



Statement of

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Good afternoon, Mr. Chairman, Members of the Subcommittee. Thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration (HRSA) to discuss the Health Center and National Health Service Corps (NHSC) Programs. I appreciate your support and awareness of the importance and critical role these safety net programs play in ensuring access to care for millions of Americans.

Background

I would like to begin with the Health Centers Program, its history, administration, and budget. Health centers are community-based and consumer-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing. I also want to recognize the incredible efforts of the clinicians and staff of the Nation's health centers. Their contributions to remedying the problems of the underserved and uninsured are undeniable and significant. Their patients and communities know and rely on them.

Health Centers: Forty-Two Years of Essential Service to America

In 1965 health centers were first funded by Congress to provide primary health care services to communities in need. These centers were designed to provide accessible, dignified personal health services to low-income families. Community and consumer participation in the organization and a patient-majority governing board were and continue to be hallmarks of the Health Center model.

Specifically, health centers are governed by community boards composed of a majority (51 percent or more) of health center patients who represent the population served. HRSA believes that the patient-majority governance requirement is a cornerstone of the Health Center program that assures community input and representation in the leadership and decision making of the health center.

Health centers provide comprehensive primary and preventive health care services as well as supportive services (education, translation, and transportation) that promote access to health care. Services are available to all with fees adjusted based on one's ability to pay. Health centers must also meet performance and accountability requirements regarding administrative, clinical, and financial operations. Health centers are located in medically underserved areas and/or serve medically underserved populations. Nearly 82 percent of Health Center funding is awarded to community health centers, with the remaining 18.5 percent divided across migrant (8.6 percent), public housing (1.2 percent), and homeless health centers (8.7 percent).

Honed by years of bipartisan efforts from a supportive Congress, this community-based primary care service delivery model has worked effectively over many years. We thank the Committee for their efforts in reauthorizing the program.

Health Services for School-Aged Children

HRSA recognizes that school-aged children are an important segment of the underserved population served by health centers. Approximately 23 percent (over 3.4 million) of health

center patients are school-aged children (ages 5-18). In addition, 37 percent (5.5 million) of health center patients are children under the age of 19. As a result of the ongoing support of the Administration and Congress in expanding health centers, services to school-aged children continue to grow. We believe new authority for school based clinics is unnecessary as the existing statute provides us with the authority and flexibility to help reach millions of school-aged children and provide them with much needed primary care services, either in school based sites or traditional health center settings. Moreover, the Nation's health centers are located in communities of great need and serve the entire family, not just one age group.

Also, HRSA provides services to school-aged children through the Maternal and Child Health (MCH) Block Grant. Approximately \$100 million of the Federal block grant goes to this population. About 16 million school-aged children are served by the block grant. The funding is provided to State health departments, local health agencies, local education agencies, and pediatric specialty providers. The MCH Block Grant provides a variety of health services and health education programs. Examples of activities which States have reported include: in Kansas, the Coordinated School Health programs provide grants for schools to form School Councils and complete the School Health Index. These grants can be used to prevent obesity and encourage physical activity. In Maryland, in 2006, the grants supported 20 of the State's 24 local health departments' provision of oral health care, ranging from some preventive services to comprehensive clinical programs including restorative services. The MCH Block Grant also provides direct services to special needs school-aged children. MCH grant funds can be used to provide pediatric specialty services including cardiology, neurology, and orthopedic services.

The President's Health Center Initiative

I am proud to update you on the success and growth of the program to date. By any measure, we have been enormously successful implementing the President's Health Center Expansion Initiative. In the 2000 campaign, the President committed to create 1,200 new or expanded Health Center sites to increase access to primary health care, which has served over 15 million patients in 2006—an increase of 46 percent or 92.5 million since 2001. The final FY 2007 Congressional appropriation included an increase of more than \$203 million for Health Centers. These additional funds are supporting the establishment of over 330 new and expanded health center sites in FY 2007. Of these awards, 80 are supporting new health center sites in counties with high rates of poverty that currently do not have access to health center services—as part of the President's Initiative to provide a health center in every poor county that lacks a Health Center site and can support one, thus extending the benefits of health center care to the hardest-to-reach, poorest areas of the country. As a result, health center sites will exist in more low-income counties than ever before, and some 300,000 people in some of the poorest communities in the country will gain access to primary care, many for the first time. These expansion efforts continue to be a priority because we know these funds go to provide direct health care services for our neighbors who are most in need.

