

An Ethnography of Bureaucratic Practice in a New York State Federally Qualified Community  
Health Center

David James Breslich Erickson

Submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
under the Executive Committee  
of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2020

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## ABSTRACT

### An Ethnography of Bureaucratic Practice in a New York State Federally Qualified Community Health Center

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Federally Qualified Community Health Centers - aka *FQHCs*, *Community Health Centers (CHCs)*, *Neighborhood Health Centers*, or simply *Health Centers* - are public and private non-profit healthcare organizations funded under Section 330 of the Public Health Service Act, directed by a consumer board of directors, and complying with Federal requirements to serve medically underserved populations. In 2017 FQHCs saw more than 27 million individual patients in the United States, of whom approximately two million were seen by health centers in New York State (Bureau of Primary Health Care 2017). Despite these staggering figures, relatively little academic work has investigated how these health centers operate at an administrative and bureaucratic level.

To study the bureaucratic practice of FQHCs, this research utilizes an ethnographic approach, conducted over a period of three-plus years at a FQHC in New York State (pseudonymously called Care Center). It incorporates structured interviews, informal interviews, the collection of fieldnotes, and participant observation, as well as qualitative data analysis. Collectively this research approach produces a complex portrait of how bureaucratic activity at the specific FQHC field site was organized, conducted, and structured within the context of substantial growth in the FQHC program. The setting of the study offers a unique opportunity to explore the implications of this bureaucratic activity on FQHCs and, by extension, other safety-net healthcare institutions in the United States.

This research also delivers a substantial historical account of the emergence of the FQHC program in order to connect that account to the broader arc of healthcare history in the United States during the 20<sup>th</sup> and 21<sup>st</sup> centuries. This connection demonstrates the linkages between specific aspects of FQHC bureaucratic practice and larger trends in health care more generally. The emphasis on “need” as a discursive object that is frequently referenced and utilized as an organizing mechanism by FQHC bureaucracy allows us to better understand and problematize the use of need as a criterion for organizational growth.

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## Acknowledgements

Several fortuitous circumstances, failures, and chance encounters produced this dissertation. I am deeply indebted to the numerous friends, family members, colleagues, and mentors who helped me along the way.

First and foremost, I benefited from financial support as a research assistant for Dr. Jennifer Hirsch at Columbia University's Sociomedical Sciences Program (SMS) during my coursework. Her subsequent mentorship in navigating IRB processes and departmental requirements has been fundamental to the success of this project. Thank you! The opportunity to work as a teaching assistant for the Sociomedical Sciences Program with Dr. Ana Abraido-Lanza opened my eyes to a breadth of perspectives on healthcare institutions that I likely could not have gained through coursework alone. Thank you also to Edgar Rivera-Colon for the time I spent as his teaching assistant in SMS's qualitative research methods course.

Academic bureaucracy is as intricate as that of healthcare institutions and sifting through its twists and turns requires expert guidance. Andrea Constancio at SMS never ceases to astonish me with her familiarity of process, her willingness to tirelessly pursue solutions on behalf of students in the department, and her capacity to comfort those of us in distress. I would have been lost without her.

I am deeply grateful to my committee members: Kim Hopper, Helen-Maria Lekas, Peter Messeri, Virginia Ashby Sharpe, and David Alfandre. For taking me on as an advisee amidst his considerable teaching obligations I remain especially indebted to Kim Hopper. Marilena Lekas has aided me in more ways that I can count and given me emotional encouragement balanced in equal parts with her tremendous intellectual and practical insights.

To my colleagues, supervisors, and direct reports at Care Center, I am so grateful for your willingness to support my project. I benefitted greatly from my experience as an employee but am forever changed by my interactions with you all. It is my sincerest hope that you see parts of the Care Center world in this dissertation, and I hope that I have done justice to the words you were willing to share with me. I could never have made it to the finish line without you.

My parents, John and Helen Erickson, and brother, Paul Erickson, have given me a lifetime of encouragement and always persuaded me to value intellectual endeavors, be it in canon law, landscape architecture, music, or history. It is because of them that I was in any way prepared to pursue academic study. I love them very much.

There is one person whom I met while doing this project who has suffered its ups and downs more than anyone, Lana Klemeyer. I am endlessly grateful for her understanding, her proofreading and editorial talents, and her love.



