The Role of Federally Qualified Health Centers in Serving the Underserved: Understanding the Past to Navigate the Future

By

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Abstract

Federally Qualified Health Centers (FQHCs) have provided over 40 years of continuous service to the poorest patient populations in the country. Born out of the strongly democratic ideals of the civil rights movement of the 60s, they have continued to emphasize patient-centered care despite the ever-changing political landscape around them. FQHCs have demonstrated positive outcomes and effectiveness in their communities that gradually gained them faithful bipartisan support and advocates. One supporter was President George W. Bush. This paper reviews the Bush Administration expansion of FQHCs, the largest in their history. The study explores important motivators driving this rapid expansion and investigates the political and functional effect the expansion had on community health centers. METHODS: We used systematic literature review, review of Congressional documents, and structured interviews of elite stakeholders as the key data sources for this study. CONCLUSIONS: Many motivators lead to the legislative decision to expand federally qualified community health centers including convincing data of their effectiveness, demonstrated cost-efficiency, sense of urgency in the face of the worsening health care crisis, and a desire to avoid more drastic system-wide change. Ultimately, FQHCs continue to function well in the post-expansion era, however, many gaps in service delivery remain. RECOMMENDATIONS: Safety net expansion alone cannot adequately address growing health care needs in this country. However, FQHCs are an important part of the safety net and should be protected and preserved as we move incrementally towards more systemic change.
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Preface

Why did President Bush decide to endorse the health center movement, and what effect has his promotion of them had on their performance? I began my investigation with some skepticism about this unexpected move and hypothesized that his decision was largely a popularity play which ultimately would have no effect on health centers at best, and even possibly have negative consequences. I set out to probe and test this hypothesis by review of evidence from multiple sources.
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Introduction

The American health care safety net is made up of many parts, including Emergency Rooms, free clinics, and other ambulatory care centers. One part of this safety net has received attention and much needed funding increases over the past several years. Federally Qualified Health Centers (FQHCs), also called federally supported community health centers (CHCs), received a significant increase in funding during the Bush administration. While this increase in funding is eagerly accepted by advocates for CHCs and underserved populations, the underlying policy decisions that motivated this change are worth investigating, particularly since this originally Democratic program had its largest expansion in history under Republican leadership.

This analysis elucidates the decision making process that led to the passage of the CHC expansion bill by triangulating several methods, including a review of portrayals of the expansion in the popular media, primary federal documents, and interviews with key stakeholders to understand the policy making process from multiple perspectives. This multi-level approach allows for the possibility that the different data gathering techniques will converge on a single answer, strengthening analytical conclusions. Understanding this transition will help us interpret future changes in CHCs and may also be helpful for understanding political partnerships for other federal initiatives.

Historical Context

Doctors Sydney and Emily Kark were the pioneers of the community oriented primary care (COPC) movement. Doing most of their work in impoverished, rural South Africa in the 1940’s, the Karks quickly recognized the importance of public health principles to ensuring the health of the population. “COPC is a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services,” (p. 1750)¹. The Karks
achieved this by working in multidisciplinary teams and emphasizing prevention. Modern CHCs in this country, and many others, have borrowed on the foundational principles of COPC.

Community health centers were first established in the United States in 1965 as a part of the Johnson administration’s “War on Poverty” (See Table 1). They were designed to provide health and social services to poor and medically underserved populations and promote community empowerment. To this day, FQHCs have remained true to these original founding principles. FQHCs must meet these requirements (See Table 2)

- Being located in a federally designated medically underserved area or serve a federally designated medically underserved population
- Have non-profit status, public, or tax-exempt status
- Provide comprehensive primary health care services, referrals, and other enabling services needed to facilitate access to care, such as case management, translation, and transportation
- Have a governing board, the majority of whose members are patients of the health center
- Provide services to all in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts to family income

In the past 40 years, the community health center initiative in the United States has been able to demonstrate health delivery efficacy and cost efficiency. CHCs have been recognized as an integral part of the safety net and a model example of the medical home concept. A medical home is "a patient-centered, regular, and continuous source of primary care, proven to provide better health outcomes and lower costs of care." Having a medical home is a greater predictor of the likelihood of receiving health care than is health insurance status. Community health centers use and build on the medical home model to reduce health disparities among underserved populations and ensure a high quality of health care services. Over the years, performance research and cost analysis have repeatedly illustrated the worth of CHCs.
In 1994, the Institute of Medicine (IOM) defined primary care as, “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Policy researchers have since summarized and simplified this definition by breaking primary care down into its component parts: access, longitudinality, comprehensiveness, and coordination.

CHCs fulfill this definition by providing a medical home for patients that is a patient-centered, regular, and continuous source of primary care. The American Academy of Family Physicians, the American Academy of Pediatricians, and the American College of Physicians agree that medical homes should provide high-quality health care services by physicians, care for patients throughout the life cycle, deliver care in a team based setting, and coordinate/integrate social services to enable patient adherence. Medical homes provide better health outcomes and lower costs of care than disjointed acute health delivery systems (e.g. emergency rooms). While not completely exclusive to CHCs, this is one advantage that health centers have over several other health care delivery models in the safety net.

The mission of FQHCs necessitates their commitment to providing the underserved with a fully functioning medical home, no matter the constraints they face. In a challenging economy, some safety net providers may reduce the amount of charity care they can provide. In 2007, the Center for Studying Health System Change's survey of CHCs found that they were treating more patients, at least partly because of a decline in alternative options for receiving care.

Over the years, community health centers' clients have continued to be the uninsured and underinsured, people of low socioeconomic status, people in rural communities, immigrants without other options, and members of many minority groups. In fact, they do serve the most vulnerable of patients (See Table 3). Racial and ethnic minorities make up more than half of the patient population at CHCs. Almost two-thirds of CHC users are either uninsured or
Medicaid insured compared to less than 50% of these patients in hospital clinics and less than 20% in private practices nationally.\textsuperscript{6, 9} Uninsured CHC patients are also more likely to be poorly educated than are uninsured patients nation-wide. For example, 61% of uninsured CHC adults reported not completing high school compared with 49% of uninsured adults nationally.\textsuperscript{8} The majority of uninsured CHC patients, 60%, live near or below the Federal Poverty Level (FPL). This is a full 20-percentage points higher than uninsured patients nationally.\textsuperscript{2, 6, 8} This difference remains even why you control for age, race/ethnicity, and education level.\textsuperscript{2}

Given the high burden of disadvantage among CHC users, it is not surprising that CHC patients tend to report poorer health status and higher morbidity rates than patients nation-wide.\textsuperscript{2, 6, 8} Additionally, the number of uninsured continues to grow yearly as employers drop insurance plans and the unemployment rate climbs. A recent study found the number of Americans under age 65 who was without insurance at some point during 2006-2007 to be as high as 86.7 million, or approximately one out of three people.\textsuperscript{10} Nearly a quarter of these had been uninsured for 2 consecutive years.\textsuperscript{10} The proportion of uninsured considered “middle class” is growing substantially so that access to affordable, quality health care is no longer a concern only for the poor.\textsuperscript{11} All of this combines to mean that the number of medically disadvantaged/underserved in this country is growing, placing an even greater burden on health care safety net providers.

In large part, the federal government has responded to this call for expansion by renewing investment in the community health center model. An initiative to significantly increase spending on CHC practices was put in place during the Bush administration (See Table 4).\textsuperscript{12} This has resulted in about 1,000 health centers presently, which represents an increase of more than 600 new and expanded sites since 2001.\textsuperscript{2} The numbers specifically quoted by the Department of Health and Human Services is a total of 630 new health center sites opened during this period of expansion. This more doubled the number of centers, from
570 in FY2001 to 1,200 by FY2007. Also, the number of patients treated by health centers increased 46%, "the most significant and rapid growth in the past 40 years." \(^2\)

The questions remain as to whether this rapid period of expansion has caused a departure from the historical roots of the health center program, and whether the expansion will compromise the record of positive outcomes achieved by the health center program.

**Hypotheses**

My focused policy question for this project was to understand why the largest expansion in FQHC history occurred under Republican leadership. What motivators were in play that resulted in this action? I also wanted to understand what impact the expansion has had on the role of FQHCs in the safety net.

Going into the study I hypothesized that the decision to expand health centers was mostly a superficial pledge to garner public favor, and as such, would have little to no true positive impact on the daily operations of health centers. In fact, I hypothesized that superficial expansion might even have a negative effect on the efficiency and effectiveness of health centers in that it might lead to compromising of the core values of the program.

I began the study outlined below for the purposes of testing these hypotheses and gathering data to inform future policy decisions.

**Methods**

This policy analysis collects several different kinds of data using different methods. Ideally, such triangulation is intended to determine whether the different data can converge on a single answer, strengthening our confidence in the answer's validity and reliability. \(^3\), \(^4\) I conducted a limited systematic review of the literature about community health centers, real-time interviews with elite policy stakeholders, reviewed federal documents. A more detailed account of how each tool was used is described in the following sections.
**Systematic Review of Literature.** I conducted a systematic review of the literature archived in PubMed, the U.S. National Library of Medicine's electronic archive, in Spring 2008 to uncover prior studies and data on community health centers. In order to cast a broad net, I used quite general search terms, as illustrated in the following algorithm (constructed in consultation with a public health librarian):

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{""community health centers"[All Fields] OR "community health centers"[MeSH Terms])
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This search yielded 398 articles, of which I included 165 articles accessible through the UNC library proxy, and excluded 233 articles for which full text electronic versions were not available. I reviewed abstracts of included articles, and excluded those that focused on dental health, substance abuse, or mental health, as well as studies done outside of the United States or done exclusively in non-FQHC settings. My exclusion criteria were designed to restrict the literature review to articles that focused explicitly on FQHCs' delivery of standard primary medical care such as prevention, chronic disease management, acute care, and hospital follow-up for example. It should be noted, though, that the included literature showed some FQHCs provide far more comprehensive care like dental services and on-site advanced mental health services.

