 million in COVID-19 emergency funding to its clinics. The same month, HRSA awarded nearly \$165 million to small rural hospitals and telehealth resource centers in rural communities to fight the pandemic. In May 2020, HRSA provided \$225 million to rural health clinics to fund COVID-19 testing.

Through this funding and support from HRSA and other parts of the government, health centers were able to weather the initial blow of the first months of the pandemic. The next challenge was responding directly to the virus to track its spread and protect patients from harm.

COVID-19 Testing, Contact Tracing, Treatment, and Vaccines

By May 2020, 90 percent of health centers were providing testing, and about two-thirds of these health centers provided walk-up or drive-through testing. A majority of the people tested were racial or ethnic minorities (Corallo & Tolbert, 2020). Health centers provided a crucial source of COVID-19 testing, at a time when it was not easy to find a test, and when the ability to accurately identify individuals who were infected could mean the difference between life and death.

Health centers also played an important role in contact tracing—the process of identifying people who might have been exposed to an infection, so that they could be tested and begin to quarantine. According to James W. Hunt, Jr., former CEO of the Massachusetts League of Community Health Centers:

Here in Massachusetts, all of our health centers contracted with partners to provide contact tracing for many thousands of individuals. Many were BIPOC, people who were underserved, the hardest to reach and probably the most reluctant to give up personal information except to a trusted source. Who was the trusted source? Their community health center.

We issued the COVID-19 funding without any applications being submitted. We did all the work on the back end, and that was novel both from a programmatic standpoint and also from a systems standpoint. We had to create new ways to get the money out, and we worked with our IT and grants colleagues to figure out how to do it, to get that money into the health centers' hands as quickly as we could. It was critical.

—Matt Kozar, BPHC official

When the story of this pandemic is written, you're going to stand out among its heroes. —President Joe Biden to health center representatives at the National Association of Community Health Centers conference in February 2022

As monoclonal antibody treatments became available in the fall of 2020, health centers were among those offering the treatment. And when the first vaccines became available in December 2020, health centers were chosen to spearhead their delivery to underserved communities. Health centers began vaccinating their staff and their most vulnerable patients in January 2021, at a time when vaccines were in extremely short supply. Then in February 2021, the Health Center COVID-19 Vaccine Program was launched.

The Vaccine Program was a departure for BPHC. “The bureau really had to pivot,” according to Diana Koorkanian-Sauders. “Suddenly we were involved in logistics and shipping. That was a really new experience.” Because of the challenges involved in launching an entirely new program of a type that was novel to the bureau, the Vaccine Program started small, with just a pilot group of 250 health centers in its first month. The program expanded to an additional 700 health centers in March 2021, and it opened to all health centers and look-alikes in April 2021. Participating health centers could request shipments of vaccine directly allocated from HRSA, to supplement the vaccine they were receiving through their states or jurisdictions.

Throughout the spring and summer of 2021, as vaccine supplies across the country remained limited, the Health Center COVID-19 Vaccine Program ensured that a dedicated supply of precious vaccines was being provided to those who needed them most—people experiencing homelessness, residents of public housing, migratory and seasonal agriculture workers, the elderly, those with low income, racial and ethnic minorities, and all the other underserved individuals and communities who rely on health centers for their care.

Many health centers held community vaccination events. For instance, in January 2021, Community Health Center, Inc. (CHC) put together a mass drive-through vaccination clinic in a stadium in East Hartford, Connecticut—planning the entire operation in a matter of days (Barber, 2022). Two staff members worked to map out the site, arrange for staff and equipment, obtain trailers, traffic cones, lights,

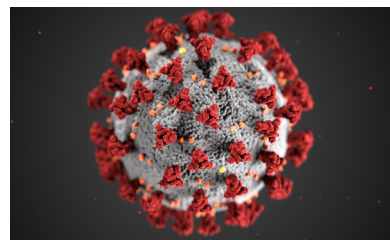
portable toilets, refrigeration and freezer units, plus National Guard support. Hundreds of providers, including physicians, nurses, dentists, psychiatrists, podiatrists, veterinarians, and more, answered the call to help administer vaccines. Within weeks, CHC was administering thousands of vaccines a day at the site. By November 2021, they had administered more than 550,000 vaccine doses, enabling Connecticut to rank as one of the top states in the nation with the highest vaccination rates and lowest infection rates.

