United States Government Accountability Office

GAO

Report to the Honorable Judd Gregg, U.S. Senate

July 2005

HEALTH CENTERS

Competition for Grants and Efforts to Measure Performance Have Increased

GAO-05-645

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Highlights

Highlights of GAO-05-645, a report to the Honorable Judd Gregg, U.S. Senate

Why GAO Did This Study

Health centers in the federal Consolidated Health Centers program provide comprehensive primary health care services at one or more delivery sites, without regard to patients' ability to pay. In fiscal year 2002, the Health Resources and Services Administration (HRSA) began implementing the 5-year President's Health Centers Initiative. The initiative's goal is for the program to provide 1,200 grants in the neediest communities—630 grants for new delivery sites and 570 grants for expanded services at existing sites—by fiscal year 2006. GAO was asked to provide information on (1) funding of health centers and HRSA's process for assessing the need for services, (2) geographic distribution of health centers, and (3) HRSA's monitoring of health center performance.

What GAO Recommends

GAO recommends that the Administrator of HRSA ensure that the agency collects reliable information from grantees on the number and location of delivery sites funded by the program and accurately reports this information to the Congress. HRSA said that it has efforts under way to increase the accuracy of delivery site data, but HRSA did not indicate whether it plans to revise its method of counting and reporting delivery sites to include all delivery sites funded since the President's Health Centers Initiative began.

www.gao.gov/cgi-bin/getrpt?GAO-05-645.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marjorie Kanof, (202) 512-7119.

What GAO Found

Competition for Consolidated Health Centers program funding increased over the first 3 years of the President's Health Centers Initiative, and HRSA's process for assessing communities' need for additional primary care sites is evolving. Program funding, which primarily supported continuing health center services, increased from fiscal year 2002 to fiscal year 2004. However, funding for new access point grants, which fund one or more new delivery sites, decreased by 53 percent during this period. At the same time, the number of applicants for these grants increased by 28 percent. As a result, the proportion of applicants receiving new access point grants declined from 52 percent in fiscal year 2002 to 20 percent in fiscal year 2004. In fiscal years 2002 through 2004, HRSA funded 334 new access point grants and 285 grants for expanded services at existing sites. While HRSA includes an assessment of communities' need for services in its process for awarding new access point grants, agency officials indicated that they were not confident that the process has sufficiently targeted communities with the greatest need. Therefore, the agency is considering changes to the way it assesses community need and the relative weight it gives need in the award process.

The number of health centers receiving new access point grants varied widely by state—from 1 to 57—during fiscal years 2002 through 2004, but HRSA lacks reliable data on the number and location of health centers' delivery sites. Although HRSA uses data on the number of delivery sites to track the progress of the Consolidated Health Centers program, it is not confident that grantees are accurately identifying delivery sites funded by the program. Furthermore, in its reporting, HRSA counted each new access point grant funded in fiscal years 2002 through 2004 as a single delivery site, although some represent more than one site. HRSA needs to collect and report accurate and complete delivery site data to give the agency and the Congress data they need to make decisions about the program.

HRSA has increased the role of performance measurement in its monitoring of health centers and has improved its collection of data that could help measure overall program performance. In 2004, the agency began to use a new process for on-site monitoring of health centers that focuses on each center's performance on measures tailored to its community and patient population. However, the new review generally does not provide standardized performance information that HRSA can use to evaluate the health center program as a whole. The agency is using other tools to collect health outcome data on patients that could help measure program performance. Continued attention to such efforts could improve the agency's ability to evaluate its success in improving the health of people in underserved communities. In addition to developing these data collection tools, HRSA has taken steps to improve the accuracy and completeness of its Uniform Data System, a data set that HRSA uses to monitor aspects of the health centers' performance. For example, HRSA provided grantees with more detailed instructions on how to identify their delivery sites.

Contents

Abbreviations

BPHC	Bureau of Primary Health Care
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OPR	Office of Performance Review
PCER	Primary Care Effectiveness Review
UDS	Uniform Data System

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, D.C. 20548

July 13, 2005

The Honorable Judd Gregg
United States Senate

Dear Senator Gregg:

The nationwide network of health centers in the federal Consolidated Health Centers program is an important component of the health care safety net for vulnerable populations, including Medicaid beneficiaries,[1] people who are uninsured, and others who may have difficulty obtaining access to health care. The centers provide comprehensive primary health care services—including preventive, diagnostic, treatment, and emergency services and referrals to specialty care[2]—without regard to patients' ability to pay. They also provide enabling services, such as transportation and translation, that help patients gain access to care. In 2003, through this program, the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) was funding nearly 900 health centers with one or more delivery sites. The health centers provided comprehensive primary care services to over 12 million people—including over 4 million Medicaid patients and nearly 5 million uninsured patients. To increase access to health care for vulnerable populations, HRSA began implementing the 5-year President's Health Centers Initiative in fiscal year 2002. The initiative's goals are for the Consolidated Health Centers program to provide 1,200 grants in the neediest communities—630 grants to health centers for new primary care delivery sites and 570 grants to health centers

[1]Medicaid is a joint federal-state program that finances health insurance for certain low-income adults and children.

[2]Specialty care is health care services provided by medical professionals with advanced training focused on a specific field, such as cardiology, dermatology, and orthopedics.

for expanded services at existing sites[3]— and increase the number of people served annually to about 16 million by the end of fiscal year 2006.[4]

Federal community and migrant health centers were established in the mid-1960s, and other types of health centers—such as homeless and public housing centers—were established subsequently. The Health Centers Consolidation Act of 1996 created the Consolidated Health Centers program by combining these various types of health center programs under Section 330 of the Public Health Service Act.[5] In fiscal year 2004, funding for the Consolidated Health Centers program was about $1.6 billion, of which about $1.4 billion was allocated to grants for health centers. The Health Care Safety Net Amendments of 2002 reauthorized the Consolidated Health Centers program through fiscal year 2006.[6]

In light of the goals of the President's Health Centers Initiative and in preparation for consideration of the reauthorization of the Consolidated Health Centers program, you asked us to provide information on the program, including health centers' efforts to link patients with specialty care. In this report, we discuss (1) funding of health centers and HRSA's process for assessing the need for services; (2) the geographic distribution of health centers; (3) HRSA's monitoring of health center performance; and (4) health centers' efforts to provide specialty care for their patients.

To conduct our work, we analyzed national data that HRSA collects from health centers that receive grants through the Consolidated Health Centers program. We also reviewed information on health center funding, grant applications, and grant awards during fiscal years 2002 through 2004. We assessed the reliability of these data by interviewing agency officials

[3]New primary care delivery sites are sites that were not previously part of health centers funded by the Consolidated Health Centers program. These sites may be newly established facilities or facilities that already existed at the time their health center first received program funds. Sites providing expanded services are previously existing program sites whose health center is receiving additional funds to increase the site's service capacity.

[4]HRSA reported that in fiscal year 2001, before the President's Health Centers Initiative began, the number of primary care delivery sites whose health centers were receiving Consolidated Health Centers program funding was 3,317, and the number of people served was 10.3 million.

[5]Pub. L. No. 104-299, 110 Stat. 3626 (1996) (codified at 42 U.S.C. § 254b). The Consolidated Health Centers program also funds school-based health centers.

[6]Pub. L. No. 107-251, § 101, 116 Stat. 1621, 1622-27 (2002).

knowledgeable about the data and the systems that produced them, and we determined that the data were sufficiently reliable for the purposes of this report. We interviewed HRSA officials and representatives of state and national health center membership organizations and conducted structured interviews with officials of 12 health centers in urban and rural areas of California, Illinois, Pennsylvania, and Texas. We selected these states because they vary in geographic location and were among the states with the highest number of health centers. We conducted our work from August 2004 through June 2005 in accordance with generally accepted government auditing standards. (For additional information on our methodology, see app. I.)

Results in Brief

Competition for Consolidated Health Centers program funding increased over the first 3 years of the President's Health Centers Initiative, and HRSA's process for assessing communities' need for additional health center delivery sites is evolving. Program funding, which primarily supported continuing health center services, increased from fiscal year 2002 to fiscal year 2004. However, funding for new access point grants, which fund one or more new delivery sites operated by either new or existing grantees, decreased by 53 percent during this period. At the same time, the number of applicants for these grants increased by 28 percent. As a result, the proportion of applicants receiving new access point grants declined from 52 percent in fiscal year 2002 to 20 percent in fiscal year 2004. While HRSA includes an assessment of communities' need for services in its process for awarding new access point grants, agency officials indicated that they are not confident that the process has sufficiently targeted communities with the greatest need. Therefore, the agency is considering changes to the way it assesses community need and the relative weight it gives need in the award process.

The number of health centers receiving new access point grants varied widely by state during fiscal years 2002 through 2004, but HRSA lacks reliable information on the number and location of the delivery sites where health centers provided care. During this period, about half of the 334 new access point grants HRSA awarded were in 10 states, and the number of grantees in each state ranged from 1 to 57. While HRSA can provide information on the geographic distribution of health center grantees, it does not have reliable information on the number and geographic distribution of delivery sites where the centers provide care. In its budget documents and performance reports, HRSA has used the number of delivery sites it funds to provide information on its progress toward

achieving its health center program goal of increasing the number of health center access points. Although HRSA mostly uses delivery site data from its Uniform Data System (UDS), the program's administrative data set, to measure this progress, the agency is not confident that grantees accurately report to UDS the sites supported by program dollars. In addition, HRSA has underestimated the number of delivery sites it funded in fiscal years 2002 through 2004 by counting each new access point grant as a single delivery site regardless of how many sites the grant supports. It is important for HRSA to ensure that it is collecting and reporting accurate and complete information about the number and location of delivery sites where health centers are providing care. HRSA officials and the Congress need this information to make decisions about managing and funding the health centers program.

HRSA has increased the role of performance measurement in its monitoring of health centers and has improved its collection of data that could help measure overall program performance. In 2004, the agency began to use a new process for on-site monitoring of individual health centers that focuses on each center's performance on measures tailored to the specific needs of its community and patient population. The new review also provides specific feedback to each health center on ways to improve its performance. However, the new review generally does not provide standardized performance information that HRSA can use to evaluate the health center program as a whole. The agency is using other tools to collect data that could help measure overall program performance. For example, HRSA is collecting patient-level health outcome data through its Sentinel Centers Network—a network of health centers designed to be geographically and sociodemographically representative—and through its Health Disparities Collaboratives, which collect standardized data on patients with chronic diseases such as diabetes and asthma. Continued attention to such efforts could improve the agency's ability to evaluate its success in improving the health of people in underserved communities. In addition to developing these data collection tools, HRSA has taken steps to improve the accuracy and completeness of UDS, which it uses to monitor aspects of the health centers' operations and performance. For example, to improve the accuracy of UDS data on health centers' delivery sites, for 2004, HRSA revised the instructions to health center grantees for identifying their delivery sites. In providing this new guidance, HRSA has taken a step toward improving the quality of its information on the number and location of the delivery sites it funds. However, the agency will need to carefully assess the effectiveness of the guidance and, if necessary, take additional steps to ensure that delivery site information is accurate.