Health Center Patients

Health centers provide comprehensive, culturally competent, quality primary health care services to a diverse patient population. This includes access to pharmacy, mental health, substance abuse, and oral health services. In 2006, health centers served 15 million individuals at an

average cost of about \$538 per patient, and provided over 59 million patient visits. The proportion of uninsured patients of all ages held steady at nearly 40 percent while the number of uninsured patients increased from 4 million in 2001 to 6 million in 2006. In 2006, the current health center population served is 23 percent African American, 36.1 percent Hispanic, 4.5 percent Asian/Other (American Indian, Alaskan Native, Pacific Islander) and 36 percent White. These percentages represent almost twice the proportion of African Americans and over two and a half times the proportion of Hispanics reported in the overall U.S. population. Health Centers serve over 807,000 Migrant and Seasonal Farmworkers and their families, nearly 829,000 individuals experiencing homelessness and over 129,000 residents of public housing.

Health Center Effectiveness in Delivering Care and Reducing Disparities

The value and effectiveness of the Health Center Program has been proven in numerous studies and evaluations. Peer reviewed literature and major reports document that health centers successfully improve access to care, improve patient outcomes for traditionally underserved patients, and are cost effective. Studies have also shown that health centers facilitate the use of preventive care, especially among minority and low income patients. Health centers provide continuous and high quality primary care and reduce the use of costlier providers of care, such as emergency departments and hospitals.¹ Additionally, uninsured people living within close proximity to a health center are less likely to have an urgent unmet medical need.²

Health centers have been found to improve patient outcomes and reduce racial and ethnic disparities in health care.³ For example, the health center low birth weight rate for African

¹ Proser. Journal of Ambulatory Care Management 28(4), 2005.

² Hadley J and Cunningham P. Health Services Research 39(5): 2004.

American patients is lower than the national rate for African American infants.⁴ Also, health centers show demonstrable success in chronic disease management, and a high proportion of health center patients receive appropriate care. Researchers have also found that quality of care (e.g., patient rates of blood pressure control) delivered by health centers was comparable to and sometimes better than the quality of care delivered in other settings for the underserved.

In addition, Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere. Health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care.⁵

Health Information Technology and Quality

A key goal of HRSA's is to transform systems of care for safety net populations through the effective use of Health Information Technology (HIT). In FY 2007, HRSA awarded a total of 46 grants worth \$31.4 million to expand the use of health information technology at health centers. Grants were awarded to support implementation of Electronic Health Records (EHRs) at health centers and in networks that link multiple health center grantees, to help health centers in planning activities that will prepare them to adopt EHR or other HIT innovations such as electronic prescribing, physician order entry, or personal health records. As a condition of grant

³ O'Malley AS, et al. Health Affairs 24(2): 2005, Shin P, Jones K, and Rosenbaum S. George Washington University: 2003, Shi, L., J. Regan, R. Politzer, and J. Luo. International Journal of Health Services 31(3): 2001.

⁴ Shi et al. Health Services Research, 39:2004.

⁵ Falik M. et al. Journal of Ambulatory Care Management 29, 2006.

funding, recipients are required to utilize certified HIT products where available and to implement data standards that will make HIT interoperable.

HRSA is currently involved in an agency-wide effort to improve quality and accountability in all HRSA-funded programs that deliver direct health care. Our vision is to have HRSA-funded programs provide the highest-quality clinical care in the entire American health care sector. One of the key steps we have taken in this area is to establish a core set of clinical performance measures for all health centers. Among health centers, advancing quality is not a new concept. Health centers have been on a quality quest since their inception, grounded in the principles of community-oriented primary care.

NHSC: Thirty-Five Years of Quality Service to America

The NHSC was created with the Emergency Health Personnel Act of 1970 to address a need: too few clinicians were training in needed specialties, practicing in unserved areas, or seeing people who needed health care. Its charge was simple: place clinicians in areas of need. Within six months of its initial operation in 1972, the NHSC had placed 180 volunteer clinicians in over 100 communities. Also in 1972, the Emergency Health Personnel Act Amendments established the NHSC Scholarship Program, which linked award of a full scholarship (tuition, fees, stipend) to a commitment on the part of the scholar to serve in an underserved area. The NHSC continued to place volunteers in the interim years while the first scholars were chosen, completed their training, and began service in 1977.