Bobbi Ryder recalls her pride at receiving her COVID-19 vaccine at a similar event at a health center she had helped establish in San Antonio, Texas:

From the 1980s to today, health centers went from being the world's best kept secret to being, I think in many ways, the savior of public health. I got my vaccination for COVID-19 in January 2021 at my local health center, and I was so proud I could have burst. They had the whole thing set up in the parking lot. They had nurses and medical assistants going from car to car, administering vaccines through the car windows. The only thing they were lacking was roller skates.

Recovering from the Pandemic and Finding a New Normal

In April 2021, HRSA distributed \$6.1 billion in American Rescue Plan Act funding for health centers to continue COVID-19 vaccination, testing, and treatment, as well as other critical activities. This was followed in July by \$144 million in American Rescue Plan Act funding for look-alikes, and then in September by nearly \$1 billion in additional funding for health centers to undertake construction and renovation projects. (For context, the Health Center Program's original total appropriation for 2021 was just under \$5.7 billion.)



2020
Health centers receive \$2 billion in emergency supplemental funding to respond to the COVID-19 pandemic.



2021
Health centers receive \$6.1 billion in emergency supplemental funding to respond to the COVID-19 pandemic.

HRSA launched additional programs in late 2021 and early 2022 to provide at-home self-testing supplies and high-quality face masks for free distribution by health centers, and also to provide health centers with a dedicated supply of COVID-19 oral antiviral medications. These programs helped to blunt the later waves of the pandemic.

The Vaccine Program ended in August 2023, having provided a final total of nearly 15.3 million vaccine doses for the nation's underserved. Health centers would continue to receive vaccines through the commercial market, with support from CDC's Bridge Access Program ensuring continued access for uninsured or underinsured adults through the end of 2024. Including vaccines received from all sources, health centers had administered more than 24 million total doses by the end of 2023.

The Health Center Program changed during the pandemic in some ways that seem likely to be here to stay. For example, BPHC began conducting virtual OSVs, reviewing documents electronically and communicating with health center leadership and staff via teleconferencing. The process has proven so successful, the bureau continues to use it in many cases even as in-person visits have also resumed.

With the experience gained during the pandemic, and with the capital investments made through the American Rescue Plan Act, health centers are poised to flourish in the coming years as the nation continues to recover from the trauma of COVID-19.

Summary

The Health Center Program has increasingly been called upon to respond during crises. From hurricanes, to wildfires, to almost anything else that threatens the health of communities across the nation, health centers are a crucial part of the response. When a global pandemic threatened the lives and well-being of millions of Americans, falling especially hard on the low-income, the elderly, racial and ethnic minorities, and other underserved or at-risk communities, health centers were ready to answer the call.

BPHC has made great strides in the last decade—as it did in each of the decades before—to strengthen its ability to provide resources where they are needed the most, to ensure proper oversight of those resources, to help health centers when they need assistance, to share lessons-learned so that all may benefit, and to collect comprehensive data that enables the bureau to keep telling the story of this program and all that it has accomplished.