Although Consolidated Health Centers program funding has enabled health centers to expand the availability of primary care services, health centers often face difficulty ensuring that patients receive the specialty care they need. About one-third of health centers provide some specialty care on site, but health centers more often provide referrals to specialty care outside the center. Officials from most of the health centers in our review told us that there was a shortage of certain types of specialists available to receive referrals and some specialists were not willing to provide free care for uninsured patients.

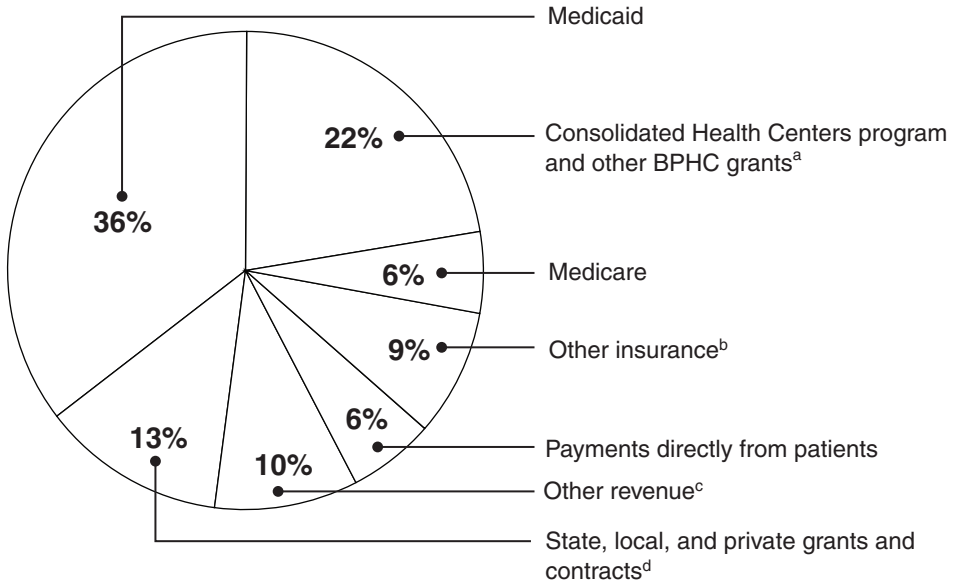
We are recommending that the Administrator of HRSA ensure that the agency collects reliable information from grantees on the number and location of delivery sites funded through the program and accurately reports this information to the Congress.

In commenting on a draft of this report, HRSA acknowledged that more accurate and timely delivery site data would allow for improved management of the Consolidated Health Centers program and said that the agency has efforts under way to increase the accuracy of these data. HRSA did not indicate whether it plans to revise its method of counting delivery sites for its future reports on the progress of the health centers program to include all delivery sites funded since the President's Health Centers Initiative began. We believe that it is important for HRSA and the Congress to have complete and accurate information on all delivery sites funded by program dollars.

Background

The Consolidated Health Centers program is administered by HRSA's Bureau of Primary Health Care (BPHC). In addition to program grants from HRSA, which constitute about one-quarter of the centers' budgets, the health centers receive funding from a variety of other sources, including Medicaid and state and local grants and contracts. (See fig. 1.) In 2003, health centers reported total revenues of about $5.96 billion.

Figure 1: Health Centers' Sources of Revenue, 2003



Source: GAO analysis of HRSA's UDS, *Calendar Year 2003 Data: National Rollup Report*, Exhibit A.

Note: Percentages do not total to 100 percent due to rounding. Health centers reported total revenues of about $5.96 billion in 2003.

[a]Other grants administered by BPHC account for 1 percent of health center revenue and include grants for capital improvement and management information systems.

[b]Includes private third-party insurance (6 percent) and other public insurance (3 percent).

[c]Includes funding from other federal grants (3 percent), indigent care programs (4 percent), and nonpatient-related funding not reported elsewhere (3 percent).

[d]State and local grants and contracts account for 9 percent and private grants and contracts, including foundations, account for 3 percent. Percentages do not total to 13 percent due to rounding.

Health centers are required by law to serve a federally designated medically underserved area or a federally designated medically underserved population.[7] In 2003, 69 percent of health center patients had a family income at or below the federal poverty level, and 39 percent were uninsured. In addition, 64 percent of patients were members of racial or

[7]42 U.S.C. § 254b(a). Criteria for designating a medically underserved area or population include the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the federal poverty level, and percentage of the population age 65 or older. In 2004, the federal poverty level for a family of four was an annual income of $18,850 in the 48 contiguous states and the District of Columbia.

ethnic minority populations, and 30 percent spoke a primary language other than English.[8]

Health Center Organization and Services

Health centers are private, nonprofit community-based organizations or, less commonly, public organizations such as public health department clinics. The centers are typically managed by an executive director, a financial officer, and a clinical director. In addition, health centers are required by law to have a governing board, the majority of whose members must be patients of the health center.[9,10]

Health centers are required to provide a comprehensive set of primary health care services, which include treatment and consultative services, diagnostic laboratory and radiology services, emergency medical services, preventive dental services, immunizations, and prenatal and postpartum care. Centers are also required to provide referrals for specialty care and substance abuse and mental health services, and although centers may use program funds to provide such services themselves or to reimburse other providers, they are not required to do so. In addition, a distinguishing feature of health centers is that they are required to provide enabling services that facilitate access to care, such as case management, translation, and transportation. The health care services are provided by clinical staff—including physicians, nurses, dentists, and mental health and

[8]Information on health center patients is based on UDS data. The percentages related to income level and race/ethnicity exclude patients whose status HRSA reported as unknown. The income level of 20 percent of patients was reported as unknown, and the race/ethnicity of 6 percent of patients was reported as unknown.

[9]42 U.S.C. § 254b(k)(3)(H). According to the health centers statute, HRSA must waive the governing board composition requirement for a center that proposes to serve homeless, migrant, or public housing populations exclusively and for those that are located in sparsely populated rural areas if the center can show "good cause" for the waiver. HRSA's application guidance indicates that a waiver will be granted only if applicants show they cannot meet the composition requirement and that arrangements are in place to ensure appropriate patient input and involvement. HRSA program guidance indicates that a legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a patient for purposes of board representation.

[10]HRSA and some health center officials we interviewed believe patient representation on the governing board is key to identifying the health care needs of the community. Several representatives from health centers that do not receive Consolidated Health Centers program funding told us that the governing board requirement for majority patient representation deters some potential applicants for program funding because of concerns that the requirement could limit the financial and managerial expertise of the board.

substance abuse professionals—or through contracts or cooperative arrangements with other providers. Health center services are offered at one or more delivery sites and are required to be available to all people in the center's service area.[11] Services must be provided regardless of patients' ability to pay.[12] Uninsured users are charged for services based on a sliding fee schedule that takes into account their income level, and health centers seek reimbursement from public or private insurers for patients with health insurance.

HRSA's Award Process for Grants Funded through the Consolidated Health Centers Program

HRSA uses a competitive process to award grants to health centers. Grant applications undergo an initial review for eligibility in which HRSA screens applications based on specific criteria—the applicant must be a public or private nonprofit entity, the applicant must be applying for an appropriate grant (e.g., certain grants funded by the program are available only to existing grantees), and the application must include the correct documents and meet page limitations and format requirements.[13] Independent reviewers who have expertise in the health center program are selected by HRSA to review and score all eligible applications. The reviewers score an application by assessing each component of the applicant's proposal, including descriptions of the need for health care services in the applicant's proposed service area, how the applicant would integrate services with other efforts in the community, and the applicant's capacity and readiness to initiate the proposed services. The Administrator of HRSA makes final award decisions and is required to take into account whether a center is located in a sparsely populated rural area, the urban/rural distribution of grants, and the distribution of funds across types of health centers (community, homeless, migrant, and public housing).[14] In addition, the Administrator of HRSA also considers geographic distribution in making award decisions. The scope of a health center's grant is delineated in its application and consists of its services, sites, providers, target population,

[11]42 U.S.C. § 254b(a)(1). The requirement to serve all people in the center's service area does not apply to centers that are specifically funded to serve homeless people, migratory and seasonal agricultural workers, or residents of public housing. 42 U.S.C. § 254b(a)(2).

[12]42 U.S.C. § 254b(k)(3)(G)(iii).

[13]HRSA officials told us that, in general, fewer than 10 percent of applications are deemed ineligible.

[14]42 U.S.C. § 254b(p), (k)(4), (r)(2)(B).

and service area. (See app. II for additional information on HRSA's process for awarding health center grants.)

BPHC administers several competitive grants under the Consolidated Health Centers program, including new access point, expanded medical capacity, service expansion, and service area competition grants. (See table 1.) HRSA approves funding for a specific project period—which can be up to 5 years for existing grantees and up to 3 years for new organizations—and provides funds for the first year. For subsequent years, health centers must obtain funding annually through a noncompeting continuation grant application process in which the grantee must demonstrate that it has made satisfactory progress in providing services. A grantee's continued receipt of grant funds also depends on the availability of funding.

Table 1: Description of Competitive Grants Funded through the Consolidated Health Centers Program

Type of grant	Purpose	Eligibility	Maximum annual funding for each awarded grant in fiscal year 2004
New access point	To fund additional delivery sites that offer comprehensive primary and preventive health care services	Existing grantees and organizations that currently do not receive program funding	$650,000
Expanded medical capacity	To increase the number of people served in a health center's existing service area by expanding the capacity of existing sites, such as by increasing the number of medical providers, expanding hours of operation, expanding existing services, or adding new types of services through contractual relationships	Existing grantees	$600,000
Service expansion	To create and expand access to mental health, substance abuse, and oral health care services	Existing grantees	$250,000 (oral health—new access) $160,000 (mental health/substance abuse—new access) $150,000 (oral health and mental health/substance abuse—expanded access)
Service area competition	To open competition for existing service areas when a health center's project period is about to expire	Existing grantees and organizations that currently do not receive program funding	The maximum level of support is not expected to exceed the previous annual level of program funding for this area or population

Source: GAO analysis of HRSA documents.