The full results of the systematic review appear in Appendix 1. I have used findings from this search strategy below to help elucidate the quality of care delivered by FQHCs and the deficits and needs that remain in FQHCs. I have called the latter a "virtual needs assessment" since it is based on literature review and not direct polling of FQHCs.

**Review of Public Documents.** My second source of data came from public documents associated with the passage of the Health Care Safety Net Amendments of 2002 and related
Acts. In reviewing these documents I was most interested to identify the congressmen and congresswomen associated with these policies and in the documented congressional conversations surrounding them.

With the assistance of my advisor and the public health librarians I conducted a THOMAS search for the relevant documents (THOMAS is the Library of Congress' electronic archive of legislative information). Once within THOMAS I selected the "Congressional Record" search and searched the 107th Congress for key words "Health Care Safety Net", the title for the finalized amended bill that I had discovered during my literature review. Entries number 2 and 3 on the results list lead to a PDF link with recorded congressional statements and the official finalized bill, "The Health Care Safety Net Amendments of 2002" (PL 107-251).

I also used THOMAS to identify the sponsors and cosponsors of the bill. To do this I selected the "Bills, Resolutions" search and then chose the sub-category "Search Bill Summary & Status" which identifies facts about congressional bills and amendments that are not included in the text itself (e.g. sponsor, cosponsors, short titles, recent actions). I then chose a "Popular and Short Titles" search of the 107th Congress for key words "Health Care Safety Net."

I was unable to interview knowledgeable Members of Congress or their staff (see below). My inability to interview Members of Congress or congressional staffers made the review of these congressional documents even more important, since the documents were "speaking" for the Members of Congress who created and advocated for them.

**Elite Interviews.** My final data source came via telephone interviews with elite stakeholders involved in FQHC policy building and implementation. My list of eight elites (see Appendix 2) also come from various backgrounds and were brought to my attention by different methods, all of them related to reputational sample development and "process tracing". Some were public health researchers whose articles appeared frequently in my literature review. Others were referred to me by my second reader and other personal contacts. In an attempt to capture regional variation, I blindly emailed and called several FQHC directors in
North Carolina, Massachusetts, and California via contact information on the National Association of Community Health Centers (NACHC) website. Results from early interviews and my review of public documents led me to make several attempts to contact Senator Edward Kennedy's office. The Senator's diagnosis of brain cancer in the summer of 2008 and the presidential campaign impeded my ability to reach the Senator and his staff members.

My advisor and I sought IRB approval to conduct the elite stakeholder interviews (see Appendix 3 for the full IRB-approved interview protocol. All interviews were conducted after IRB approval in early summer 2008. Respondents were given the option of anonymous quoting and offered an opportunity to revise their interview transcripts for errors of fact.

I coded and collated the responses in a method similar to that described in by Aberbach and Rockman in "Conducting and Coding Elite Interviews". In this method, some codes are developed before interviewing begins based on knowledge of the field and anticipated answers. Other codes are discovered and developed during the interview process as multiple respondents report common observations. I did diverge from their method in that there were no parallel coders or intercoder reconciliation and reliability to consider, as I was the lone coder for my dataset. My findings are provided below and include the use of direct quotations from the interviews whenever possible. The results of these elite interviews represent the bulk of my primary research for this paper and independent contribution to the public health community.

Community Health Centers in the Literature

The desire to prove that a given action produces an intended outcome is not a new concept in medicine. Today we are probably living in the heyday of randomized controlled trials and evidence based practice, but the desire to demonstrate the worth of medical intervention harkens back to earlier days. At the turn of the 20th century, surgeon and medical pioneer E. A. Codman devoted—and nearly lost—his career to persuading others of the necessity of good recordkeeping to the proper practice of medicine. Codman argued that medicine is an industry
and that all industries should have measurable product for the sake of record keeping, allocating value, and improving the system. His idea, the "End Results" system, has become the modern-day physician's note and is the basis of accreditation processes for hospitals and medical trainees. What was a novel and reluctantly adopted idea then is commonplace now, to the extent that its absence is thought to be malpractice.

We still, however, have failed to capture the full spirit of Codman's ideas. In the 1980's, William Roper and colleagues proposed federal involvement in the health record keeping of health programs that receive federal funding such as Medicare and Medicaid. They suggested that a centralized system of reporting, analyzing, and redistributing information would help clarify the true effectiveness of medical interventions and thus clarify health decision making. Like Codman, Roper and colleagues realized that without an outcome measure reflecting the effectiveness of interventions, it is impossible to determine the value of the system. Without efforts to measure the product, the worth of the medical industry is largely unknown.

Federally qualified health centers (FQHCs) are community based health delivery offices that receive federal financial support. As such, FQHCs have taken up the call to report outcomes and to build in processes that improve their outcomes. The following sections summarize the results of a review of the literature on community center outcomes (more information on the systematic review can be found in Appendix 1).

_Federally Qualified Health Centers (FQHCs) and Effectiveness._ Federally supported community health centers (CHCs) meet their goal of caring for the country's vulnerable populations. Of all the outpatient health visits made in the United States throughout the 1990s, a little less than half were visits to primary care physicians (PCPs); 43.5-45.6% to be exact. While community health centers accounted for only 4% of all PCP visits during that period, their patient population contained a disproportionately large amount of the medically underserved. Sixty-five percent of patients using CHCs were either uninsured or Medicaid insured compared to 43.0% of patients in outpatient hospital settings and 18.5% of patient visiting standard
The patient population at CHCs is also composed of more ethnic minorities, more rural patients, and more females in need of obstetrical care, than are other health care settings.9

Community health centers fill in some of the gaps of unmet medical need. A recent study found that proximity to a CHC “reduced unmet medical needs and emergency department use and increased the proportion of people with a usual source of care,” and also that, “…health center patients had better access to care, continuity of care, and patient-provider interactions and received more comprehensive preventive services compared to non-health center patients from vulnerable populations.”2

Federally supported community health centers are also committed to providing effective, high quality care. FQHCs demonstrate their effectiveness by tracking patient outcomes, a process that has facilitated outcomes comparisons across different health delivery models. One nationally representative study of CHCs investigated chronic disease management for diabetes, hypertension, and asthma. “For the majority of indicators, we found that the quality of care delivered in CHCs is comparable to that delivered in other settings that provide care for underserved populations and to some national benchmark data from other sources,” 21 In fact, the investigators found that blood pressure control in CHCs was better nearly 50% of the time than that achieved in hospital-associated clinics or the VA. CHCs also had higher levels of appropriate use of influenza vaccine, anti-inflammatory medications, and inhaled corticosteroids for asthmatics compared to the national average. Ultimately, the investigators concluded. “Our findings are consistent with studies reporting that CHCs provide better quality care than other health care segments as measured by reduced hospitalizations and ED visits, higher rates of vaccination among children and the elderly, and higher rates of cancer screening among the poor and elderly” (p. 1720).21 This echoes and ratifies the finding of a decade earlier that the use of community health centers lowers the rate of preventable hospitalizations.22
Community health centers have also made strides towards reducing health care inequalities. "Low socioeconomic status pregnant women of all racial and ethnic groups who received care at health center experience better birth outcomes that did low-socioeconomic status women receiving care elsewhere," and also, "areas with high health center penetration have smaller Hispanic/White disparities in infant mortality, prenatal care, tuberculosis case rates, and age adjusted death rates," (p. 134). In another study, investigators found that low-SES women using CHCs had higher than average rates of breast and cervical cancer screening and African American women at CHCs had lower rates of low-birth weight babies.

**Patient-Level Measures of Quality via Process.** Measures that capture the quality of processes in medical care delivery focus on what services were or were not conducted during health care visits. Studies printed in the *Journal of Ambulatory Care Management* have reported such process level outcomes twice in the last decade. In a 2001 study, Carlson and colleagues investigated the care of uninsured patients at CHCs versus other settings. In 2007, Shi and colleagues repeated this study adding Medicaid insured patients to the data. Both these studies used patient reported measures of the services received in a particular primary care setting to make quality comparisons (e.g. quality of processes). Both groups of investigators used National Health Interview Survey (NHIS) responses for patients seeking care outside of CHCs. These were compared to responses for the Community Health Center (CHC) User Survey. The CHC User Survey was designed to mimic the NHIS, so the responses are thought to be comparable.

The comparison produced several statistically significant differences in the patient-reported quality of care received by uninsured and Medicaid insured patients at CHCs versus other primary care delivery systems. Let us consider the results in terms of the components of primary care as outlined previously in the IOM definition.