## **Dedication**

For hardworking bureaucrats everywhere.

## **Introduction: Welcome to Care Center<sup>1</sup>**

*On a frigid, crystal-clear day in December 2016, I joined a procession of cars as they inched along a narrow road running parallel to Long Island Sound. We were all en route to the same place, Care Center's annual staff party. The event, heralded by an email invitation decorated with silver and teal orbs surrounding the health center's logo, had been held annually by the health center since its inception, according to the accounts of the health center's most senior employees, including the CEO. I pulled out of the stop-and-go traffic, parked, and began to walk alongside the cars still pushing onward toward a wrap-around driveway and a crew of listless valets. The event space turned out to be a massive "wedding and gala venue" featuring various patios and garden terraces, which no doubt served as the backdrop for innumerable photographs during the more temperate months. In winter, the remains of old snowbanks and grasses browned from winter hibernation were less picturesque.*

*Entering the front doors into a vestibule with a slick marble floor, I immediately faced a table staffed by several women, all clad in rather subdued outfits in comparison to the ornate dresses, suits, ties, and the occasionally gaudy "holiday sweater" of the people leaving their keys with the valet. As I walked over to the table, I heard someone I hadn't noticed calling my name. "David! Now we've got all these lovely things! Here's an animal, a nice little wine holder, a lovely coloring book holder. What're you going to get?" It was Cheryl Jacobs, who was dressed in a dark velvet dress and almost bounced as she talked. As soon as I saw her, I realized that this was a group of women from the health center's migrant farmworker sites. They had sewn together these objects and were selling them to raise money for migrant youth*

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<sup>1</sup> "Care Center" and the names of Care Center personnel are pseudonyms, as are the place names associated with Care Center sites. For a full discussion of my use of pseudonyms please see the section titled **Methodology: Some Ethical Considerations, and a Discussion about Pseudonyms and Anonymity.**

*programs planned for the coming summer. Since the 1990s, a group of Catholic nuns had run an outreach program for the farmworker community, particularly children, off in the Uplands service area. The summer program gave children a chance to go swimming, have writing workshops, take walking tours, and go on library visits, all while their parents worked in the onion fields. The sisters were retiring and had passed on the responsibility for running the summer program to Jacobs, a member of the health center staff who was leading the area migrant committee. Jacobs was a woman of frenetic energy who, at various points, had been a registered dietitian, the director of the health center's human resources department, the health center's chief operating officer, and the director of the health center's training program. "I'll take this one," I told her, selecting what looked like a slightly misshapen cloth bag with a plastic holly berry and a bow tied to it. I fished \$40 dollars out of my pocket and handed it to one of the ladies. I turned to say something to Jacobs, but she was already chatting with another attendee, excitedly showcasing the hand-crafted assortment.*

*I turned to my left, where a series of doors led into the main room of the building, from which I heard a din of voices punctuated every so often by a laugh or exclamation of surprise or excitement. As I turned down the hallway, I saw a cluster of people excitedly taking photographs with their cellphones. It was not until I got a little closer that I realized the group included several people who weren't people at all, but rather life-sized cutouts made of thick poster board. The three figures represented were Mary Reagan, the health center's CEO on the left, modestly smiling with her hand resting on her waist, Roberta Thompson, the health center's executive vice president (and sole surviving founder) in the center, wearing a white peplum jacket embellished with a black paisley trim along the bottom edge and sleeves, and Zeke Benjamin, Care Center's CFO, on the right, dressed in a dark pinstriped suit, arms outstretched*

*as if to exclaim “ta-da!” Gathered around this trio were several members of the health center’s billing and informatics department. They were taking turns photographing themselves gesturing and posing in various ways, some vulgar, with the cutouts.*

*I made my way past this scene and entered a massive ballroom that spanned the entire length of the building. The noise was overwhelming as I observed nearly a thousand people milling about a vast sea of tables tightly packed from wall to wall, with space in the center for a dance floor. The noise from the crowd was drowning out a speaker at a podium at the head of the dance floor. I realized it was Mary Reagan speaking, and at one point, before the noise of the crowd drowned her out completely, I heard her describing a staff luncheon from years ago, when the employees of the health center’s first (and then only) site in Wilthook, NY gathered at an adjacent diner to celebrate. I thought I knew the place, “the dirty diner” it was fondly referred to by some of the friends I’d made from the Wilthook site. Others would tell me that the holiday parties sometimes weren’t even held at a venue, but right in the health center itself, potluck style, with everyone bringing a dish from home.*