HRSA's Monitoring of the Consolidated Health Centers Program

To monitor health centers' performance and compliance with federal statutes, regulations, and policies, HRSA relies on periodic on-site monitoring reviews, as well as ongoing monitoring. Through early 2004, HRSA used BPHC's Primary Care Effectiveness Review (PCER) to provide periodic on-site monitoring of health center operations. The PCER was scheduled to occur every 3 to 5 years as a mandatory part of the competitive grant renewal process when a health center's project period was about to expire. During on-site PCER visits, a team of reviewers identified strengths and weaknesses in health center administration, governance, clinical and fiscal operations, and management information systems. According to HRSA officials, review team members were generally not HRSA staff, but contractors. The last PCER review was conducted in March 2004.

HRSA created a new process for the periodic on-site review of all agency grantees, including health centers, and reviewers from HRSA's Office of Performance Review (OPR) began to use this new process in May 2004. OPR reviews grantees in the middle of their project period—in the second year for new grantees and in the third or fourth year for existing grantees. According to HRSA officials, a goal of the OPR performance review process is to reduce the burden on grantees by consolidating the on-site monitoring of all HRSA grants to a health center into one comprehensive review. For example, if a health center receives a Ryan White Title III HIV Early Intervention grant,[15] the OPR performance review covers both the Ryan White grant and the Consolidated Health Centers program grant(s). Each health center review team has three or four reviewers; HRSA's goal is for the reviewers to be OPR staff, who are located in HRSA's regional offices, with contractors being used to supplement OPR staff only when necessary. For each health center review, the review team prepares a performance report describing its findings. As necessary, the report identifies the health center's technical assistance needs and actions the center needs to take to ensure its compliance with program requirements.

HRSA also conducts ongoing monitoring of health centers through its project officers, who serve as grantees' main point of contact with the agency. Project officers use various tools to monitor compliance with program requirements and to assess the overall condition of health centers. For example, project officers review annual noncompeting continuation

[15]42 U.S.C. §§ 300ff-51 through 300ff-78.

grant applications, conduct midyear assessments, and regularly examine available data, including financial audits and UDS data. They are also expected to have regular contact with health centers by telephone and through e-mail and to connect grantees to resources for assistance when necessary, such as referring a health center to a HRSA-funded contractor for technical assistance to improve health center operations. In July 2003, HRSA transferred project officer responsibilities from its 10 regional offices and centralized this function within BPHC to improve the consistency of program oversight.

In addition, about one-third of the health centers funded under the Consolidated Health Centers program are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and receive additional periodic on-site monitoring.[16] These reviews include an assessment of a health center's compliance with program laws and regulations, clinical procedures, and organizational processes, such as performance improvement activities and human resource management. HRSA began promoting accreditation for health centers in 1996, and under its current agreement with JCAHO, HRSA pays the fees for health center surveys,[17] reducing the financial burden of accreditation for health centers. HRSA also provides financial support to the National Association of Community Health Centers to encourage accreditation and educate health centers about its benefits.

HRSA uses UDS data to monitor aspects of health center and overall program performance. Each year, health centers are required to report administrative data on their operations through UDS. These data include a list of each center's service delivery sites and information about the center's patients (e.g., race/ethnicity, insurance status); revenues; expenses; and service, staffing, and utilization patterns. HRSA uses UDS data to prepare its annual *National Rollup Report*, which summarizes the Consolidated Health Centers program; to prepare Comparison Reports, which allow the centers to compare their performance on certain measures

[16]JCAHO is a not-for-profit organization that evaluates and accredits more than 15,000 health care organizations and programs in the United States using its own standards for the quality and safety of care provided by health care providers, including hospitals, ambulatory care providers, nursing homes, and home care organizations.

[17]The surveys include an initial survey, subsequent triennial surveys, and, as necessary, laboratory accreditation and behavioral health surveys.

(e.g., productivity, cost per encounter) against that of other centers; and to generate analyses that HRSA uses when evaluating the program.

In March 2000, we reported on HRSA's monitoring of the Consolidated Health Centers program.[18] We analyzed UDS data from 1996 through 1998 and noted deficiencies in data completeness and quality. Specifically, some grantees failed to report certain data elements or reported them very late, resulting in missing data. Furthermore, we found that the data editing and cleaning processes that were in place at the time did not always correct data errors that they were designed to detect. We recommended that HRSA improve the quality of UDS data and enforce the requirement that every grantee report complete and accurate data. In response to the recommendation, HRSA reported that a new requirement was in place for grantees to submit their UDS reports electronically, which improved the timeliness and accuracy of data by eliminating the need for a second level of data entry. In addition, the agency implemented formal training for centers on how to report UDS data.

Competition for Health Center Funding Has Increased, and HRSA Is Evaluating Its Process for Assessing Need

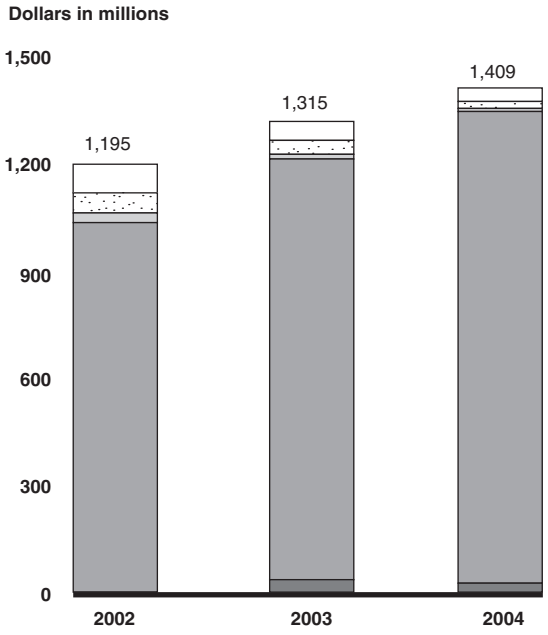
Competition for new access point, expanded medical capacity, and service expansion grants increased during the first 3 years of the President's Health Centers Initiative. For example, while HRSA funding of new access point grants decreased by about half from fiscal year 2002 to fiscal year 2004, the number of applicants rose by 28 percent. HRSA is concerned that its current process for awarding new access point grants may not be consistent with the goal of funding health centers in the neediest communities. Therefore, the agency is considering both revising the measures it uses to assess need and increasing the relative weight of need in the award process.

[18]GAO, *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success*, GAO/HEHS-00-39 (Washington, D.C.: Mar. 10, 2000). This report focused only on community and migrant health centers.

Funding for Grants to Increase Health Center Services Has Become More Competitive Since the President's Health Centers Initiative Began

Competition for new access point grants increased over the first 3 years of the President's Health Centers Initiative. Although the majority of grant funds are awarded for continuation grants, for which funding increased, funding for other types of grants declined. (See fig. 2.) For example, funding for new access point grants decreased from about $80 million in fiscal year 2002 to about $38 million in fiscal year 2004, a 53 percent decline.

Figure 2: Allocation of Consolidated Health Centers Program Funding, by Type of Grant, Fiscal Years 2002 through 2004



Type of grant	2002	2003	2004
New access point	$80	$53	$38
Expanded medical capacity	56	39	19
Service expansion	27	13	9
Continuation[a]	1,032	1,175	1,318
Base adjustment[b]	0	35	25
Total	**$1,195**	**$1,315**	**$1,409**

Source: GAO analysis of HRSA data.

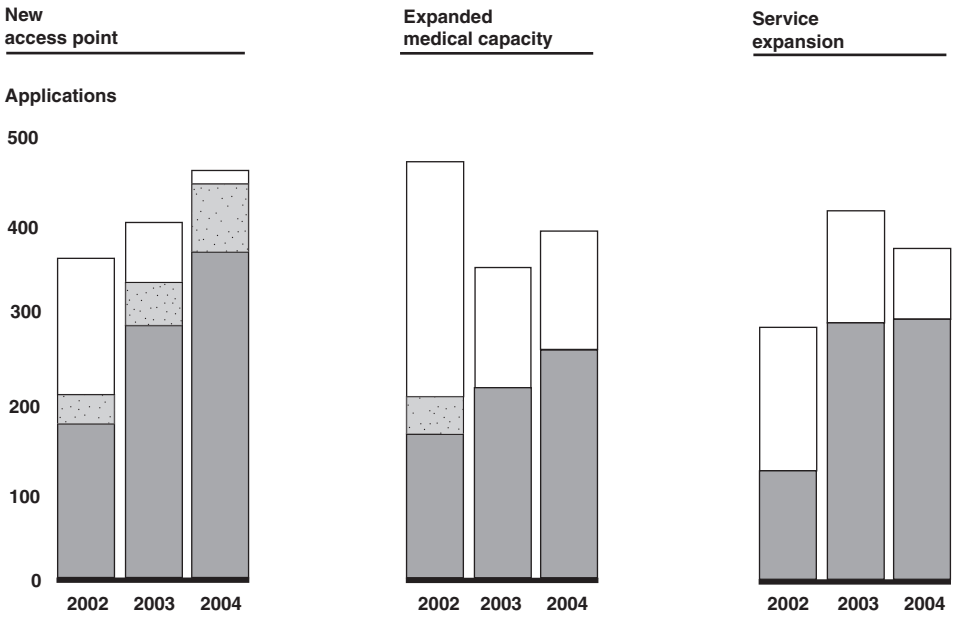
[a]Continuation grants are noncompeting continuation grants and service area competition grants.

[b]Base adjustments are supplemental funding that HRSA awards to existing grantees to help offset rising costs.

At the same time, the number of eligible new access point applications increased by 28 percent. Combined with the decrease in new access point funding, this resulted in a decrease in the proportion of applicants that HRSA funded—from 52 percent of fiscal year 2002 applicants to 20 percent of fiscal year 2004 applicants. Some of these applicants received funding in the same year they applied, and others received funding the following year.[19] (See fig. 3.) The percentage of new access point applicants HRSA funded in the same year they applied decreased from 43 percent in fiscal year 2002 to 3 percent in fiscal year 2004. In addition, HRSA approved 17 percent of the applications it received in fiscal year 2004 for funding in fiscal year 2005.

[19]HRSA officials told us that awards to be funded in the following year are contingent on the availability of funds at that time.