Community Health Centers provide patients better **access and longitudinality** of care. Uninsured and Medicaid insured CHC users were more likely than uninsured and Medicaid
insured patients nationally to have had a primary care visit at some point during the previous year and to have seen their doctors multiple times in the same year. CHC users also were significantly more likely than non-users to report having a regular source of care. This difference was the most pronounced in comparing uninsured CHC users (96% with a regular source of care) to uninsured patients nationally (60% with a regular source of care). (p. 164)

Community Health Centers also perform highly at the level of the comprehensiveness of care given to patients. Uninsured and Medicaid insured CHC users were significantly more likely than their national counterparts to have seen an Ob/Gyn, a vision care specialist, or a mental health provider. CHC users also have better rates of receiving preventive care services and counseling than uninsured and Medicaid insured patients nationally. For example, in terms of preventive care screening, "...84% of Medicaid and 73% of uninsured CHC patients reported having a mammogram in the past 2 years versus 60% of Medicaid and 59% of uninsured patients nationally (both \( P < .001 \))." (p.165)

Even in the absence of a procedural expense associated with the prevention method, as is the case with counseling, CHC users were still more likely to receive the intervention than uninsured and Medicaid insured patients nationally. "...87% of Medicaid and 72% of uninsured CHC patients reported receiving counseling on smoking, versus 61% of Medicaid and 62% of uninsured patients nationally (both \( P < .001 \))." (p.165)

The NHIS and the CHC User Survey (which was designed from the NHIS) do not ask questions about coordination of care, but investigators completing another study used a different survey tool to ask eight coordination questions including these four (p. 790):

Coordination of Services (8 items)
1. Did your doctor suggest that you see a specialist or receive special services?
2. Did the doctor know you made these visits to the specialist or to special services?
3. Did your doctor discuss with you different places you could have gone to get help with that problem?
4. Did your doctor or someone working with your doctor help you make the appointment for that visit?
This study found that CHC users had significantly higher rates of coordination of care than users of a Health Maintenance Organization in the same community even after controlling for race, income, insurance, duration of usual source of care, and physician choice.\textsuperscript{2}

Even though users of CHCs were significantly more likely to report their health status as fair/poor than were non-users\textsuperscript{6,8}, the former consistently reported better quality, in terms of process measures, in their primary care experiences than non-users of CHCs.\textsuperscript{2,6,8} The investigators of these cross-sectional studies show that, CHC use is positively associated with high-quality processes by patient report. Though we cannot conclude causality in this association, these studies raise interesting quality questions that warrant further investigation.

The latter part of the IOM’s definition of primary care also describes physician responsiveness to the needs of the patient, the patient’s family, and community at large.\textsuperscript{5} We attempt to capture this construct via measures of \textit{patient satisfaction with care}. This type of quality measure may be more difficult to understand because it does not simply amount to a list of services that were or were not offered in a clinical setting.\textsuperscript{24} Satisfaction questions try to capture the intangible experiences of patients that are not easily quantified. Yet, subjective evaluations are at the very center of patient-level quality measures. Ultimately, while we may need different measurement tools to generate data in this area, we cannot simply ignore it.

In their 2001 study, Carlson and colleagues did ask users of CHCs to report satisfaction measures. Specifically, they asked the question, “Thinking about the last time you visited the place you usually go to, were you satisfied with: The waiting time to get an appointment? The waiting time to see the doctor? The way your questions were answered? Your ability to get all the care you thought you needed? The overall care you received?” (p. 49)\textsuperscript{8}

In this study, uninsured CHC adults' satisfaction with CHC services ranged from a low of 82% who were satisfied with waiting time at the physician’s office to a high of 94% for the way questions were answered. Unfortunately, the NHIS did not collect similar data for adult non-
users of CHCs, preventing comparative analysis beyond noting a generally favorable satisfaction rating among uninsured users of CHCs.

A supplement to the NHIS for children, however, did contain patient satisfaction questions. Generally, uninsured children using CHCs did as well or better than did uninsured children nationally in the area of patient satisfaction. Satisfaction rates among uninsured, child CHC users ranged from a low of 79% satisfied with waiting time at the physician’s office to a high of 99% for the way questions were answered. These results were statistically similar to those from the national control group except in the area of responsiveness to questions, where CHC children had significantly higher satisfaction levels.

Another study of patient satisfaction with primary care used the Primary Care Assessment Tool—Adult Edition (PCAT-AE) for data collection. In this study, Health Maintenance Organization (HMO) patients and CHC patients from the same city in South Carolina were surveyed with the same tool.

The PCAT-AE goes beyond just measuring satisfaction. It asks patients to rate how well their doctor knows their social and medical issues. It asks about how comfortable a patient feels in interacting with their doctor. The PCAT-AE even specifically asks question regarding community responsiveness. For example (p. 791):

**Community Orientation (3 items)**

1. Would anyone at the doctor’s office ever make a home visit?
2. Does your doctor know about health problems in your neighborhood?
3. How does (Dr. /Place) get opinions and ideas from people that will help provide better health care?
   Do they:
   a. Conduct surveys of their patients to see if their services are meeting people’s needs?
   b. Conduct surveys in the community to find out about health problems that they should know about?
   c. Ask family members to be on the board of directors or advisory committee?

In this study the investigators again found that patients at CHCs are generally pleased with the care they receive. Aside from ease of first contact, in which HMO patients gave significantly higher ratings, "CHC patients reported significantly higher scores on all other primary care domains (ongoing care, coordination of service, comprehensiveness, and
community orientation). CHC patients also reported a higher overall primary care total score than HMO patients did." (p.791)²

Though patient satisfaction is difficult to measure and challenging to link to health outcomes, these two studies demonstrate that patients at CHCs perceive their care to be of high quality on multiple levels, including responsiveness to patient questions and commitment to the general health of the community. There is even some evidence that CHC patients in general are more satisfied with their care than HMO patients who generally have more access to health care services.²

**Other Important Contributions.** Community health centers fill in some of the gaps of unmet medical need. A recent study found that proximity to a CHC “reduced unmet medical needs and emergency department use and increased the proportion of people with a usual source of care,” (p. 134).² Also, “...health center patients had better access to care, continuity of care, and patient-provider interactions and received more comprehensive preventive services compared to non-health center patients from vulnerable populations. (p. 134).²

Community health centers have made strides toward reducing health care inequalities. “Low-socioeconomic status pregnant women of all racial and ethnic groups who received care at health centers experienced better birth outcomes than did low-socioeconomic status women receiving care elsewhere,” (p. 134)². A similar trend appeared in another study that found “areas with high health center penetration have smaller Hispanic/White disparities in infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates,” (p. 134)².

In addition to demonstrated efficacy, community health centers have continually operated in a cost-efficient way. In 2004, the Office of Management and Budget rated the Health Centers program as one of the most effective programs for the financial year. CHCs enjoy strong bipartisan support by legislative officials because of this long record of efficacy and cost-efficiency.²
Community health centers have also been involved in health care innovation for their patient populations (please see relevant literature in Appendix 1). Some examples of innovation include vaccine compliance studies, substance abuse cessation studies, and specialty referral trials that have been conducted at health centers across the country.

**Conclusions from the literature.** This review of studies of CHCs/FQHCs suggests that community health centers are a cost-effective and high quality mechanism for providing health care to the underserved. The diversity of their patient mix and the complexity of health and social issues they encounter mean that community health centers provide more services than does the average primary care provider. For instance, they also provide their patients with case management, translation, transportation, outreach, eligibility assistance, and health education. Thus, they are able to produce outcomes equal to or even better than other primary care sites for this population while maintaining adequate patient satisfaction levels and are a worthy investment of federal dollars.

"Virtual Needs Assessment"

I also screened the results of my literature review for published literature on the current needs of community health centers. I call this my virtual needs assessment.

The current community health care structure still does not meet 100% of unmet medical need. In 1996, the Bureau of Primary Health Care (BPHC) that oversees CHCs estimated that, "...community health centers provide services for just 1 in 6 persons who lack access to a primary care practitioner," (p. 2077). In the period since the rapid expansion, CHCs still do not provide care for all vulnerable people (uninsured, poor, immigrants, rural citizens, etc.) in need of health services.

Some services, especially specialty care, mental health services, and dental care, are still difficult for health centers to deliver. One study conducted in 2004 found health center patients in Miami waiting for months for specialty referral appointments at the county hospital.
Nationally it is particularly difficult for many sites to get referrals to five specialties: gastroenterology, orthopedics, cardiology, endocrinology, and dermatology. New federal funding dollars, focused on primary care services, do not directly address this problem.

Community health centers also face a challenge on the service delivery side because of a shortage of physician employees. On average, a little over 13% of all funded CHC positions for full-time doctors are unfilled. Rural communities bear the brunt of the burden with higher physician vacancy rates than is true of their urban counterparts.

The current trend in practice choices of medical school graduates suggests that the understaffing problem may only get worse in the near future. Presently, Family Medicine doctors account for 48.1% of the total physician staff in CHCs. Family medicine doctors are the largest specialty group in both rural and urban centers. Specialty trends also indicate that family medicine practitioners are more likely than are other physicians to work in underserved populations. Yet a recent study found that the "...production of family physicians has decreased rapidly in the last 7 years, with the number of US medical graduates matching in family medicine declining 51.6% from 1997 to 2005," (p. 1046).

Another challenge for health centers is the fact that the physician staff is largely dependent on a transient and continually changing pool of applicants. Three major federal programs, the National Health Service Scholarships (leading to service in the National Health Service Corps), the loan repayment program, and the J-1 visa waivers, draw physicians into CHCs with additional, non-salary incentives. However, "physician turnover in CHCs is rapid, with a large proportion of physicians leaving after discharging their scholarship obligations or paying off their loans," (p. 1045). Also, international medical school graduates change their immigration status after several years of working in the United States and no longer depend on J-1 visa waivers to remain in the country. This poses interesting challenges to continuity of care.
The support for CHCs has not kept pace with the rising costs of operating expenses, as patient loads swell with the growing number of uninsured. The financial stability of the health center program is still at risk. Presently, CHCs are enjoying a period of federal support and expansion, yet mounting data suggests that even this may not be enough. A study conducted in 2005 by the Kaiser Family Foundation found that federal spending on the medical safety net increased 1.3% between 2001 and 2004. This was greatly outstripped by an 11.2% increase in uninsured Americans over the same time period. The study also specifically reported that CHCs were spending almost twice as much in uncompensated care dollars in 2004 as they had in 2001. Also, in FY2004 one in ten qualified applications for FQHC designation was denied because of lack of funding despite the additional funds allocated for this purpose.