2021-2023

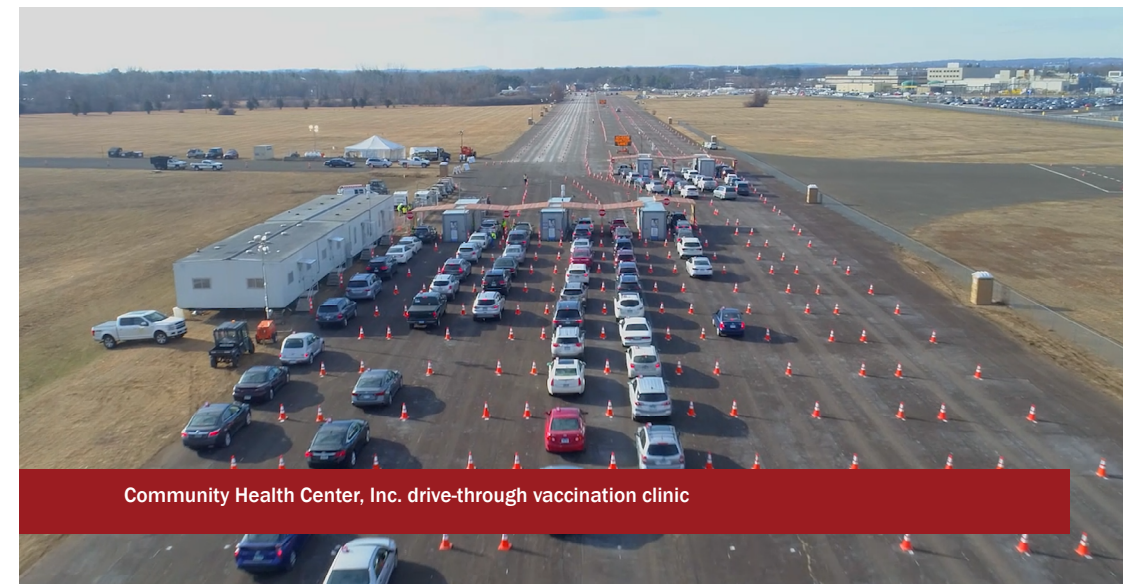
Health Center COVID-19 Vaccine Program provides nearly 15.3 million vaccine doses to underserved individuals and communities.

“I think from the beginning, health centers have understood that the bureau really is their partner,” former HRSA official Jack Egan reflects. “The bureau is in it with them. It’s not just some ghostly bureaucratic system. It’s an organization that really connects with the communities and connects with the grantees. And I think that’s pretty unique for a federal program.”

The Health Center Program is the product of starry-eyed idealists, dedicated project officers and program staff, skilled technicians, legislative experts, data gurus, and innovative managers within the government who have shaped the program over nearly six decades. But it’s also the product of partnership. As BPHC Associate Administrator Jim Macrae puts it:

One of the things that has made the bureau so effective over the years is our engagement directly with community members. Whether it’s CEOs of health centers, board members of health centers, our patient surveys, our recent workforce survey.... That’s one of the core values of this program: we listen to the communities and we work in partnership with them.

Whatever challenges the future may bring, health centers will be there on the front line—and BPHC will be right there with them.



Community Health Center, Inc. drive-through vaccination clinic

We probably would not have survived the pandemic if it weren't for community health centers.
—Bobbi Ryder, former director, National Center for Farmworker Health

Epilogue: What Comes Next

History doesn't stop and wait while you write it down. During the period of time this report was being developed, a variety of new projects took shape within the Bureau of Primary Health Care (BPHC) that will impact the bureau's work in the coming years. Here are just a few.

Workforce Well-Being Survey

"One of the things I'm most worried about right now is the health center workforce," BPHC Associate Administrator Jim Macrae says. "There was strain on the health center workforce prior to the pandemic, with primary care being asked to take on more and more responsibility. Then COVID-19 added to that pressure and brought so many more challenges."

To understand the impact of the pandemic and other recent trends, BPHC administered its first national Health Center Workforce Well-Being Survey between November 2022 and January 2023 (HRSA, 2023c). The survey examined job satisfaction, engagement, burnout, and whether staff intended to stay at the health center. Nearly 50 percent of all health centers and look-alikes participated, and more than 52,000 staff responded.

After analyzing the data at the state, regional, and national levels and conducting comparisons along other metrics (e.g., health center size, staffing, provider type), BPHC sent each participating health center a link to an interactive dashboard of its own survey data, which allows them to compare their results with national, regional, and state averages. Aggregated national data has also been published on the BPHC website. BPHC will support targeted training and technical assistance based on areas of need identified in the survey.

UDS+ Initiative

Leveraging advances in health information technology, health centers will soon begin reporting Uniform Data System (UDS) data at the patient level rather than aggregated at the health center level.

As a health center director said to me the other day, COVID was the biggest challenge for the last two years, but the new biggest challenge is workforce.
—James W. Hunt, Jr., former director, Massachusetts League of Community Health Centers

The patient-level data will be "de-identified," so that privacy is maintained.

This change will allow BPHC to understand with far more granularity what factors influence the care patients receive and the outcomes they experience. With patient-level data, BPHC will be able to advance its quality improvement and health equity efforts by providing more tailored technical assistance and funding opportunities.