Figure 3: Disposition of Applications, by Type, Fiscal Years 2002 through 2004



	New access point			Expanded medical capacity			Service expansion		
	2002	2003	2004	2002	2003	2004	2002	2003	2004
Eligible applications funded in the **current** fiscal year	152	67	15	131	67	66	160	125	79
Eligible applications funded in the **next** fiscal year	33	48	76	21	0	0	0	0	0
Eligible applications not funded	171	281	363	80	106	127	121	286	290
Total applications	**356**	**396**	**454**	**232**	**173**	**193**	**281**	**411**	**369**

Source: GAO analysis of HRSA data.

Note: Eligible applications meet the following criteria: the applicant is a public or private nonprofit entity, the applicant is applying for an appropriate grant (e.g., expanded medical capacity and service expansion grants are available only to existing grantees), and the application includes the correct documents and meets page limitations and format requirements.

Competition for expanded medical capacity and service expansion grants also increased during the President's Health Centers Initiative. Funding for expanded medical capacity grants decreased from about $56 million in fiscal year 2002 to about $19 million in fiscal year 2004, and funding for service expansion grants decreased from about $27 million in fiscal year 2002 to about $9 million in fiscal year 2004. With the decrease in funding amounts, the percentage of funded applicants also decreased. HRSA funded 66 percent of fiscal year 2002 expanded medical capacity applicants

and 57 percent of fiscal year 2002 service expansion applicants;[20] in fiscal year 2004, it funded 34 percent and 21 percent of the applicants, respectively.

Although HRSA funded fewer grants to increase health center services during the second and third years of the President's Health Centers Initiative, HRSA officials believe program funding for fiscal year 2005 and the President's proposed budget for fiscal year 2006 will allow them to exceed the initiative's goal.[21] From fiscal year 2002 through fiscal year 2004, HRSA funded 334 new access point grants and 285 expanded medical capacity grants, representing about half of the initiative's 5-year goal of providing 630 new access point grants and 570 expanded medical capacity grants.

HRSA's Process for Assessing Need for New Access Point Grants Has Changed

The process HRSA uses to assess the need for services in a new access point applicant's proposed service area has changed since the beginning of the President's Health Centers Initiative. In fiscal year 2002, new access point applicants were ranked according to both the score they received on a need-for-assistance worksheet[22] and the score assigned by independent reviewers after they evaluated the technical merit of the application. In fiscal years 2003, 2004, and 2005, however, HRSA did not use the worksheet scores to rank applicants. Instead, it used the worksheet scores to screen applicants; only applicants that scored 70 or higher on the worksheet had their application forwarded to independent reviewers for an evaluation of its technical merit. In addition to changing the role of the need-for-assistance worksheet score, HRSA also increased the relative weight of the need criterion in the application score. In fiscal year 2002, the maximum

[20]Nine percent of the fiscal year 2002 expanded medical capacity applicants received their funding in fiscal year 2003.

[21]Estimated federal funding for the Consolidated Health Centers program was about $1.69 billion in fiscal year 2005. The President's proposed budget for fiscal year 2006 allocated about $1.99 billion to the program.

[22]HRSA uses the need-for-assistance worksheet to measure barriers to obtaining care and to measure health disparity factors in the applicant's proposed service area. Barriers to care include the distance or time to the nearest primary care provider and percentage of the population age 5 years or older who speak a language other than English. Health disparity factors include the rates of specific diseases and health outcomes, such as cancer, infant mortality, low-birth-weight infants, and teen pregnancy. Applicants can score up to 100 points on the worksheet.

need criterion score constituted 5 percent of the maximum total application score; in fiscal years 2003, 2004, and 2005, the maximum need criterion score constituted 10 percent of the maximum total score.

HRSA has raised concerns that its current process for assessing the need for services in a new access point applicant's proposed service area may not be consistent with the goal of the President's Health Centers Initiative to fund health centers in the neediest communities. HRSA reported that the process had resulted in little distinction among applicants' need-for-assistance worksheet scores and that almost all applicants received a score of 70 or higher. During the first 3 years of the President's Health Centers Initiative, only 24 of 1,346 applications scored lower than 70 points. In addition, HRSA reported that the relative weight assigned to an applicant's description of the need for health care in its proposed service area (10 percent) might be too low. In light of these concerns, HRSA commissioned a study to evaluate whether the measures in the need-for-assistance worksheet reflected the relative need of different applicants and whether the review criteria were weighted appropriately to ensure that grants were awarded to the neediest communities. The report, which was issued in November 2003, recommended several changes, including revising measures in the need-for-assistance worksheet and increasing the maximum need score from 10 percent to 20 percent of the maximum total score.[23]

In response to these recommendations and feedback from program applicants, HRSA is considering revising the method it uses to assess the need for services in new access point applicants' service areas. On February 4, 2005, HRSA issued a *Federal Register* notice seeking comments on a proposal to change the measures used in the need-for-assistance worksheet and to substitute the need-for-assistance worksheet for the current need criterion in the grant application.[24] HRSA also sought comments on what weight the agency should give need in the application score. Comments on the *Federal Register* notice were due on March 7,

[23]Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill and Health Systems Research, Inc., *Evaluation of Need for Assistance Criteria and Weighting of Overall Criteria in the Requirements of Funding New Start and Expansion Grant Applications for Health Centers*, report prepared at the request of HRSA, November 2003.

[24]Development of Revised Need for Assistance Criteria for Assessing Community Need for Comprehensive Primary and Preventive Health Care Services under the President's Health Centers Initiative, 70 *Fed. Reg.* 6016-6023 (Feb. 4, 2005).

2005, and HRSA expected to complete its analysis by June 2005. HRSA reported it would delay the May 23, 2005, due date for new access point applications until its analysis was complete.[25]

To further strengthen its ability to award new access point grants in the neediest communities, HRSA has indicated that it may focus its efforts on high-poverty counties without a health center delivery site.[26] In its fiscal year 2006 budget justification, HRSA noted that, without special attention to high-poverty counties, the current award process may result in some of these counties not having a health center site. For example, it may be difficult for an applicant in a high-poverty county to demonstrate its financial viability. In the budget justification, HRSA requested funds specifically for awarding new access point grants to centers serving high-poverty counties and planning grants to community-based organizations to support the establishment of centers in such counties.

Number of New Access Point Grantees Varies Widely by State, but HRSA Lacks Reliable Information on Delivery Sites

The number of health centers receiving new access point grants varied widely by state during the first 3 years of the President's Health Centers Initiative.[27] During that period, HRSA awarded 334 new access point grants,[28] with at least one grantee in each state.[29] About half of the grantees were in 10 states—Alaska, California, Illinois, Massachusetts, New Mexico, New York, Oregon, South Carolina, Texas, and Virginia. The number of grantees in each state ranged from 57 in California to 1 each in Delaware, the District of Columbia, Kansas, and Wyoming. (See app. III for additional information on the number of new access point grants by state and territory. See app. IV for the numbers of all health center grantees, by state and territory, operating in 2001—before the initiative began—and in 2003—the most recent year for which data were available at the time we conducted our review. Figure 4 shows the location of health centers that HRSA was funding in 2003.)

[25]May 23, 2005, was the due date for the second round of fiscal year 2005 new access point applications. December 1, 2004, was the due date for the first round of applications.

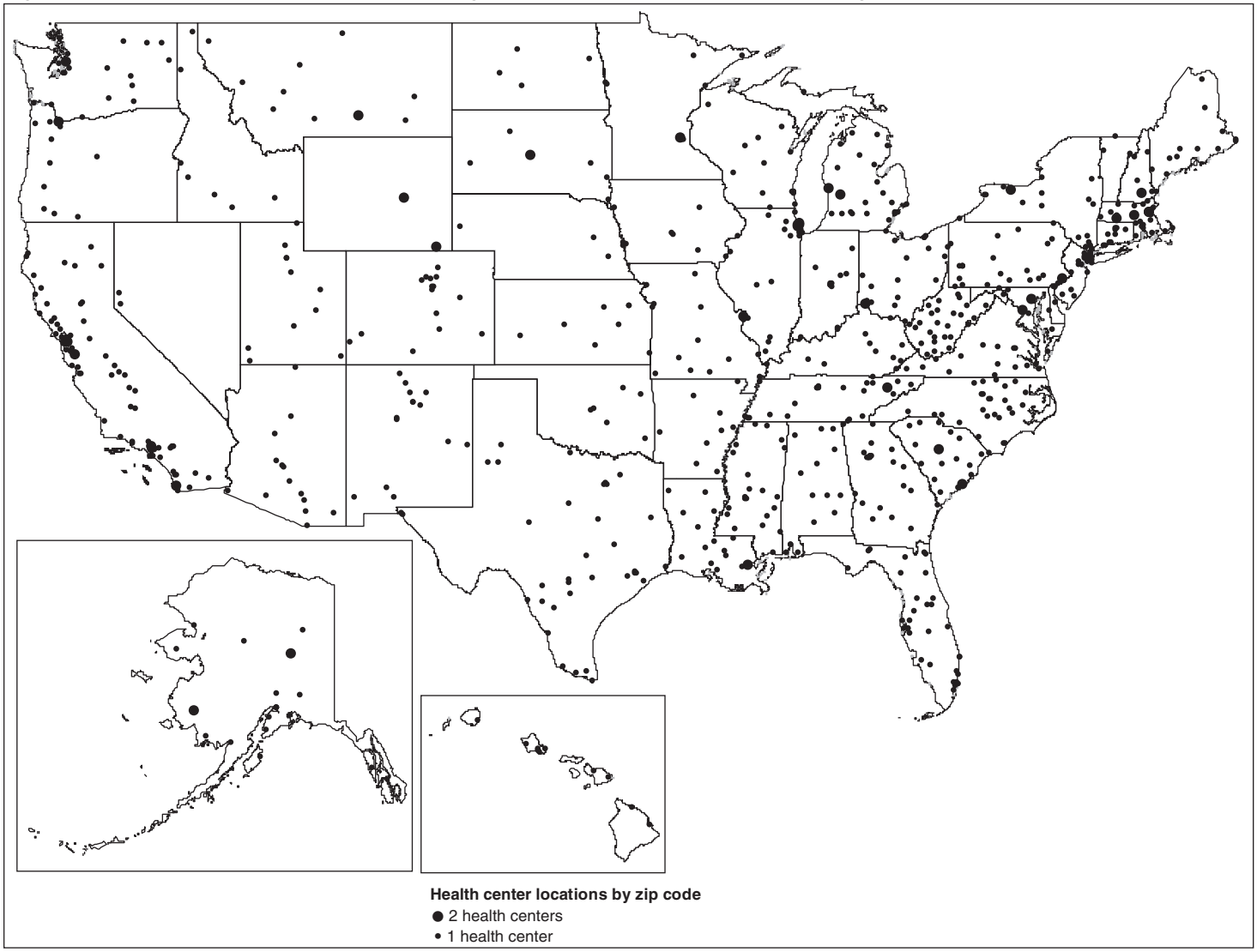
[26]HRSA officials said the agency has not yet determined what constitutes a high-poverty county.