Additionally, cuts to the Medicaid program also contribute to a precarious financial situation for the health center program. In 2004, Medicaid provided 36.4% of total revenue for CHCs, making it the single largest source of health center revenue. In order to balance budgets, states have increasingly cut Medicaid benefits, thereby threatening health centers’ single largest source of revenue. Federal legislation requires that states have to pay FQHCs prospective cost based reimbursement, and they cannot get federal waivers to this requirement. States cannot cut certain optional benefits, like transportation, translation, or other enabling services that are mandatory administrative services, but FQHCs may not be paid for these services through the regular Medicaid service rates. States can, however, affect payments to FQHCs by, for example, cutting dental services for adults, affecting FQHCs who provide dental services. Any threat to the FQHC financing structure, obviously, could undermine the provision of core services that have produced successful results in marginalized populations for years.
Review of Public Documents

The Health Care Safety Net Amendments Act of 2002 (PL 107-251) is a collection of measures amending the Public Health Service Act in order to strengthen health care delivery to underserved populations. It was originally proposed in October of 2001 by a lone sponsor, Senator Edward Kennedy, a long-time champion of the FQHC model. After an amending process, it passed Congress and was signed by President Bush in October of 2002. Notably, this policy came after President Bush issued the "President's Health Center Initiative" in 2001 in which he expressed his commitment significantly to expand the number of FQHC sites and the number of patients served over a 5 year period.

Table 4 about here

Senators Frist (R-TN), Gregg (R-NH), and Kennedy (D-MA) all addressed the Senate at the time of the final vote in that chamber, on April 16, 2002. They also acknowledged one another's joint contribution to the effort during their respective speeches. These speeches and their content argue for seeing the three Senators as the primary advocates of the safety net amendments. The health Care Safety Net Amendments, as did other bills in this period, required an unusual amount of partisan compromise, since Senate leadership changed hands twice from 2001 to 2003, and "control" suggests more power than either party could boast; Democrats led with a 1-seat majority at the beginning of the Congress, and the Republicans led with two seats at its end. Senator Frist, momentarily the Senate Minority Leader (before assuming the majority leader position late 2002) and Chairman of the National Republican Senatorial Committee, spoke prior to the final reading of the amendments. Senator Kennedy, Democrat and, at that time, Chairman of the Senate Health, Education, Labor, and Pensions Committee spoke after the reading of the bill. He was followed by Senator Judd Gregg, a Republican moderate from New Hampshire who often voted with the Democrats on health issues. This troika indicates the delicate partisan balance necessary to assure passage of the
safety net amendments, a balance also reflected in the passage of the Senate legislation by
Unanimous Consent, not necessarily the norm for health reform legislation of any kind.

The bill appears to have been largely a Senate initiative. In the House, the related
legislation (HR 3450) had 236 bipartisan cosponsors, including many, such as Bob Barr (R) of
Georgia and Bobby Rush (D) of Illinois, who seldom collaborated on legislation. The House
passed the Senate version of the legislation 392 to 5 on October 16, 2002, and it was signed by
the President 9 days later.

A revise of the Congressional Record mentions of the bill makes it apparent that many
variables converged on the congressional decision to support these amendments. The strength
of the bipartisan agreement on the framing of these amendments was not only evident by the
background of its endorsers but also directly acknowledged by them. Senator Gregg said “I
believe this legislation represents what can be achieved when good policy and bipartisanship
overcome politics.” Senator Kennedy said this bill “…could not have been realized without
strong support received from both sides of the aisle.”

Senate members also seemed to be motivated by the depth of the health care crisis; all
three speakers alluded to it. Senator Frist remarked, “Far too many Americans lack health
insurance today. We must tackle this problem head on to reduce the number of people who are
not receiving care.” In stronger words, Kennedy claimed, “Today, the need for a robust safety
net is more pressing than ever before.” Senator Gregg also used direct and compelling
language to outline the problem when he said, “With the recent announcement by the U.S.
Census Bureau that there are now 41.5 million uninsured Americans, this legislation comes at a
crucial time.” This kind of rhetoric is the norm for speeches on the floor, of course, but it does
seem that members of both chambers felt compelled to do something urgently in light of the
growing number of people without recourse to health care.

Some evidence in the commentary surrounding the passage of the amendments
suggests that Congress members understood that focusing on health centers would be a well-
placed investment of resources. The language of Senator Kennedy is clearest on this point: “In 2000, health centers provided more than 9.6 million people with cost-effective, high quality, preventive and primary care at more than 3,000 sites across the country... Clearly, this program has been successful in meeting the goals of its creators.” Senators Frist and Gregg both identified the strength of FQHC’s dedication to working with the uninsured and other medically underserved communities as a rallying point.

The influence President Bush’s Health Center Initiative had on the legislative process cannot be overlooked. Both Republican speakers pointed out the President’s support for the FQHC program in giving their remarks. Frist reasoned, “A key component of the bill is an increase in funding for the Consolidated Health Centers program, providing more than $1.3 billion for this program...This is critical to achieving President Bush’s goal of doubling the number of community health centers across America.” A sentiment echoed later by Gregg who commented, “A priority for President Bush, this legislation is an important piece of his agenda...” Interestingly, it seems that President Bush’s Initiative may have significantly influenced Congressional members to support these amendments and secure its success.

Perspectives of Policy Actors and Observers

As mentioned in the methods section, the bulk of my effort in this project revolved around completing, coding, and collating a series of interviews from elite stakeholders. Respondents included local and national members of the National Association of Community Health Centers, published public health researchers, and clinical practitioners (see: Appendix 2 for the interview protocol and Appendix 3 for a list of respondents).

My opening interview question asked my respondents to consider the most important motivating factors that drove the President to begin a multi-year initiative to strengthen the health care safety net by expanding the Federally Qualified Health Center (FQHC) network. Five of the eight respondents cited the cost-efficiency of the FQHC system as a key factor in the
President's decision to invest in this particular approach. Cost efficiency was followed closely by mentions of community health centers' reputation for high quality services, and commitment to improving care for the uninsured and underinsured, each of which was mentioned by half of the 8 respondents.

The public health literature discussed earlier substantiates the respondents' judgments about the attractiveness of FQHC centers' cost efficiency and commitment to quality. Respondents from various perspectives reported that President Bush felt confident that "good data" supported this investment. Ms. Lisa Cox, a NACHC administrator specializing in reauthorization, commented that he had a belief in the effectiveness of health centers to provide cost-effective services to underserved populations. She said that President Bush was impressed by FQHC clinical outcomes.

My legislative respondents identified personal experience as another possible motivator. Ms. Lynn Williams, a field organizer for NACHC in TN, noted that Bush had been a strong supporter of community health centers when he was governor of Texas. This observation was also made by Mr. Sawyer, a federal level NACHC administrator focused on budget issues and appropriations, who commented, "[Bush] was a strong supporter of community health centers in the state house and familiar with the work that they did on the ground level." Respondents also felt that his support then and now was partially due to the model of local control intrinsic to the CHC model.

Two other Presidential motivators identified during the study took on a slightly different spin. The first is the political palatability or popularity of community health centers. Dr. Roger Rosenblatt, a physician and scholarly expert on the health care safety net, told me that the presence of community health centers in every state made them a rallying point around which every congressperson could connect. Dr. Schmidt, a local community health center leader, also noted preexisting history of bipartisan support as a factor on which the President capitalized.
These comments suggest that Bush's health center initiative was a politically feasible approach to addressing health care that could easily get Congressional approval.

A related and more frequently reported motivator speaks to this issue more directly. Four out of eight respondents suggested that the President's initiative was a way for the administration to do something about health care without tackling the bigger issues at the heart of the health care crisis. For example, Mr. Sawyer commented, "...universal health insurance was not really part of the debate in 2002, and in 2000 in the campaign, but this was a way for the administration to pursue expanded access to care without having to support a universal health insurance plan." Dr. Rosenblatt more ardently remarked, "Number one it was his reluctance to do anything fundamental about our tattered health care system." As half of my respondents point out, the flip side of political feasibility angle was the President's reluctance to take on more difficult and divisive yet fundamentally important issues such as health insurance reform.

**Factors Influencing Congress.** While CHC's long standing reputation for high quality, cost-efficiency, and dedication to the underserved were also reported to be important motivators for Congress, respondents identified a distinctly different key motivator for this group. Six respondents from multiple categories reported grassroots efforts such as interest group lobbying, letter writing, and touring of constituent health centers as having a major impact on the decision of Congressional leaders.

Mr. Benjamin Money, associate director of the North Carolina Community Health Center Association (NCCCHCA), pointed out that, "...there are community health centers in every state. And they have developed relationships with their members of congress to advocate for that support at a grassroots level." Mr. Sawyer further elaborated on this point when he remarked, "I think that, particularly with Congress, that they have very personal connections in many cases to the community health centers in their states and districts. And have, in many instances,
toured those centers and have the personal relationships so they knew it was a good investment going in."