Health centers were invited to submit patient-level data during the 2023 UDS reporting cycle on a voluntary basis. Eventually all health centers will be required to do so.

Tonya Bowers, BPHC's Deputy Associate Administrator, describes this and other advances in UDS as critical for the bureau's future success:

The most important thing we can do right now is to continue to push forward on asking our health centers to deliver data. It is the most valuable currency that our health centers and our program are going to have. It's essential to have that data and to be able to demonstrate the impact that health centers are having in their communities, to be able to really see down to the patient level, in order to understand the impact of care over time.

BPHC 2035

BPHC has embarked on a new strategic planning initiative, focused on positioning the bureau for the future and ensuring that the Health Center Program continues to be a leader in providing access to care, improving health outcomes, and advancing health equity.

The initiative will involve outreach to health centers and other organizations that serve or support the work of health centers. "Health Center Network Partners" will consist of key partner groups that can help BPHC understand the broad implications of different possible strategies. "Affinity Groups" will focus on specific sub-populations and bring participants' on-the-ground, lived experience into the discussion. A "Strategy Council" will capture the perspective of BPHC staff.

Together, these groups will help the bureau anticipate future trends, challenges, and opportunities in community health care. Ernia Hughes, director of BPHC's Office of Health Center Investment Oversight, emphasizes the importance of remaining alert to the ever-changing landscape:

The changing landscape of health care always impacts the Health Center Program. We do not operate in isolation. Delivery of health care is a dynamic process, and we always need to keep pace with the forces in the ecosystem. That is a never-ending thing we have to be mindful of.

There are a lot of insurance providers that want to get to value-based payment, but we also need to demonstrate that it's not just paying for the physician. How do we demonstrate the value of what the community health worker is doing, or the nutritionist? How do we show that all the members of the health center team are contributing to improved health outcomes, so we can ensure the payment system reflects that?
—Margaret Davis, former BPHC official

Value-Based Care

One of the trends in health care today is the move toward value-based care. This is a health care delivery model that ties payments to patient outcomes, rather than reimbursing based on visits and services.

“So much of the reimbursement now is driven by the number of visits, but that does not always result in the best quality of care,” Jim Macrae observes. “So how do we redesign the payment system to make the most difference? To reflect the outcomes we want to see?”

BPHC is supporting health centers that provide value-based care, as well as health centers that are moving toward readiness to do so. BPHC is also working closely with the Centers for Medicare & Medicaid Services to provide input on potential value-based care models that are in development.

Health Equity and the Social Determinants of Health

“We’ve got pockets of people all over this country who are still severely underserved,” remarks Bobbi Ryder, former director of the National Center for Farmworker Health. “There’s a saying, ‘A society is only as strong as its weakest link.’ And I think that when we have a lot of weak links, it makes us as a nation very vulnerable.”

From its earliest days, the Health Center Program has been focused on improving health equity and reducing (indeed, eliminating) health disparities. But as the program has grown—with increasing focus on data, compliance monitoring, progress reporting, financial audits, and other oversight responsibilities—it has sometimes been too easy to overlook the larger context in which care is provided.

Rachel Gonzales-Hanson, longtime CEO of Community Health Development, Inc. and later an executive at the National Association of Community Health Centers, points out the many roles a health center may play in its community:

In a lot of communities, especially rural and frontier areas, it's more than just a health center. Sometimes they have to be the community action agency, as well as the food bank, the daycare, or whatever else the community needs that nobody else can provide or is providing. Understanding that is part of addressing the social drivers of health.

Sara Rosenbaum, a longtime expert on the health center movement, suggests that health centers should become more involved with community projects, like improving transportation infrastructure, helping to develop parks or community gardens, and other things “that make a community well, not just making the patients well.” As she points out: “That was Jack Geiger’s original vision—that the health center was going to change its community, not just tend to its patients.”

One of the goals of BPHC in the coming years—alongside the rest of the Health Resources and Services Administration (HRSA)—is to continue its work to improve health equity by addressing the social determinants of health. As HRSA Administrator Carole Johnson puts it:

Health care is about the circumstances in which people live, and the ways we make it possible—or challenging—for them to access services. If you have to take off work, and lose a couple hours of wages, and take two buses, and find child care in order to go see your provider, it makes it less likely you will seek that care. So we need to do everything possible to bring down those barriers, to make it easier for people to access the care they need.