[27]Unless otherwise noted, in this report, "states" refers to the 50 states and the District of Columbia.

[28]About half of the grants went to health centers that were new to the program, and about half went to health centers already in the program that were adding to their delivery sites.

[29]HRSA also funded grants in American Samoa, Puerto Rico, and the Virgin Islands.

Figure 4: Health Center Grantees Funded through the Consolidated Health Centers Program, 2003



Source: GAO analysis of 2003 UDS data.

Note: The map depicts 863 health center grantees in the 50 states and the District of Columbia that submitted data to the 2003 UDS; 27 grantees in the territories also submitted data to the 2003 UDS. HRSA was funding an additional 9 grantees in 2003, but 7 of these grantees were not required to report to the 2003 UDS because they either did not operate for more than 90 days in 2003 or merged with another grantee. The other 2 grantees were required to report, but did not submit data. The map indicates a single location for each health center grantee. However, grantees provided services at one or more delivery sites.

In 2003, the distribution of all health center grantees was 48 percent urban and 52 percent rural.[30] HRSA is required by law to make awards so that 40 to 60 percent of patients expected to be served reside in rural areas.[31] HRSA officials told us that the agency meets this requirement by ensuring that the proportion of awards to rural health centers is from 40 to 60 percent. Based on the numbers of patients reported by health centers to the UDS, the proportion of patients served by urban health centers in 2003 was 54 percent and the proportion served by rural centers was 46 percent.

While HRSA can provide information on the geographic distribution of health center grantees, it does not have reliable information on the number and geographic distribution of the delivery sites where the centers provide care. In its budget justification documents and Government Performance and Results Act reports, HRSA has used the number of delivery sites it funds to provide information on its progress toward achieving its goals for the Consolidated Health Centers program. For example, in its fiscal year 2005 performance plan, HRSA has a performance goal of increasing access points in the health centers program, and it used 2001 UDS data on the number of health center delivery sites as a baseline to measure progress toward this goal. HRSA, however, is not confident that UDS data accurately reflect the number of sites supported by program dollars. HRSA officials told us that the agency does not verify the accuracy of the delivery site information grantees provide to UDS. They also said that UDS delivery site data through 2003 may include sites not funded by the health centers program and sites that HRSA did not approve in the scope of a health center's grant. Moreover, HRSA has been reporting inconsistent data on the number of health center delivery sites in the program. For example, in its fiscal year 2005 performance plan, HRSA reported funding 3,588 delivery sites in fiscal year 2003, consisting of 3,317 delivery sites operating in fiscal year 2001 and 271 new access point grants funded in fiscal years 2002 and

[30]The urban/rural designation is self-reported by health centers in their grant application. HRSA instructs health centers to classify themselves as urban or rural based on where the majority of their patients reside. For example, if a health center is located in an urban area, but more than 50 percent of its patients reside in rural areas, the center should classify itself as rural.

[31]42 U.S.C. § 254b(k)(4). This requirement has applied to all types of health centers since the programs were consolidated in 1996. Health Centers Consolidation Act of 1996, Pub. L. No. 104-299, sec. 2, § 330(k)(4), 110 Stat. 3626, 3639 (1996). Prior to the consolidation, this requirement applied only to community health centers, and it was added to their authorizing legislation by the Health Services and Centers Amendments of 1978, Pub. L. No. 95-626, § 104(d)(5)(B), 92 Stat. 3551, 3557-58 (1978).

2003; however, some of the new access point grants represent more than one delivery site. As a result, HRSA underestimated the number of new program delivery sites operating in fiscal years 2002 and 2003.

HRSA Has Increased the Role of Performance Measurement in Monitoring and Improved Its Collection of Health Center Data

HRSA's new tool for periodic on-site review of health centers—the OPR performance review—focuses on monitoring individual health centers' performance on selected measures, including health outcome measures. The OPR performance review generally does not provide HRSA with standardized performance information for evaluating the Consolidated Health Centers program as a whole. However, the agency is using other data collection tools, such as its Sentinel Centers Network, that could help it measure overall program performance. HRSA also uses UDS to monitor aspects of health centers' performance, and the agency has taken steps to improve the accuracy and completeness of that data set.

HRSA's New Process for Monitoring Health Centers and Other Data Collection Tools Include Patient Health Outcome Measures

HRSA's new health center reviews, conducted by OPR staff, focus on evaluating selected measures of performance and identifying ways to improve health centers' operations and performance.[32] OPR works with each health center to select three to five measures that reflect the specific needs of the center's community and patient population, and then to ascertain the health center's current performance on each measure.[33,34] For the health centers we contacted that had undergone the OPR performance review,[35] most of the measures were health outcome measures. These measures included the average number of days that asthmatic patients are symptom free, percentage of patients age 60 or older receiving influenza and pneumonia immunizations, and percentage of low-birth-weight infants

[32]As of February 2005, 100 health center reviews had been conducted; an additional 220 reviews were scheduled to be conducted in 2005.

[33]If the health center receives grants from other HRSA programs, additional measures are selected for those grant programs.

[34]HRSA officials told us that, beginning in January 2005, all health center reviews began to include the number of patients receiving care as one measure. They said the agency is exploring the use of additional measures that would be included in all health center reviews starting in 2006.

[35]In addition to our interviews of officials from 12 health centers, we also interviewed officials from 6 other health centers that had completed an OPR performance review.

born to health center patients.[36] Health centers may set performance goals related to these measures. For example, one health center adopted the goal set by Healthy People 2010 of reducing the percentage of low-birth-weight infants born to its patients to less than 5 percent.[37] HRSA officials told us that the agency intends to follow up annually on grantees' performance on these measures. When possible, HRSA plans to track progress using data the grantee already reports. For example, HRSA would be able to use UDS data to track progress on the number of health center patients receiving care. HRSA officials told us that because the OPR performance reviews began recently, the agency is still determining how it will track performance on other measures, including many related to patient health outcomes.

After assessing the health center's performance on each measure, the review team analyzes the factors that contribute to and hinder the center's performance on these measures, including the processes and systems the health center uses in its operations. During an on-site visit, the review team meets with health center staff to discuss these factors and determine which are the most important to address. The review team also identifies potential actions that could help the center improve its performance and identifies possible partners in making improvements. For example, to improve one health center's performance on its low-birth-weight measure, the review team suggested the center undertake provider and patient education, training for health center staff, continued partnerships with other service providers and community groups, and an analysis of patient medical charts to identify the risk factors of patients who gave birth to low-birth-weight infants.

HRSA requires that grantees develop an action plan to improve performance in response to the review team's findings. The action plan describes the specific steps the grantee plans to take to improve performance on each measure and provides estimated completion dates. For example, the health center discussed above proposed hiring an outside physician to conduct chart reviews and showing a video on cultural competence to all staff as two specific actions to improve performance on its low-birth-weight measure.

[36]Other measures selected by health centers related to the number of health center patients receiving care, accuracy of data, and the financial condition of the health center.

[37]HHS's Healthy People 2010 is a set of health promotion and disease prevention objectives for the nation to achieve by 2010.

While the OPR review primarily focuses on health centers' performance on specific measures, the reviews also verify key aspects of health centers' compliance with Consolidated Health Centers program requirements. The review teams examine information HRSA maintains on each health center, including grant applications and financial audits. According to HRSA officials, OPR reviewers also follow up on concerns identified by project officers, who are the agency's primary means for ongoing monitoring of health center operations and compliance. If the review team identifies any instances of noncompliance with program requirements—such as those related to the types of services the center must provide and the composition of its governing board—HRSA requires grantees to address them in the action plan.

HRSA officials told us they hoped that in addition to providing information on individual health centers, the OPR performance reviews would result in information that could improve other centers' services and operations. HRSA officials said that as reviewers gained more experience in evaluating health centers, they would be better able to identify best practices that contribute to outstanding patient health outcomes and share these practices among health centers. HRSA officials told us that OPR planned to use this information to develop a list of successful practices employed by health centers, such as a patient tracking system or prescription drug subsidy program. They said they expected to generate this list three times a year and to make it available as a resource for project officers and OPR review teams to share with other health centers.

The health center officials we interviewed whose centers had undergone the OPR performance review said that, in general, it provided helpful suggestions for improving services and operations.[38] Officials from some health centers told us that they planned to incorporate the performance goals and their progress in achieving them into their future grant applications. Health center staff also described the reviews as accurate and thorough and said they appreciated the in-depth method of looking at performance in targeted areas. Officials from a few health centers also noted that their reviewers had expertise on the health centers program

[38]Health center officials told us their center also used other tools and local data sources to measure performance and identify areas for improvement. Some of these tools included UDS data, county and community health assessments, patient surveys, patient health data, and the center's governing board. For example, one official told us the center regularly compared its individual performance with federal and state disease and infant mortality rates.

because the reviewers had previously been project officers for the program; one health center official said that this expertise was critical to the review process. In many cases, HRSA field office staff conduct performance reviews of health centers in states or communities with which they are already familiar. HRSA officials told us this experience has allowed the OPR reviewers to understand performance in the context of the local, state, and regional environment, such as the effect state Medicaid funding and policy changes might have on the number of people receiving health center services.

While the OPR review evaluates the performance of individual health centers, it generally does not provide standardized performance information for the Consolidated Health Centers program as a whole, and HRSA is using other tools to collect information that could help measure overall program performance. In 2002, HRSA began collecting data on health centers' services and patient populations through its Sentinel Centers Network—a network of health centers designed to be geographically and sociodemographically representative. As of February 2005, 67 health centers, with more than 1 million patients, were participating in the network. Participating health centers report patient-, encounter-, and practitioner-level data.[39] The network is intended to supplement HRSA's other data sources, such as the Community Health Center User and Visit Survey,[40] which is conducted only every 5 to 7 years, and the UDS, which generally provides grantee-level data.