The National Association of Community Health Centers (NACHC), while not the only group involved in lobbying for this legislation, was specifically mentioned by half the respondents as a major influence on Congress. Dr. Schmidt said "the NACHC is very well informed, very articulate in how they present their arguments and they were very aware that you ... need to know the people who work, whether they’re Republican or Democrats.” Later on in the interview in commenting on the importance of interacting with Congress she also commented, “It becomes extremely important to get to know them whether they’re Republicans or Democrats and letting them become part of your inclusive circle...NACHC has done that extremely well in working at a national level.”

The interview responses suggest that members of Congress and their staff were well briefed on access questions, if they had not been knowledgeable about them before. Half of the respondents (4 or 8) reported a need to do something in the face of mounting statistics as a congressional motivator. For example, a physician and community health center director based in California cited primary care shortages as a major congressional motivator. Dr. Schmidt agreed: "I think that there was clear recognition on the part of the members that there is a basic need to improve the health of the people of this country... I do think that they recognized that we are considered the most affluent, but really if you look at health statistics we’re down there, 27, 28...so I think there was some recognition that they had to do something." On the other hand, looking back, only two respondents cited health care shortages as a presidential motivator.

**Stakeholders Involvement.** I also asked the respondents to indicate who were the major policy players involved in pushing this legislation forward and how they accomplished this. As notable elites in their respective fields and key stakeholders in community health centers and the health care safety net in general, I also asked them to consider how they got involved in the process from their own perspective.
As mentioned above, respondents thought that interest groups were heavily involved in lobbying and building momentum for the passage of the Health Care Safety Net Amendments of 2002. As Ms. Lynn Williams pointed out, “As a rule, grassroots advocacy does play a role in pushing policy forward because the people in the districts and in the states who are in contact with their representatives tell them how they believe that the legislation should be passed or not passed.”

The respondents identified many members of the health care safety net who petitioned for these reforms, including the National Rural Health Association, the National Health Service Corps, and the National Association of Public Hospitals and Health Systems. Advocacy groups such as migrant health associations, health care for the homeless programs, and multiple caucuses representing various ethnic groups were also involved.

Ultimately, the National Association of Community Health Centers (NACHC) was the group that was likely most visibly involved in this legislation as reflected in that 7 out of 7 respondents who answered this question mentioned NACHC by name. NACHC also was likely the group most intimately involved in the ultimate structure of the final legislation.

Two of my respondents, John Sawyer and Lisa Cox, are staff members in the federal NACHC offices and were able to give more insight. Mr. Sawyer said that members of NACHC collaborated with committee members and the chairmen of the House and Senate to advocate for legislation to the benefit member CHCs.

Beyond collaboration and advocacy, Ms. Cox, a specialist in reauthorization, gave several examples of how members of NACHC were closely involved in the legislative process from beginning to end. To start, NACHC members organized a CHC task force involving representative CHC leaders and providers from across the country to collect data on performance and remaining needs. They then provided this background info and data to Congress to support CHC expansion. Finally, NACHC members also directly helped in drafting
the legislation by submitting written suggestions and recommendations to Congressional policy writers.

The two public health researchers included in my interview sample were well-informed on the part they have to play. For example, Rosy Chang-Weir, a senior research assistant for the Association of Asian Pacific Community Health Organizations (AAPCHO), had a very introspective comment regarding the role of the elite critical observer in shaping public policy. She pointed out that carefully constructed, systematic research generates the data needed to support and argue the necessity of specific services (transportation, translation, case management, health outreach, health education) provided by health centers. Researchers also help keep policymakers accountable by tracking and reporting outcomes.

Two of my respondents also mentioned Senator Edward Kennedy and his staff by name as major congressional backers of the expansion of community health centers in the safety net amendments. The public record seems to support the conclusion that Senator Kennedy may have been the most significant Congressional actor, not the least because of his long history of advocating health policy and his seniority in the Senate. The initiative began as a sole-sponsor Kennedy introduction. But Senators Frist and Gregg also have long track records in health policy. I did not directly ask respondents questions about influence inside Congress – I asked only about the three most important influences on Congress. In the circumstances, then, respondents’ spontaneous mention of Senator Kennedy seems to support the appearance of his leadership in the public record. The scope of the present analysis, however, does not permit further conclusions about internal Congressional brokering.

Interestingly, physicians and clinical staff working at the patient care level in community health centers, while important stakeholders by nature of their position, were seemingly not directly involved in shaping this policy change. In fact Dr. Rosenblatt a physician and published health policy elite, commented that, "...the average physician probably didn't even know it was happening." This sentiment was internally validated when a health center practitioner stated
that he felt that health center physicians in general had "very little" direct policy input in regards to the amendments.

Physicians tend to defer to aggregate bodies when it comes to policy issues. As Dr. Schmidt pointed out, patient care is the first priority for busy physicians. She also made the point that, ironically, heavy patient load and limited resources may make clinical staff members of health centers the least able to break away from clinical responsibilities to pursue policy issues. Allowing professional organizations like the American Medical Association (AMA) and health center interest groups to take the lead on policy issues is an easy way for health center practitioners to feel like their concerns are being voiced without having to sacrifice their own patient care hours. However, clinical staff at health centers will have to consider other options for raising their concerns if they are interested in getting legislation that is more and more tailored to their specific needs.

Measures of Success. One of the more revealing questions in my interview protocol asked respondents to consider if the combined efforts of the President's Initiative and the Congressional Amendments have achieved their intended goals. Specifically, I challenged my respondents to consider success in both objective and thematic terms. In other words, did the legislation achieve hard targets and further more did it actually achieve the softer mission of strengthening and bolstering the health care safety net in America.

Respondents from all levels were in agreement that the 2002 legislation produced many important gains. They were nearly unanimous (7 of 8) in citing the increased number of health centers as direct proof, at least in part, of an accomplished goal. Mr. Sawyer, a NACHC budgetary and appropriations specialist, commented, "The President laid out a goal of 1,200 new or expanded health center sites which was met with the fiscal year 2007 appropriations. Yet Congress continues to support expansion of the health centers program even beyond the President's initiative! I think that the Health Center Safety Net Amendments laid a strong foundation for the growth of the program and improved the system of care for millions of low-
Ben Money, a local associate director of the NCCHCA, said that we have been "very successful" in terms of the President's initiative in that we have met the goals the President set for the number of new centers opened and number of patients served.

Even the staunchest political critics in my sample agreed that there have been real successes in the ensuing seven years since the original 2002 Safety Net Amendments were passed. Dr. Rosenblatt remarked, "Well, the community health centers certainly have got the funding to expand and that's good." Dr. Schmidt, a NC health center clinician and director, agreed: "Well they've certainly increased the number [of health centers] which means access."

Respondents are in agreement that President Bush's initiative and the supporting Congressional policies that followed were successful, at the very least, at increasing the number of centers, and the number of patients centers could, thus, serve.

The softer goal of success on thematic grounds, however, was not as clear cut. Interestingly, a divide seemed to fall roughly along hierarchical lines with those closer to legislative process being more likely to claim success on all counts while those further away were more likely to qualify "success" or even, in some instances, to cite a straining of relationships in the post amendment years.

Both federal level NACHC staffers felt that this period of policy driven growth has strengthened the mutual confidences of federal legislators and ground level health center workers in one another. For example, John Sawyer said, "I think in some ways it really made the federal government the champion of the health center expansion." Lisa Cox argued that each reauthorization and each new bill that passes that benefits health centers adds to the reputable history of the program and builds credibility. She also pointed out that the health center program was able to undergo a period of fairly rapid expansion without compromising/eliminating any of the core requirements like community board members, medically underserved location, and provision of service regardless of ability to pay.
On the other hand, some respondents who were further away from the legislative process indicated problems and even some contradictions that limited the benefit of the health care safety net amendments. Ben Money noted remaining needs in terms of workforce issues when he said, “Right now there is a dearth of primary care providers. So while we have the patients and while we have the organization, finding providers and retaining providers is really a challenge.” Rosy Chang-Weir, a public health researcher, pointed out that the reforms inadequately addressed enabling services (e.g. transportation, translation, health outreach) that have been proven to be crucial by the public health literature in providing effective health care for the marginalized communities that health centers serve. She also informed me of some proposed changes to the “medically underserved” definition that would actually threaten funding sources for existing health centers, though these changes were not finalized at the time of our interview.

Ground level practitioners, the furthest away from the legislative process, were the most likely to voice some frustration with this particular health policy period. Dr. Rosenblatt is a public health researcher and active rural physician. He commented, “On one hand he [President Bush] increased money for the health centers. On the other hand he gutted the money to train primary care clinicians. So he gave on one hand and then he made it impossible for them to staff up on the other hand… most of everything else he has done has been to undermine the expansion of the community health centers.”

Dr. Schmidt, medical director of the Lincoln Community Health Center in Durham, NC said that health legislation under the Bush administration has actually strained relationships between health centers and the government. The reorganization the Department of Human Health Services caused many regional directors to relocate to Washington D.C., making them less accessible to the communities they represent. She also identified the failure to improve practitioner compensation rates, the lack of funds for new buildings for established centers, and
the inattention to enabling services as major limitations to the impact the Health Care Safety Net Amendments had on the day to day operations of FQHCs.

Considering the responses of the group together it seems that success on thematic grounds, in terms of enabling FQHCs to fulfill their mission better, is murky at best. In light of the health center physician staff shortages and the rising number of uninsured and underinsured in our country illustrated in earlier segments of this paper, their may be a worsening of the health center crunch in the coming years despite the passage of the new legislation.