Health centers make a life-changing difference in communities across this country, day after day. Here in HRSA, we are committed to ensuring that every community—whether it's a densely-populated urban area, or a rural community, or a frontier community—can continue to have access to high-quality care, and that health centers can keep changing people's lives for the better.

Appendix: Interviews

The following individuals were interviewed for this project. The authors offer grateful acknowledgment to these individuals for their time and assistance.

Rhoda Abrams
Onyekachukwu Anaedozie
Von Bailey
Katie Ballengee
Kelvin Benford
David Benor
Richard Bohrer
Tonya Bowers
Carolyn Bull
Darryl Burnett

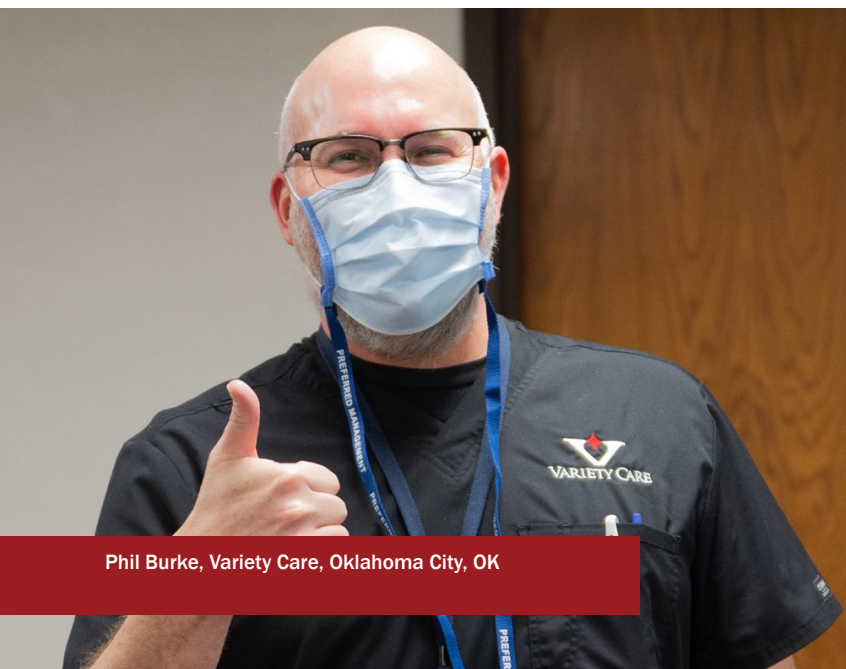
Gina Capra
Tina Cheatham
Thomas Coughlin
Regan Crump
Angela Damiano-Holder
Beverly Dart
Erin Davis
Margaret Davis
Barbara DiPietro
Jack Egan

Jana Eubank
Joe Fitzmaurice
Amanda Ford
Elmer Freeman
Roland Gardner
Marilyn Gaston
Rachel Gonzales-Hanson
John Hisle
Ernia Hughes
James W. Hunt, Jr.

Carole Johnson
Andy Jordan
Jennifer Joseph
Amanda Pears Kelly
Diana Koorkanian-Sauders
Matt Kozar
Tess Kuenning
Jacqueline Leifer
Jim Macrae
Edward Martin

Mark Masselli
Kate Mitchell
Timothy Montgomery
Suma Nair
Tracey Orloff
Joe Pierle
Angela Powell
Kyu Rhee
Bruce Riegel
Sara Rosenbaum

Bobbi Ryder
David Stevens
Charles Van Anden
Don Weaver
Brenda Wise
Lathran Woodard



Phil Burke, Variety Care, Oklahoma City, OK



Welcome sign at Family Health Centers, Louisville, KY



HRSA staff observe American Heart Month

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Nearly 60 years ago, the federal government launched a program that has changed the delivery of health care in this country.

From two initial clinics founded in the 1960s, the Health Center Program has grown to become an essential part of the nation's health care delivery system. Today more than 30 million people receive high-quality, affordable primary health care at one of the 1,400 health centers supported by the Health Resources and Services Administration. Learn about the history and critical events that shaped the program and the people who made it happen.

This is the story of a highly successful partnership between community organizations and the federal government.