HRSA also collects information that could help it measure overall program performance through its Health Disparities Collaboratives, which the agency views as a tool for improving the quality of care. Participating health centers use a model for patient care that includes evidence-based practice guidelines. The model also includes a database in which the health centers collect standardized patient-level health outcome data that are used to track progress and are shared with all health centers in the

[39]Patient-level data elements include sex, ethnicity, race, education level, smoking status, weight, and blood pressure and cholesterol levels. Encounter-level data elements include the date the service was provided and procedure and diagnosis codes. Practitioner-level data elements include primary and secondary specialties and number of years the practitioner has been employed by the health center.

[40]The Community Health Center User and Visit Survey collects information from about 2,000 health center patients about their health center experiences.

collaborative.[41] HRSA plans to expand the collaborative model from a focus on specific diseases to a focus on primary care in general. Through 2004, 497 health centers had implemented the collaborative model for at least one disease. An additional 150 centers began the collaborative process in February 2005.[42] In the future, HRSA officials would like to extend the model to all health centers in the Consolidated Health Centers program.

HRSA has a contract with Johns Hopkins University for evaluating data from the Sentinel Centers Network and other health center data, such as UDS data.[43] According to HRSA officials, the purpose of this contract is to provide timely, short-term statistical analyses and longer-term evaluation studies using databases that contain information on health centers. One planned study will examine preventive services provided by health centers, and several will focus on the role of health centers in reducing racial/ethnic and socioeconomic disparities in health outcomes for health center users.

[41]In 1998, HRSA and the Institute for Healthcare Improvement (a private not-for-profit organization) developed the first Health Disparities Collaborative, which focused on diabetes care. Since that time, additional collaboratives have focused on asthma, depression, cardiovascular disease, and cancer.

[42]Health centers participating in a Health Disparities Collaborative initially go through a 12-month training period. Teams from the health centers attend learning sessions, test and implement changes in practice, and collect data to measure the impact of these changes on patient health outcomes in specific disease areas. HRSA's service expansion grants have included awards to support health centers' continued implementation of the collaborative model after the training period; 52 health centers in fiscal year 2003 and 32 health centers in fiscal year 2004 received, on average, about $40,000 each. HRSA officials told us that these grants are often used to support centers' infrastructure, such as computer systems for data management.

[43]Past studies of the health center program that HRSA conducted with researchers from Johns Hopkins included a study that examined the role of health centers in reducing disparities in access to care and a study that examined the role of health centers in reducing ethnic disparities in perinatal care and birth outcomes. See Robert Politzer and others, "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care," *Medical Care Research and Review*, vol. 58, no. 2 (2001); and Leiyu Shi and others, "America's Health Centers: Reducing Racial and Ethnic Disparities in Perinatal Care and Birth Outcomes," *Health Services Research*, vol. 39, no. 6, Part I (2004). HRSA also has contracts with other organizations for evaluating health center data. For example, HRSA has contracts with researchers at Harvard Medical School and the University of Chicago Medical School to evaluate the effect of the collaboratives on patient care.

HRSA Has Taken Actions to Improve the Completeness and Accuracy of Its Uniform Data System

Since our previous report on the health centers program in March 2000,[44] HRSA has taken steps to improve the UDS data collection and reporting process by trying to ensure that all Consolidated Health Centers program grantees report to the system and that the information they report is complete and accurate. HRSA's efforts resulted in near-universal reporting—99.8 percent—by grantees for 2003. HRSA contacts grantees that do not submit UDS data for the preceding calendar year by February 15. HRSA officials told us that after they made several efforts to try to obtain UDS data, only 2 of the 892 grantees required to report in 2003 did not submit data.[45]

To minimize errors in the data set, HRSA implements data quality assurance procedures in the UDS data collection process. Specifically, HRSA has programmed 474 edit checks into the software that grantees use to report UDS data. These edit checks detect mathematical and logical errors and are triggered while grantees are entering or verifying data. Mathematical edit checks ensure that rows and columns sum to the total submitted by the grantee, and logical edit checks ensure consistency within and across tables. For example, one logical edit check ensures that the total number of patients reported by age and sex equals the total number of patients reported by race/ethnicity. The grantee is prompted to address inaccuracies or inconsistencies identified by the edit checks before submitting the data to HRSA.

When HRSA receives grantees' UDS submissions, its contractor conducts additional edit checks. The contractor confirms that grantees' submissions are substantially complete, which includes ensuring that tables are not blank, and forwards satisfactory submissions to an editor.[46] The editors review the mathematical and logical checks triggered by the software and the checks for completeness conducted by the contractor. The editors also conduct 304 additional edit checks, which include comparisons to data submitted in the previous year and comparisons to industry norms. When they find an aberrant data element, editors contact grantees to determine if

[44]GAO/HEHS-00-39.

[45]In 2003, all grantees that had been operating for more than 90 days were required to submit UDS data.

[46]When submissions are unsatisfactory, the contractor follows up with grantees to obtain missing data.

there is an error in the data or if there is a reasonable explanation.[47] If there is an error, the editor and grantee agree on a process and timeline for the grantee to submit corrected data, and the grantee's UDS data are revised.[48] HRSA officials told us that editors were experienced with UDS, the Consolidated Health Centers program, and data editing. The editors have also attended training to ensure consistency across editors and to learn about new edit checks. In addition, editors are assigned to grantees in a single state or region to facilitate their understanding of unique regional issues that could affect UDS data, such as managed care participation.

We found the UDS data for the selected data elements we evaluated to be generally accurate. For the mathematical and logical edit checks of 25 data elements we conducted, we found very few errors, and each error was due to missing data.[49] In addition, we found no discrepancies in our replication of five analyses in HRSA's 2003 *National Rollup Report*.

To improve the accuracy of UDS data on the number and location of health center delivery sites, for 2004, HRSA revised the instructions to grantees for identifying their delivery sites. The new instructions specified that grantees should report delivery sites that provide services on a regularly scheduled basis and that are operated within the approved scope of the health center's grant. HRSA also provided more detailed instructions to help grantees determine which delivery sites they should include in their UDS submission and which sites they should exclude. As of June 2005, HRSA had not validated the accuracy of the 2004 UDS data on delivery sites.

[47]HRSA officials said nearly all submissions generate at least one potential error that requires an editor to contact a grantee.

[48]If the editor is unable to obtain accurate data, the information is rated "questionable" and the editor documents the reason.

[49]We conducted 25 edit checks for all 890 grantees reporting to UDS in 2003. For 16 of the 25 checks, there were no missing data, 8 checks had missing data for 1 or 2 grantees, and 1 check had missing data for 12 grantees.

Health Centers Often Face Challenges Securing Specialty Care for Patients

In addition to providing comprehensive primary and preventive health care services, most health centers receiving Consolidated Health Centers program grants provide specialty care on site or have formal arrangements for referring patients to outside specialists for care. According to the 2003 UDS data, 32 percent of health centers provided some specialty care on site.[50] Specialists providing services on site include health center employees and volunteers. In addition, 83 percent of health centers reported that they had formal referral arrangements for some specialty care,[51] which included agreements with community providers, such as local hospitals and networks of specialty care providers. Almost all of these health centers reported that they did not pay for some of the services for which they referred patients. In addition to formal referrals, health centers also informally refer patients to specialty care. Health center officials told us that many of their referrals for specialty care were arranged informally through discussions between health center staff and the specialty care provider,[52] and specialists donated their time to provide services to the health center's patients.

Health center officials told us that obtaining specialty care for center patients, especially patients who are uninsured, could be difficult. Officials from most of the health centers in our review said that there was a shortage of certain specialists available to receive referrals from their health center. For example, one official told us that there were only two specialists providing gynecologic oncology services in the county, and both physicians were overbooked with paying patients. Health center officials told us that some specialists—such as orthopedists, neurologists, oncologists, cardiologists, ophthalmologists, and dermatologists—were difficult to find.

[50]UDS defines specialty care as services provided by medical professionals trained in allergy, dermatology, gastroenterology, general surgery, neurology, optometry, ophthalmology, otolaryngology, pediatric specialties, and anesthesiology. UDS also collects data on other specialty care services—directly observed tuberculosis therapy (delivery of therapeutic tuberculosis medication under direct observation of health center staff) and respite care (recuperative or convalescent services used by people who are homeless and have medical problems but are too ill to recover on the streets or in a shelter)—and certain professional services, such as podiatry.

[51]A formal referral arrangement means the health center either had a written agreement with the specialty care provider or could document the service in the patient record.

[52]In some cases, health centers referred patients to specialty care services beyond those included in UDS's definition of specialty care, such as orthopedics, cardiology, oncology, and rheumatology.

This problem is exacerbated because, according to officials from most of the health centers in our review, some specialists are not willing to provide free care for uninsured patients. As a result, there are often long waiting lists for health center patients to see a specialty care provider who is willing to provide donated services. For example, one health center official told us that a patient might have to wait 9 months for an appointment with a dermatologist. One health center official characterized the center's efforts to secure specialty care for patients as "begging." Although these issues present a problem for health centers in both urban and rural areas, people living in rural communities could face additional challenges affecting their access to care, such as a need to travel a long distance to obtain care.

Conclusions

HRSA's Consolidated Health Centers program has played a pivotal role in providing access to health care for people who are uninsured or who face other barriers to receiving needed care. When HRSA makes decisions about awarding program funds to support additional health center delivery sites, it is faced with the challenge of identifying applicants that will serve communities with a demonstrated need for services and that will operate centers that can effectively meet those needs and remain financially viable. HRSA has indicated that it is not confident that its award process for new access point grants—which is intended to meet this challenge—has sufficiently targeted communities with the greatest need. HRSA's recent effort to evaluate the assessment and relative weight of need in the award process could result in greater confidence that the agency is appropriately considering community need in distributing federal resources to increase access to health care.

In light of the growing federal investment in health centers during the President's Health Centers Initiative, it is important for HRSA to ensure that health centers are operating effectively and improving patient health outcomes. HRSA's adoption of a performance monitoring process that includes emphasis on patient health outcomes and its efforts to collect health outcome data constitute an important step in improving the agency's capacity to assess health centers and the health centers program. Continued attention to such efforts could improve HRSA's ability to evaluate its success in improving the health of people in underserved communities.