It is also important to bring the big picture into view at this point. As Dr. Rosenblatt rightly points out, "Community health centers play a very valuable role, but they're a tiny player in the whole spectrum of health care services." When we add the increasing health center crunch to the proportionally limited part health centers play in the grand scheme of health care delivery, I think it is fair to conclude that this period of health policy activity will have very limited impact on the overall health care crisis in America. This is likely because the Health Care Safety Net Amendments, while making important advancements in access for underserved populations, fail to hit at the very core of the health care problem.

Where should we go from here?

In my closing questions I asked my respondents to reflect on the lessons learned through the legislative process surrounding community health center expansion and to suggest ideas for future health reform directions based on these reflections. The collection important lessons learned is a nice reflection of the depth of perspective and enhanced comprehension we get when we include many different players in the policy analysis process.

From the federal NACHC members involved most closely in the legislative process I learned of the importance of keeping and reporting data. Ms. Cox also provided examples of cultivating bipartisan support by knowing which battles can be tabled in the interest of achieving the greater goal. Ms. Williams, a NACHC field organizer, emphasized the importance of
mobilizing an informed grassroots constituency when she said, “...communities, providers, managers, and consumers, need to be vigilant to the shifting nature of federal funding as it relates to politics. They need to be involved as voters and as vocal constituents who build and nurture relationships with their federal, state, and local elected ...to strengthen the potential for ongoing success in the future.” Ms. Chang-Weir, a public health researcher, spoke on the importance of keeping legislators accountable to their promises and consistent in their subsequent policies, while the practitioners highlighted that federal legislation does not always translate to practical day-to-day benefit at the ground level.

Despite the variety of perspectives, nearly all respondents (6 of 7) who answered this question were in agreement that the federally qualified community health center program is and should be an important part of future attempts at health care reform. Mr. Sawyer said

"I think we need similar legislation because the health center model is one that's proven effective. It's proven to be a good investment in terms of improving quality while reducing costs of health care." Mr. Money agrees and thinks even more expansion is needed. He stated, "I don't believe that all the communities that have need have had their needs addressed...It would be wonderful if future administrations would see the need and recognize that while the short term objectives that were fulfilled during the Bush administration had a big impact, there's still a great deal of need out there."

Nearly all respondents (6 of 7), however, were also vocal in their insistence that the health center system alone cannot adequately address the health care crisis. A multipronged approach was endorsed by Dr. Schmidt who suggested that we continue to capitalize on the FQHC system we have while also moving incrementally forward towards a universal insurance plan. Mr. Money emphasized the importance of health centers in a hybrid approach:

I think that expanding community health centers is one way of bridging the health care gap in this country. I mean there is so much conversation around expanding health insurance options, but health insurance without a place to
actually access care, without an actual medical home really doesn’t meant much. It’s just a piece of paper unless you can really get the care. I think community health centers are great examples of how to get the care to people.”

Mr. Sawyer mirrored this sentiment: “I think that the lessons of the health centers expansion in the last number of years is that while improving and expanding insurance is important, you also have to be sure that people have a place to go. You have to improve and expand access to primary health care at the same time.”

As I first addressed in the “Virtual Needs Assessment,” FQHCs face significant challenges that limit their successful functioning. However, even if those shortcomings were eliminated, the ability of the health center program, or any safety net provider for that matter, to address the health care crisis in this country is seriously limited. A study from 2004 examined the relative benefits of safety net expansion and insurance expansion concluded that “Communities that have both high insurance coverage and extensive CHC capacity tend to have the best access, although the former appears more important.” (p. 234)

In fact, several studies suggest that a multipronged approach to health care reform will have the greatest reach. One study uncovered differences in patient treatment and outcomes even within the FQHC system, finding that even if patients are plugged into a high-functioning health center they still encounter barriers and access issues based on their insurance type, with uninsured patients having the most problems. Another study of attempts to coordinate hospital follow-up services for patients found that the uninsured were more frequently denied clinic appointments. Health center patients, however, were found to have better post-hospital follow up with re-hospitalization rates lower than expected given their insurance and socioeconomic status.

Insurance expansion and securing competent, dedicated medical homes for all patients are two complementary strategies of reform that can work well together. A 2006 Health Affairs article used a logistical regression model to conclude that neither eliminating uninsurance nor
would expanding the safety net alone completely eliminate access gaps. The researchers’ ultimate conclusion was that "...policies to reduce uninsurance and expand CHC capacity will increase low-income people’s access to care." (p. 1685). 34

Conclusion

The data I gathered converged to demonstrate some important policy lessons. First, I encountered some surprises. Although it is true that the President’s Health Center Initiative was a politically and publicly popular move, it seems that this was likely not the only motivation behind President Bush’s decision to support the program. My interview respondents taught me that the President actually had prior knowledge of and experience with health centers from his work in the Texas state house. His decision, then, may also have been a well-informed choice resulting from real familiarity with the program’s goals and outcomes. My review of the Congressional Record suggests that his Initiative also had a real influence on the successful passage of the amendments, by pushing Republicans including Senator Frist, in the direction of backing the Health Care Safety Net Amendments of 2002. The contribution of strong presidential support cannot be ignored.

I also found, somewhat to my surprise, that federally supported community health centers did have some positive responses to the passage of these amendments. Ultimately the program was expanded by 50% and the number of patients served grew substantially marking undeniable gains in access for underserved populations. This taught me that even if motivations do not perfectly align, as demonstrated in the elite interview section, collective effort can still produce outcomes satisfactory to all parties.

However, the policy under the Bush administration was not completely aligned with the goals of health centers, and this ultimately limited the effect of the amendments. Several respondents recounted ways in which the passage of subsequent legislation undermined the
stability and security of the health center program. In this way, the significance of ideological mismatching was revealed. As Dr. Rosenblatt commented,

...the administration had no clear idea of what it actually takes to provide services to these vulnerable populations... because they were ideologically opposed to having anything to do with the work force they didn’t engage in one of the very important parts of the equation, which was to make sure that you actually had people in the trenches who could deliver the services.

Although the Republican backers of the bill were invested in the efficiency and cost-effectiveness of the health center model, they were less aligned with more liberal concepts like enabling services and workforce distribution which are essential to the successful functioning of FQHC program. This is likely why the safety net policies, while achieving important statistical benchmarks, ultimately failed to hit major thematic goals of helping health centers fulfill their mission on a day to day basis on the ground level.

Along related lines, the results of this study emphasize the importance of shrewd policy navigators to the longevity of successful programs. These navigators are positioned centrally and at the grass roots level in the case of community health centers. For example, Lisa Cox recounted excellent examples of strategically picking battles. When some divisive bureaucratic obstructions to the use of capital funds for new buildings arose, NACHC, recognizing the possible closing of a legislative opportunity, tabled that debate for the time being in order to get the reauthorization and expansion initiatives signed. On the other hand, when legislators suggested loosening some of the core requirements, such as having community members on the board, of FQHCs, , this challenge to a key part of their mission, as they saw it, met with stiff resistance from FQHC advocates.

Similarly, health center staffers on the ground also must be shrewd navigators in order to advocate for the greatest good for their centers in the ever shifting public arena. Dr. Schmidt proved to be a good example of one such navigator when she recounted an anecdote in which
she was able, through her knowledge of past legislation and funding pools, to secure additional funding for her center despite initial denial. Also, even though she was frustrated by the DHHS reorganization she found ways to still navigate the system. She insightfully remarked, "... you know, you basically, in away there, sort of had to figure out where you would make the most mileage. Was it through the organization, direct contact with the congressional office, etc."

These partnerships between well-informed and activated stakeholders from multiple categories have been and will continue to be essential to securing continued support for FQHCs in the future. This, in turn, argues the point that CHC staffers need to be better informed and more vocal about policy issues. Ground-level practitioners were not a major direct presence in the legislative process surrounding the safety net amendments of 2002. This likely also contributed to the decreased day-to-day effect of the policies. If we hope to achieve better connection between health policies and the general functioning of health centers, we will have to figure out how better to educate and activate ground level staff members.

The study also reinforced important policy lessons about the legislative process itself. One such lesson is the importance of the interaction of multiple stakeholders in the policy process. As demonstrated in the elite interview section, great synergy of activity and understanding can result from bringing multiple perspectives to bear on a common issue. The collaboration of legislators, grass-roots advocates, public health researchers, and clinical practitioners improves transparency and keeps all parties accountable. Furthermore, this process of collaboration enriches the understanding of the legislative process and provides new ideas and direction for future efforts. This would not be possible without the contribution of many perspectives.

I was intrigued to learn that bipartisanship is a construct that has to be cultivated continually. More than just making it easier to pass legislation, bipartisanship can also have the benefit of fostering better, more intelligent legislation. As Dr. Schmidt commented, "...usually, if
you can get a compromise it's sometimes is better than either in terms of bringing the best thinking at the time to the table in how you can advance forward."

All data sources in this study suggest that the federally qualified health center program is an effective, cost-efficient, and culturally relevant primary care model that is able to achieve impressive outcomes in the underserved communities which they serve. However, CHCs face important limitations including rising patient loads and continued physician shortages. Even without these problems, community health centers are only part of realistic, comprehensive approach to addressing the health care crisis in this country.

Ultimately, I hope future legislators will continue to include health centers as part of the federal health care agenda. A multi-pronged approach might include an affordable national insurance plan that has preferential cost structures for CHCs and other primary care providers most of whose patients have Medicaid or are uninsured, for example, and for CHCs and other safety net providers, even if they are not CHCs, who meet significant quality and access standards. By whatever means, it would be wise to capitalize on this rich, ready to use resource in planning future health care policy instead of wasting what have been incomplete but real and tangible gains under the Bush administration.