By 1980 the NHSC had a Field Strength of 2,080 in service to the underserved. By the mid-1980s, it became clear that despite an increase in the number of physicians nationwide, the problem of lack of access was becoming acute among increasingly larger segments of the population. In 1987, the NHSC was augmented by the establishment of the NHSC Loan Repayment Program. This new Program recruited already trained and qualified primary care clinicians by offering incremental annual payments to be applied against their student loans in return for service in an underserved area. This enabled the NHSC to fill an immediate need for a clinician, as opposed to waiting for one to be produced out of the scholarship pipeline.

In 1990, the NHSC was reauthorized for ten years, and by 1994, the NHSC, in response to community demand, expanded eligibility for loan repayment to several mental and behavioral health disciplines. In 2000, the NHSC conducted a large study of NHSC alumni (i.e., those clinicians who had completed their service obligation up to 15 years before). Fully 52 percent of those clinicians continued to serve the underserved in their practice. The NHSC of 2002 had a Field Strength of 2,765, of which approximately 54 percent were primary care physicians. Also in that year, the NHSC was reauthorized by Congress through fiscal year 2006, and was given greater flexibility to distribute funds between the Scholarship and Loan Repayment Programs. This change in the law enabled the NHSC to direct more funding to loan repayment, with the effect that in 2006 the NHSC Field Strength grew to 4,109, a nearly 50 percent increase in the Field Strength since reauthorization in 2002. This is due in large part to the increased flexibility the program now has to shift more funding to help meet the immediate needs of underserved communities and vulnerable populations. In response to communities' demand for services, the number of NHSC dentists increased by 62 percent and the number of mental and behavioral

health professionals grew by 176 percent from 2002 to 2006. In addition, in 2006, as throughout the history of the Program, approximately 60 percent of NHSC clinicians served in rural America.

The current NHSC statute sets a funding floor for the Scholarship program, 10 percent of total NHSC appropriations. HRSA supports this existing statutory authority that provides us the administrative flexibility to determine the level of support between the Scholarship and Loan Repayment Programs, in response to community requests and areas of greatest need. This flexibility also helps us to respond quickly to changes in the health care environment across the U.S.

Current NHSC Field Strength

As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of Health Professional Shortage Areas (HPSA), removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and national organizations to help address their health care needs, and help reduce the health disparities gap. The current Field Strength (clinicians in service to the underserved) of the NHSC is 4,109. Of this amount, 2,051 are in HRSA grant-supported health centers, with the remaining 2,058 NHSC clinicians in “free-standing” sites. It is noteworthy that the percentage of NHSC clinicians working in health centers has been at 50 percent or higher since 2004, the highest, and longest sustained,

percentage in recent years. The NHSC made 1,100 NHSC placements in HPSAs in FY 2007—in response to community requests and the level of need.

Other NHSC Activities

In getting the word out to the communities about our programs, the NHSC's Student/Resident Experiences and Rotations in Community Health (SEARCH) Program is offered to State-based organizations on an annual, competitive basis. Under this program, health professions students and medical residents get experience in primary clinical care. This potentially leads to greater numbers of clinicians serving in primary care centers, including health centers. In FY 2007, 20 States and Puerto Rico participated in SEARCH at a funding level of \$1,823,068.

The NHSC Ambassador Program is a membership organization comprised of a dedicated group of volunteers on campuses and in communities across the Nation. These volunteers, or "Ambassadors," work in partnership with the NHSC, serving as mentors and trainers to Scholars and Loan Repayers.

The word is spreading. The NHSC's recruitment efforts have led to its Job Opportunity List utilized so successfully that more vacancies were filled last year by non-NHSC clinicians than by NHSC Scholars and Loan Repayers.

Conclusion

We are proud of the accomplishments of the Health Center Program and NHSC. These programs are delivering care to millions of underserved Americans with few health care

alternatives. We look forward to working with the Committee in reauthorizing these programs.

I would be happy to answer any questions at this time.