It is also important for HRSA to ensure that it is collecting and reporting accurate and complete information about the number and location of

delivery sites where health centers are providing care. In providing new UDS guidance to grantees, HRSA has taken a step toward improving the quality of its information on delivery sites. The agency will need to carefully assess the effectiveness of its new guidance and, if necessary, take additional steps to ensure that delivery site information is accurate. HRSA officials and the Congress need accurate and complete information on delivery sites to assess whether the health centers program is achieving its goal of expanding access to health care for underserved populations and to make decisions about managing and funding the program.

Recommendation for Executive Action

We recommend that, to provide federal policymakers and program managers with accurate and complete information on the Consolidated Health Centers program's activities and progress toward its performance goals, the Administrator of HRSA ensure that the agency collects reliable information from grantees on the number and location of delivery sites funded by the program and accurately reports this information to the Congress.

Agency Comments

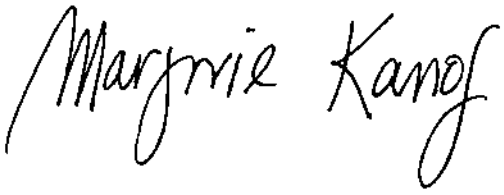
We provided a draft of this report to HRSA for comment. HRSA acknowledged that more accurate and timely delivery site data would allow for improved management of the Consolidated Health Centers program and said that the agency already has efforts under way to increase the accuracy of delivery site data. (HRSA's comments are reprinted in app. V.) HRSA stated that the accuracy of delivery site data does not affect its ability to assess and report the progress of the President's Health Centers Initiative because it believes this progress is more appropriately assessed by the number of new access point and expanded medical capacity grants HRSA has awarded. While HRSA may choose to assess the progress of the President's Health Centers Initiative on this basis, it is not appropriate to equate the number of new access point grants awarded to health centers with the number of delivery sites where these centers provide care. HRSA did not indicate whether it plans to revise its method of counting delivery sites for its future reports to the Congress to include all delivery sites funded since the President's Health Centers Initiative began. We continue to believe it is important that HRSA collect and report accurate data on the number and location of all delivery sites funded by the program so that agency officials and the Congress will have the information they need to monitor the program's progress in increasing access to health care and to make decisions about managing and funding the program. HRSA also

provided technical comments, and we revised our report to reflect the comments where appropriate.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Admiistrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7119. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. An additional contact and the names of other staff members who made contributions to this report are listed in appendix VI.

Sincerely yours,



Marjorie Kanof
Managing Director, Health Care

Scope and Methodology

To do our work, we obtained Consolidated Health Centers program documents, pertinent studies, and data from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA). We also conducted structured interviews of officials from 12 health centers in California, Illinois, Pennsylvania, and Texas. We selected these states because of their geographic diversity and because they were among the states with the highest number of health centers. Within each of the four states, we selected 3 health centers, including at least 1 urban and 1 rural center in each state. To ensure that we could obtain information about securing specialty care for uninsured patients, we selected only centers where at least 26 percent of the patients were uninsured in calendar year 2003; 75 percent of all health centers had a proportion of uninsured patients of at least 26 percent. For each state we selected, we also interviewed officials from the state's primary care association.[1] We also reviewed the relevant literature and program statutes and regulations and interviewed officials from the National Association of Community Health Centers and the National Association of Free Clinics.

To acquire information on health center funding, we examined Consolidated Health Centers program funding data by grant award type—new access point, expanded medical capacity, service expansion, service area competition, and noncompeting continuation—for fiscal years 2002, 2003, and 2004. In addition, we reviewed information on grant applications HRSA received during those 3 years. To describe the geographic distribution of health centers, we analyzed Uniform Data System (UDS) data on health center location by zip code and state and other data HRSA provided on centers' urban/rural status. We assessed the reliability of the data on health center funding and geographic distribution of health centers by interviewing agency officials knowledgeable about the data and the systems that produced them, and we determined that the data were sufficiently reliable for the purposes of this report.

To determine HRSA's process for assessing the need for services, we reviewed agency grant announcements, grant applications, and application guidance documents for the various grant types. We also reviewed the need-for-assistance worksheet and the need criteria in the new access point grant application guidance. We interviewed agency officials about the criteria used to assess the application sections on need for services and

[1]Primary care associations are private, nonprofit membership organizations of health centers and other providers.

about HRSA's ongoing consideration of revising the way need is assessed for new access point grants. In addition, we interviewed health center officials and officials from national and state associations that work with health centers about their experiences with the grant process.

To examine HRSA's monitoring of health center performance, we reviewed agency reports and protocols related to the new monitoring process conducted by the Office of Performance Review (OPR). We interviewed agency officials about the development of the new process and the roles played by different agency branches in monitoring health centers. To obtain information about health centers' experiences with the new OPR performance review process, we conducted interviews with officials from health centers that had completed the process. One of the 12 original health centers we interviewed had completed the OPR performance review process, and we also interviewed officials at an additional 6 health centers that were among the first to complete the process. In addition, we reviewed documents provided by the health centers, including performance reports and action plans. We also reviewed reports and documents related to HRSA's ongoing monitoring, including sample tools used by project officers to monitor their grantees and schedules of site visits conducted by the project officers. In addition, we reviewed documents related to HRSA's collection of health center performance data, including agency guidelines for the Health Disparities Collaboratives and the application for health center participation in the Sentinel Centers Network.

To assess HRSA's improvements to UDS, we evaluated the completeness and quality of 2003 data—the most recent data available at the time we conducted our review. To evaluate overall completeness, we obtained the master list of 2003 grantees from HRSA and matched the grantees on this list with those in the 2003 UDS data file. To evaluate the completeness and quality of specific data elements in the 2003 UDS data file, we developed and evaluated edit checks of those data elements. We selected variables that were identified as problematic in our March 2000 report[2] and others that were used in our current analysis. We also independently conducted selected analyses and compared our findings to corresponding tables in the 2003 *National Rollup Report*. For example, using 2003 UDS data, we duplicated the table on services offered and delivery method in the

[2]GAO, *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success*, GAO/HEHS-00-39 (Washington, D.C.: Mar. 10, 2000). This report focused only on community and migrant health centers.

National Rollup Report and verified that it matched the data HRSA reported. We did not perform edit checks on the delivery site data grantees reported to UDS. We interviewed agency officials about how HRSA collected UDS data on health center delivery sites and determined that the data were not sufficiently reliable for purposes of our report.

We conducted our work from August 2004 through June 2005 in accordance with generally accepted government auditing standards.

HRSA's Process for Awarding Grants through the Consolidated Health Centers Program

HRSA's process for awarding grants through the Consolidated Health Centers program involves several steps. HRSA provides initial grant information for new access point, expanded medical capacity, service expansion, and service area competition grants through the HRSA Preview, a notice available on HRSA's Web site.[1] The preview includes information on eligibility requirements; the estimated number of awards to be made; the estimated amount of each award; and the dates that application guidance will be available, applications will be due, and awards will be made. HRSA later issues grant application guidance, which includes the forms applicants need to submit (such as forms describing the composition of the applicant's governing board, summarizing the funding request, and describing the type of services to be provided) and a detailed description of the application review criteria and process.

The application guidance for new access point grants also encourages applicants to submit a letter of interest prior to submitting a grant application. In the letter of interest, the applicant describes its community's need for services and proposes services that the health center would offer to address those needs. HRSA officials told us that in fiscal year 2004, nearly one-half of applicants for new access point grants submitted a letter of interest. HRSA provides feedback to organizations on whether the proposal is consistent with the objectives of the health center program and whether HRSA thinks the organization is ready to establish a new delivery site.

HRSA also provides applicants with technical assistance resources during the development of grant applications. For example, through cooperative agreements with HRSA, state primary care associations and the National Association of Community Health Centers offer regional training sessions on various topics, including strategic planning, proposal writing, community assessment, and data collection. Potential applicants may also contact their state primary care association for individual technical assistance and application review.

[1]The 2005 HRSA preview is available on HRSA's Web site at http://www.hrsa.gov/grants/preview/.

HRSA approves funding for a specific project period—up to 5 years for existing grantees and up to 3 years for new grantees. HRSA provides funds for the first year of the project; for subsequent years, health centers must obtain funding annually through a noncompeting continuation grant application process in which the grantee must demonstrate that it has made satisfactory progress in providing services. A grantee's continued receipt of funds also depends on the availability of funding.

Applications submitted to HRSA go through several stages of review. HRSA initially screens applications for eligibility based on specific criteria—the applicant must be a public or private nonprofit entity, the applicant must be applying for an appropriate grant (e.g., expanded medical capacity and service expansion grants are available only to existing grantees), and the application must include the correct documents and comply with page limitations and format requirements.

Eligible applications go through a review process in which independent reviewers evaluate and score applications. The reviewers are selected by HRSA and have expertise in a specific field relevant to the health center program. HRSA provides reviewers with the same application guidance that it provides to applicants, and reviewers are to use their professional judgment in scoring applications.

During the first stage of the review process, HRSA forwards eligible applications to three independent reviewers, who have 3 to 4 weeks to individually evaluate the applications. Applications for new access point grants include a need-for-assistance worksheet, which is evaluated by the reviewers. HRSA uses the need-for-assistance worksheet to measure barriers to obtaining care and to measure health disparity factors in the applicant's proposed service area.[2] Applicants can score up to 100 points on the worksheet, and only those applicants that receive a score of 70 or higher on the worksheet go on to have the technical merits of their application evaluated. The reviewers evaluate the merits of all qualified

[2]Measures of barriers to care include the distance or time to the nearest primary care provider and percentage of the population age 5 years or older who speak a language other than English. Health disparity factors include the rates of specific diseases and health outcomes, such as cancer, infant mortality, low-birth-weight infants, and teen pregnancy.

applications; they base their review on a standard set of criteria (see table 2) and give each application a preliminary score of up to 100 points. For example, reviewers of new access point grant applications evaluate the need for services through the criterion that describes the applicant's service area/community and target population and assign a score from 0 to 10, which constitutes a maximum of 10 percent of the applicant's maximum final score. Similarly, reviewers evaluate the applicant's service delivery strategy and model and assign a score from 0 to 20, which constitutes a maximum of 20 percent of the maximum final score.