**Limitations/Future Directions**

One of the biggest limitations of this study is that it is very small. I interviewed only 8 respondents, and my literature search and review of public documents was necessarily targeted, and limited to what I could do in a short time with no additional resources. Although I contacted many health center directors in Massachusetts, California, and North Carolina (an attempt to uncover regional differences) I had a very poor rate of response to my interview requests. Only one Californian director responded to my request, and no directors from Massachusetts responded, adding regional skewing to the sample. The poor response rate was
likely a combination of my unfamiliarity to my contacts as well as limited time and personnel resources.

The sample was also skewed by overrepresentation of community health center advocates. My respondents included only one rural health advocate and one public health researcher. Everyone else was explicitly involved with the health center program as their means of employment, and therefore presumed to be biased in favor of FQHCs.

The results of this study also suffer from the lack of input from congressional leaders involved in the legislative process. I had neither the time nor the resources to get responses during the brief study period.

If this study were to be replicated, it would benefit greatly from the inclusion of a much broader, more geographically representative respondent pool. Perhaps partnership with, or acknowledgement of, the federal NACHC office would add familiarity and improve response rates from clinicians and legislators. I would also be interested in investigating health center medical directors' attitudes on the legislative process to help understand how to help them be more vocal.

An election, and the commencement of a new Administration, have intervened since this study began. Policy analysts and researchers need to observe the Obama Administration's intentions for the community health center program, including its role in any larger attempts to reform the U.S. health care system. President Obama, members of Congress, and surprising new allies such as Fortune 500 corporations, are placing universal health insurance coverage at the heart of health reform plans. To what degree will CHCs fit into these plans for universal coverage? Alternatively, will universal coverage signal the beginning of the end of CHCs as we know them now?

In the short term, the indications are that this administration will be committed to substantive improvements for the health center program. In the American Recovery and Reinvestment Act of 2009 Congress budgeted two billion dollars to the health center program.
The bulk of these funds, $1.5 billion, are earmarked for much needed construction, renovation, and IT development services for existing FQHCs. These are precisely the areas that many of my respondents said were left out of the Health Care Safety Net Amendments. The remaining $500 million is for providing funding grants to centers for regular operation costs.

The ARRA does not shy away from the possibility of insurance reform in the health care safety net. In fact, it specifically commissions a study to examine "methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics."(p. 129)

The ARRA also takes a holistic view of health reform. Aside from safety net issues, it allocates $500 million to addressing physician workforce issues. The ARRA also establishes an umbrella organization, the Health Information Technology Research Center, which will investigate electronic health record systems for all practices receiving federal funds including Medicare and Medicaid reimbursement.

Barely four months have gone by since the passage of the ARRA. We must continue to observe it to determine if practical change and improvement for the health center program will be an outcome of its initiatives in the next several years.

This policy analysis master's paper, while relevant and revealing, represents a small, unfunded, and limited study. Besides the results and conclusions presented here, it is my hope that these data will be the foundation for more comprehensive work in this area in the future.
REFERENCES


Table 1: Legislative Timeline of Federally Qualified Health Centers

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1962</td>
<td>President Kennedy begins his re-election with a &quot;War on Poverty&quot; domestic platform.</td>
</tr>
<tr>
<td>1963</td>
<td>Kennedy assassinated near end of first term.</td>
</tr>
<tr>
<td></td>
<td>VP Lyndon Johnson takes office and embraces/continues the War on Poverty agenda.</td>
</tr>
<tr>
<td>1964</td>
<td><strong>Economic Opportunity Act passes</strong></td>
</tr>
<tr>
<td></td>
<td>Office of Economic Opportunity (OEO) created.</td>
</tr>
<tr>
<td></td>
<td>Within months the OEO started a large variety of community action efforts in what has been called &quot;one of the fastest rollouts of new federal effort on record&quot; (p. 296). There was an interest in addressing urban and rural medical reform as part of this effort, but no good ideas found initially.</td>
</tr>
<tr>
<td></td>
<td>Dr. Jack Geiger, health field coordinator and activist, and Dr. Count Gibson, Tufts Medical School attending, collaborated to create a COP-C inspired clinic system with headquarters in Boston and clinic sites in Columbia Point (South Boston) and the Mississippi Delta.</td>
</tr>
<tr>
<td>1965</td>
<td>June 11 - The OEO supported the Geiger/Gibson endeavor financially as a viable means of community-based urban health innovation.</td>
</tr>
<tr>
<td>1966-1967</td>
<td>Mississippi Delta clinic site finally open and operational. Progress at this location had been slowed due to high racial tension in community.</td>
</tr>
<tr>
<td></td>
<td>In the meantime, the OEO supported the opening of similar clinic models nationwide including: Denver, Chicago, and Los Angeles.</td>
</tr>
<tr>
<td>Late 1960's</td>
<td>Senator Ted Kennedy impressed with results of the Columbia Point clinic in his home-state requested <strong>$51 million be invested in expanding the model</strong></td>
</tr>
<tr>
<td></td>
<td>Period of rapid expansion ushered in by revenue flow. 33 new health centers funded by the OEO opened within a year.</td>
</tr>
<tr>
<td></td>
<td>Governance disagreements start to arise between the OEO and clinic communities as the health center gain stronger identity.</td>
</tr>
<tr>
<td>1969</td>
<td>The Department of Health, Education, and Welfare (HEW), initially reluctant to directly finance the physician workforce, finally takes an interest in the growing community clinic model and funds 25 health centers.</td>
</tr>
<tr>
<td></td>
<td>HEW re-frames farm health and integrates this with the health center model.</td>
</tr>
<tr>
<td></td>
<td>HEW calls for as many as 1000 clinic sites over next 5 years.</td>
</tr>
<tr>
<td></td>
<td>President Nixon elected and introduces his &quot;New Federalism&quot; policy designed to curb the social programs created during the Kennedy/Johnson administration.</td>
</tr>
<tr>
<td>1970</td>
<td>The OEO develops more explicit requirements and expectations for health centers including significant presence of community members on executive board.</td>
</tr>
</tbody>
</table>
Table 1 (cont’d): Legislative Timeline of Federally Qualified Health Centers

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>150 clinic sites nationwide: 100 OEL funded and 50 HEW funded.</td>
</tr>
<tr>
<td></td>
<td>OEO re-organized and health center financing gradually transferred more and more to HEW.</td>
</tr>
<tr>
<td></td>
<td>Bureau for community health services established within the HEW.</td>
</tr>
<tr>
<td></td>
<td>Nixon re-elected.</td>
</tr>
<tr>
<td></td>
<td>Administration takes a sharper turn to the right and HEW funding to community clinics targeted for complete elimination.</td>
</tr>
<tr>
<td>1974</td>
<td>Senator Ted Kennedy and Congressman Paul Rogers proposal a bill to give the health center system protected programmatic rights instead of just a budget line allotment which changes year to year depending on the political climate.</td>
</tr>
<tr>
<td></td>
<td>Bill vetoed by President Gerald Ford</td>
</tr>
<tr>
<td>1975</td>
<td>The Kennedy/Rogers Bill finally passes over President Ford's veto.</td>
</tr>
<tr>
<td></td>
<td>Bureau for Community Health Services, under the direction of Dr. Ed Martin, established indices to identify &quot;medically underserved&quot; communities, set requirements for majority community board membership, and establish statistical and finance reporting requirements for health centers.</td>
</tr>
<tr>
<td>Early 1970s</td>
<td>Under Ford Administration, expansion out-stripped budgetary increases so that new center openings financed by closing old centers.</td>
</tr>
<tr>
<td></td>
<td>New grants not as far-reaching and inclusive on non-health projects to which monies could be applied (&quot;lean mean&quot; model).</td>
</tr>
<tr>
<td>Late 1970s</td>
<td>Relative &quot;breathing period&quot; for social programs under President Carter's Administration. Expansion impeded, however, by sky rocketing interest rates nationwide.</td>
</tr>
<tr>
<td></td>
<td>Rural Clinic Health Services Act passes which directs Medicare and Medicaid to reimburse these clinics at higher rates closer to coverage of true costs.</td>
</tr>
<tr>
<td></td>
<td>HEW directors attempt to restore the &quot;meat&quot; to the lean mean clinic program by re-expanding additional non-health services.</td>
</tr>
<tr>
<td>1980</td>
<td>872 health center site grantees nationwide. However, underperforming in terms of patients served (5 million served vs. the 25 million expected).</td>
</tr>
</tbody>
</table>
Table 1 (cont’d): Legislative Timeline of Federally Qualified Health Centers¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980s</td>
<td>Regan Administration initiates strongest attack on the health center program spurred on by the Heritage Foundation which saw the program as a possible seedling for a nationalized healthcare system. Serious attempts made to convert program to block grant program to states bundled with many other social initiatives. This was ultimately overturned after years of debate in Congress. For the first time in history, federal funding to community health centers cut. 187 health centers across the nation phased out bringing total down to 685.</td>
</tr>
<tr>
<td>Early 1990s</td>
<td>Bipartisanship under the President Bush Sr. Administration renews federal investment in health centers. Federally Qualified Health Center Program officially titled and secured.</td>
</tr>
<tr>
<td>1989</td>
<td>Federally Qualified Health Centers program enacted for Medicaid.</td>
</tr>
<tr>
<td>1990</td>
<td>Federally Qualified Health Centers program enacted for Medicare. Medicare/Medicaid dollars rather than direct grant allotment becomes the primary funding stream for health centers.</td>
</tr>
<tr>
<td>Late 1990s</td>
<td>FQHC program initially put in precarious situation under the Clinton Administration as staffers pushed to fit the program into the “managed competition” model of the Clinton Health plan. Bipartisan advocacy preserved the FQHC program as a stand-alone project while the Clinton plan went on to suffer defeat. Funding to FQHCs soared to new highs even after severe Democratic losses in Congress in the mid-term elections of 1994.</td>
</tr>
<tr>
<td>Early 2000s</td>
<td>Strong spirit of bipartisan support continues under the President Bush Jr. Administration. President Bush pledges commitment to FQHCs and expresses desire for rapid expansion of program over 5 year period in The President’s Health Center Initiative. Health Care Safety Net Amendments of 2002 passes (see Figure 3) and starts multi-year process of similar legislation in legislative and financial support of FQHCs.</td>
</tr>
<tr>
<td>2009</td>
<td>Under the Obama Administration the American Recovery and Reinvestment Act passes which grants funding for construction and IT development and commissions study to investigate possible quality driving reimbursement methods for federally funded health services.²</td>
</tr>
</tbody>
</table>