Table 2: Review Criteria for New Access Point, Expanded Medical Capacity, Service Expansion, and Service Area Competition Grants, Fiscal Year 2004

Grant	Criteria	Maximum points
New Access Point	Service delivery strategy and model	20
	Health care services	15
	Organizational capabilities and expertise	15
	Budget	10
	Description of the service area/community and target population	10
	Governance	10
	Readiness[a]	10
	Strategic planning	10
Expanded Medical Capacity	Need	25
	Response[b]	25
	Evaluative measures[c]	15
	Resources/capabilities	15
	Support requested[d]	15
	Impact	5
Service Expansion (mental health/substance abuse and oral health services)	Response[b]	60
	Evaluative measures[c]	10
	Need	10
	Resources/capabilities	10
	Impact	5
	Support requested[d]	5
Service Area Competition	Organizational capabilities and expertise	25
	Service delivery strategy and model	20
	Health care services	15
	Budget	10
	Description of the service area/community and target population	10
	Governance	10
	Strategic planning	10

Source: HRSA's fiscal year 2004 application guidance for new access point, expanded medical capacity, service expansion, and service area competition grants.

[a]The readiness criterion refers to an applicant's readiness to begin providing services.

[b]The response criterion refers to an applicant's description of its service delivery and business plans.

[c]The evaluative measures criterion refers to how the applicant plans to measure the success of its program.

[d]The support requested criterion refers to an applicant's proposed budget.

During the second stage of the review process, reviewers present the strengths and weaknesses of the application to a panel of 10 to 15 reviewers. After discussing the application, each panel member scores it. For each application, HRSA averages the scores assigned by each reviewer in the panel. The volume of applications may result in HRSA's using multiple review panels during a funding cycle. When this occurs, HRSA uses a statistical method to adjust for variation in scores among different review panels. The adjusted score becomes the final application score, and the final scores are used to develop a rank order list of applicants.

HRSA bases its award decisions on the rank order of scores and other factors. Two types of factors—the funding preference and awarding factors—can affect which applicants HRSA chooses for funding from the rank order list. The funding preference is given to applicants proposing to serve a sparsely populated rural area.[3] To be considered for the preference, the applicant must demonstrate that the entire area proposed to be served by the delivery site has seven or fewer people per square mile. In addition to scoring an application, the review panel evaluates the requested funding amount and determines if an applicant should be considered for the funding preference. The funding preference does not affect the score, but may place an applicant in a more competitive position in relation to other applicants. For example, if the panel has determined that the applicant qualifies for the funding preference, it may receive a grant award over higher scoring applicants that did not qualify for the preference. In fiscal year 2004, of the five applicants that received a service expansion grant to provide new oral health services, three were determined to qualify for the funding preference. These three applicants—with scores of 83, 86, and 90—were each awarded a grant over six applicants with application scores above 90.

As with the funding preference factor, the law requires HRSA to consider awarding factors in selecting applicants to fund from the rank order list. HRSA must consider the urban/rural distribution of awards, the distribution of funds across types of health centers (community, homeless, migrant, and public housing), and a health center's compliance with

[3]42 U.S.C. § 254b(p).

program requirements.[4] In fiscal year 2004, HRSA gave priority to funding homeless and migrant health centers and, from the new access point applications the agency received that year, it funded only health centers requesting homeless or migrant health center funding.[5] HRSA officials said the agency did this because the applications it had already approved in fiscal year 2003 for funding in fiscal year 2004, pending funding availability, did not include applications for homeless or migrant health center funding. In addition to the preference and awarding factors specified in the law, HRSA also considers the geographic distribution of awards in making funding decisions.

HRSA sends a Notice of Grant Award to successful applicants. The notice includes a set of standard terms and conditions with which the grantee must comply to receive grant funds, such as allowable uses of federal funds and reporting requirements. In addition, the notice may include grantee-specific conditions of award. For example, common conditions placed on new access point awards relate to the health center's being operational within 120 days, having the appropriate governing board composition, and hiring key staff. About 80 percent of new access point awards receive at least one condition, according to HRSA officials. HRSA notifies unsuccessful applicants of the outcome of the review process and provides applicants with their score and a summary of their application's strengths and weaknesses.

[4]The law requires new access point and service expansion grants to be awarded so that the population expected to be treated at centers receiving these grants is 40 to 60 percent rural. 42 U.S.C. § 254b(k)(4). The law also requires awards to be made so as to maintain funding levels for the three types of centers serving special populations (homeless, migrant, and residents of public housing) at the same proportions that existed in fiscal year 2001. 42 U.S.C. § 254b(r)(2)(B).

[5]Of the applications received in fiscal year 2004, HRSA approved other types of health centers for funding in fiscal year 2005, pending funding availability.

Distribution of Consolidated Health Centers Program New Access Point Grants, Fiscal Years 2002 through 2004

State/territory	Fiscal year 2002	Fiscal year 2003	Fiscal year 2004	Total
Alabama	1	0	2	**3**
Alaska	15	5	0	**20**
American Samoa	1	0	0	**1**
Arizona	2	4	1	**7**
Arkansas	3	1	0	**4**
California	29	19	9	**57**
Colorado	4	1	0	**5**
Connecticut	2	0	0	**2**
Delaware	1	0	0	**1**
District of Columbia	1	0	0	**1**
Federated States of Micronesia	0	0	0	**0**
Florida	4	2	1	**7**
Georgia	4	1	2	**7**
Guam	0	0	0	**0**
Hawaii	1	0	2	**3**
Idaho	2	0	1	**3**
Illinois	8	3	5	**16**
Indiana	1	2	3	**6**
Iowa	2	0	0	**2**
Kansas	0	1	0	**1**
Kentucky	2	1	0	**3**
Louisiana	1	1	3	**5**
Maine	0	0	3	**3**
Marshall Islands	0	0	0	**0**
Maryland	3	2	1	**6**
Massachusetts	5	1	2	**8**
Michigan	3	2	1	**6**
Minnesota	1	1	0	**2**
Mississippi	1	1	0	**2**
Missouri	4	0	2	**6**
Montana	2	3	0	**5**
Nebraska	0	2	0	**2**
Nevada	1	1	0	**2**
New Hampshire	2	0	1	**3**

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State/territory	Fiscal year 2002	Fiscal year 2003	Fiscal year 2004	Total
New Jersey	3	2	0	**5**
New Mexico	4	3	1	**8**
New York	9	6	2	**17**
North Carolina	2	4	1	**7**
North Dakota	1	3	0	**4**
Ohio	2	0	2	**4**
Oklahoma	3	1	1	**5**
Oregon	5	6	3	**14**
Palau	0	0	0	**0**
Pennsylvania	2	0	3	**5**
Puerto Rico	2	1	0	**3**
Rhode Island	0	2	2	**4**
South Carolina	7	2	0	**9**
South Dakota	3	1	0	**4**
Tennessee	2	3	0	**5**
Texas	5	2	5	**12**
Utah	1	2	0	**3**
Vermont	2	0	0	**2**
Virgin Islands	1	0	0	**1**
Virginia	4	3	2	**9**
Washington	2	1	2	**5**
West Virginia	3	3	0	**6**
Wisconsin	2	0	0	**2**
Wyoming	0	1	0	**1**
Total	**171**	**100**	**63**	**334**

Distribution of Consolidated Health Centers Program Grantees, 2001 and 2003

State/territory	2001	2003
Alabama	15	15
Alaska	6	21
American Samoa	0	1
Arizona	13	14
Arkansas	9	10
California	57	83
Colorado	14	15
Connecticut	9	10
Delaware	3	3
District of Columbia	1	2
Federated States of Micronesia	1	1
Florida	30	32
Georgia	20	22
Guam	1	1
Hawaii	8	10
Idaho	6	7
Illinois	25	31
Indiana	8	11
Iowa	7	8
Kansas	7	8
Kentucky	11	12
Louisiana	15	16
Maine	12	12
Marshall Islands	1	1
Maryland	11	13
Massachusetts	28	33
Michigan	24	26
Minnesota	10	12
Mississippi	21	21
Missouri	14	17
Montana	7	11
Nebraska	3	5
Nevada	2	2
New Hampshire	5	7
New Jersey	13	16

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State/territory	2001	2003
New Mexico	12	14
New York	44	51
North Carolina	21	25
North Dakota	1	5
Ohio	19	21
Oklahoma	4	6
Oregon	11	16
Palau	1	1
Pennsylvania	27	29
Puerto Rico	20	20
Rhode Island	5	6
South Carolina	19	21
South Dakota	6	7
Tennessee	19	23
Texas	31	35
Utah	9	11
Vermont	2	3
Virgin Islands	2	2
Virginia	18	18
Washington	21	22
West Virginia	22	27
Wisconsin	13	14
Wyoming	4	4
Total	**748**	**890**

Source: HRSA's UDS, *Calendar Year 2001 Data: National Rollup Report*, Rollup Summary and *Calendar Year 2003 Data: National Rollup Report*, Rollup Summary.

Note: Table includes the 748 and 890 grantees that submitted data to the 2001 and 2003 UDS, respectively. The 2001 data provide the number of grantees operating before the President's Health Centers Initiative began and the 2003 data were the most recent data available at the time we conducted our review.

Comments from the Health Resources and Services Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Resources and Services Administration

Rockville, Maryland 20857

JUN 24 2005

TO: Marjorie Kanof
Managing Director, Health Care
Government Accountability Office

FROM: Administrator

SUBJECT: Government Accountability Office Draft Report: "Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased" (Code # 290400)

Thank you for the opportunity to provide comments on the above subject draft report. Attached please find our response.

Questions may be referred to Ms. Gail Lipton in HRSA's Office of Federal Assistance Management at (301) 443-6509.

Betty James Duke

Attachment

Health Resources and Services Administration's Comments on the Government Accountability Office Draft Report: "Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased"

General Comments:

Health Resources and Services Administration (HRSA) appreciates the dialogue that occurred during the exit conference regarding the comments raised about tracking the number of delivery sites. HRSA acknowledges that more accurate and timely site data would allow for improved management of the Health Center Program. Recognizing the need for improved site data collection and verification, HRSA has already initiated activities to increase the accuracy of site-specific data through the management of databases to track changes in scope and verify sites. Furthermore, the expansion goals of the President's Health Center Initiative focus on impacting 1,200 communities and increasing access to primary health care for over 6 million additional patients. Each of the 1,200 communities impacted is represented by a new or expanded project that addresses the specific needs exhibited in each community, and those needs may be addressed by one or more sites at the discretion of the applicant organization. As a result, the goal of impacting 1,200 communities is more appropriately assessed by the number of new or expanded access point grants supported rather than the actual number of sites. Therefore, the accuracy of the number of service delivery sites supported by expansion activities does not impact the ability of the Health Center Program to assess and report the progress of the President's Health Center Initiative relative to its stated goals.

GAO Contact and Staff Acknowledgments

GAO Contact

Helene F. Toiv, (202) 512-7162

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