SOURCE:

Table 2: Overview of the Health Center Program

Excerpt from National Association of Community Health Centers website¹:

Spread across 50 states and all U.S. territories, there are 1,200 Community Health Centers that provide vital primary care to 18 million Americans with limited financial resources.

Directed by boards with majority consumer membership, health centers focus on meeting the basic health care needs of their individual communities. Health centers maintain an open-door policy, providing treatment regardless of an individual's income or insurance coverage.

Health centers serve the homeless, residents of public housing, migrant farm workers and others with emergent and chronic health care needs, but limited resources to secure treatment through traditional channels.

Health centers provide substantial benefits to their communities:

- They serve 20% of low-income, uninsured people.
- 70% of their patients live in poverty.
- They provide comprehensive care, including physical, mental and dental care.
- They save the national health care system between $9.9 billion and $17.6 billion a year by helping patients avoid emergency rooms and making better use of preventive services.

<table>
<thead>
<tr>
<th>Approximate Number of Organizations</th>
<th>1,200²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximate Number of Delivery Sites</td>
<td>7,000²</td>
</tr>
<tr>
<td>Total Patients</td>
<td>18 million²</td>
</tr>
<tr>
<td>Number Migrant/Seasonal Farmworker Patients</td>
<td>936,000²</td>
</tr>
<tr>
<td>Number Homeless Patients</td>
<td>1 million²</td>
</tr>
</tbody>
</table>

SOURCE:

Table 3: Serving the Underserved – Demographics of Health Center Patients

<table>
<thead>
<tr>
<th></th>
<th>Health Center Population</th>
<th>US Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent at or Below 100% Poverty, 2007</td>
<td>70%</td>
<td>17%</td>
</tr>
<tr>
<td>Percent Under 200% of Poverty, 2007</td>
<td>91%</td>
<td>36%</td>
</tr>
<tr>
<td>Percent Uninsured, 2007</td>
<td>39%</td>
<td>12%</td>
</tr>
<tr>
<td>Percent Medicaid, 2007</td>
<td>35%</td>
<td>13%</td>
</tr>
<tr>
<td>Percent Medicare, 2007</td>
<td>8%</td>
<td>15%</td>
</tr>
<tr>
<td>Percent Hispanic/Latino, 2007</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>Percent African American, 2007</td>
<td>28%</td>
<td>13%</td>
</tr>
<tr>
<td>Percent Asian/Pacific Islander, 2007</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Percent American Indian/Alaska Native, 2007</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Percent White (Including Hispanic/Latino), 2007</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Percent Rural, 2007</td>
<td>44%</td>
<td>16%</td>
</tr>
</tbody>
</table>

* May not sum to 100% due to rounding and non-inclusion of two or more races. 0% may indicate <0.5%.

**SOURCE:**
Table 4: FQHCs and the Health Care Safety Net Amendments of 2002

<table>
<thead>
<tr>
<th>Bill Names:</th>
<th>Public Law 107-251, Health Care Safety Net Amendments of 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Sponsors:</td>
<td>Senator Edward Kennedy</td>
</tr>
<tr>
<td>Date Passed:</td>
<td>October 26, 2002</td>
</tr>
</tbody>
</table>

Major Provisions to FQHCs via **Title I, Consolidated Health Center Program Amendments:**
- Reauthorization of the FQHC program
- Additional funding to be allocated for acquiring new leases for expansion
- Telemedicine initiative to be funded for coordination of clinics

Other Major Provisions:
- **Title II, Rural Health:** to provide grant for expanded deliver of health care service in rural areas for planning and implementation of integrated health care networks in rural areas and for small health care provider quality improvement activities
- **Title III, National Health Service Corp Program:** to reauthorize the NHS including redefining medically underserved areas and breach of scholarship requirements
- **Title IV, Healthy Communities Access Program:** to provide assistance to communities in efforts to coordinate health care services for uninsured or underinsure individuals

Outcomes:
In the five years following the passage of this bill and approval of the budget funding the provisions...

- **Health Centers doubled their delivery sites** and achieved the goal of 1,200 new or expanded centers
- **Health Centers cared for more than 16 million patients** in 2007, an increase of more than 5.8 million over 2001.
- **A total of 2.8 million patients received dental services** in 2007, more than twice as many as in 2001.
- **A total of 617,000 patients received mental health care** in 2007, more than three times as many as in 2001.

SOURCE:

Appendix I: Systematic Review of the Literature

**Inclusion Criteria:**
1. Articles exclusively about or involving Federally Qualified Health Centers.
2. The full text of the article was available online via the UNC library proxy.
3. Abstract review demonstrated study of CHC service delivery, outcomes, patient demographics, or needs assessment.
4. Studies were conducted in the United States of America

**Exclusion Criteria:**
1. Articles on ancillary health services: dental health, mental health, substance abuse/treatment.
2. Articles which did not investigate FQHCs themselves, but only used them as a host study site for innovative research.
3. Articles with foreign clinic settings.

**Search Terms in PubMed:**


<table>
<thead>
<tr>
<th>Resultant Articles</th>
<th>Eliminated Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>365 articles found by search strategy</td>
<td>→ 233 no online text available</td>
</tr>
<tr>
<td>165 with full text available via UNC Proxy</td>
<td>→ 52 published in 1999 or earlier</td>
</tr>
<tr>
<td>113 published in 2000 or later</td>
<td>→ 2 foreign studies</td>
</tr>
<tr>
<td>111 studies conducted in United States</td>
<td>→ 42 about substance abuse and/or mental health services</td>
</tr>
<tr>
<td></td>
<td>→ 6 about oral health services</td>
</tr>
<tr>
<td></td>
<td>→ 40 with FQHC as study site for innovative trial (but not a study of service delivery itself)</td>
</tr>
</tbody>
</table>

23 Final Articles reviewed in detail. FQHC patient outcomes, needs, and delivery studies for inclusion in final paper.
Appendix II: Structured Interview Protocol

1. As you know, in 2002, President Bush proposed a multi-year initiative for the Federal Consolidated Health Center Program under section 330 of the Public Health Service Act. This initiative aims to expand and strengthen the safety net for those most in need by making more primary health care services available to community health centers’ new and existing patients.

   a. What would you say were the three most important factors in the President’s decision to begin this initiative?


   a. Once again, if you could name three most important influences on Congress in these budget expansions, what would they be?

3. Did your [office/organization] have input in the drafting of these policy changes? Which ones? How would you describe that input?

4. To your knowledge, how were the interests of various other stakeholders represented in the drafting of these amendments? Who would you say were the stakeholders who had the most influence in the policy process?

5. Since 2002, the Health Center Initiative has been amended and affected by other legislation.

   a. In your opinion, how successful have the passage of the Health Care Safety Net Amendments been in meeting the goals of the President’s health center initiative?

   b. And how successful have they been in helping to support and grow CHCs? What needs have they met? What would you say is left to be done?

6. In your opinion, how has the passage of these amendments influenced the overall relationship between the federal government and FQHCs?

7. Last question! I’m sure you’ve thought about the lessons we should draw from the passage of the Health Care Safety Net Amendments. What lessons do you think will help the planning for future needs?

   a. And do we need other, similar legislation? Or something different?
## Appendix III: Elite Interview Respondents

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Cox</td>
<td>NACHC Director of Federal Affairs, Reauthorization</td>
</tr>
<tr>
<td>John Sawyer</td>
<td>NACHC Director of Federal Affairs, Appropriations &amp; Budget Issues</td>
</tr>
<tr>
<td>Lynn Williams</td>
<td>NACHC - Grassroots Field Organizer, Tennessee</td>
</tr>
<tr>
<td>Benjamin Money</td>
<td>North Carolina Community Health Center Association (NCCHCA), Associate Director</td>
</tr>
<tr>
<td>Rosy Chang-Weir</td>
<td>Association of Asian Pacific Community Health Organizations (AAPCHO), Senior Research Associate</td>
</tr>
<tr>
<td>Dr. Roger Rosenblatt</td>
<td>MD/MPH; Family Medicine Doctor &amp; published health policy researcher</td>
</tr>
<tr>
<td>Dr. Anonymous</td>
<td>West Coast CHC Medical Director</td>
</tr>
<tr>
<td>Dr. Evelyn Schmidt</td>
<td>Lincoln Community Health Center of Durham, NC</td>
</tr>
</tbody>
</table>