*I wandered through the hall greeting some of the people I’d met before. I introduced myself to a few of them, asking where they worked, and how long it took them to travel to the event. Several were slurring their answers, but I could make out that it had taken them several hours in a minibus to get to the venue and that they had been “pre-gaming” on the way in. “You know how it is, baby - we got to get that Malibu<sup>2</sup> going,” said one raising a Nalgene water bottle and throwing her arm around the woman sitting beside her. As I slipped out of the hall, I cast a backwards glance at the CEO, who was still standing at the microphone, still saying words, but at the rear of the room they were so muffled that I couldn’t make out a single one.*

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<sup>2</sup> A coconut flavored liqueur made with Caribbean rum.

When I wrote the basic content of the foregoing fieldnote, I had just initiated the formal collection of data as part of my dissertation research. But I had worked at Care Center, a Federally Qualified Community Health Center (FQHC), for approximately two and a half years. At Care Center I had managed New York State Department of Health grants and overseen various ad hoc projects ranging from preparation for Health Resources and Services Administration (HRSA) operational assessment to renovations on nursing stations in one of Care Centers health center sites. While I worked at Care Center, I began to consider the possibility of conducting ethnographic work there, but not among its patients and doctors. Instead, and possibly because of the work I was doing at Care Center, I became intrigued by the life and work of health center administrators, its project managers, its credentialing specialists, its executives, its financial analysts, etc. In short - Care Center's bureaucracy. When the project was approved, I opted to continue formally working at Care Center, and as result I found myself frantically scribbling furtive notes at meetings, during conference calls, and at events such as the one I have described above.

Although I continued to actively conduct research at Care Center for two more years, I found myself puzzling over this early fieldnote even as I accumulated dozens of transcripts based on formal interviews, a substantial library of health center documents, and recorded notes and observations based on hundreds of exchanges I had during that time. To some degree this is the result of an anthropological dedication to explain the extraordinary as a logical extension of the everyday, and to understand the mundane as something extraordinary. The staff recognition luncheon occurred once a year, and was, in that sense, an extraordinary departure from daily life at Care Center. But the event also marked the first time I actively recorded observations that would evolve into the major thematic areas I intend to address in this dissertation, all of which

provide different vantage points from which to assess Care Center's bureaucracy. These themes include grassroots fundraising, a striving to maintain (or at least simulate) connections to Care Center's origins, personality-driven leadership, and a celebration of individuals. These themes and their relationship to Care Center's organizational structure and bureaucracy will be set forth in the body of this dissertation.

The staff recognition luncheon was unique, at least in terms of my interest in organizational structure and bureaucracy, because it represented the best opportunity to observe all of Care Center's staff together in one setting at a given time. It also dramatically demonstrated the size of the organization and its expansion over time. Through luck or happenstance, I began my research at a moment of tremendous corporate growth and evolution. While once all the staff could comfortably gather in a tiny railcar diner adjoining its one and only site, now the single largest venue in the region was bursting at the seams to hold them. This sense of growth and awareness of the changes it produced within Care Center's bureaucracy provides the backdrop against which I initially worked as an employee, and then conducted my research and analyses. Additionally, because so many staff members were in attendance, I used the event as an anchoring point for my research. I included a standard question in my structured interviews in which I asked about the luncheon, and specifically about the cardboard triumvirate that greeted attendees upon their arrival. The absence of patients apart from Cheryl Jacobs' group also stood out, and indeed many of the Care Center staff I spoke with thought the cutouts were peculiar insofar as they seemed to celebrate the CEO and her top team members, not the patients that the health center served.

At a very basic level, the event raised, at least in my mind, a few fundamental questions about what community health centers have been and what they are, and whether it is possible to

maintain the organizational forms that have contributed to their flourishing in the United States. FQHC chronicler Bonnie Lefkowitz has argued that health centers “didn’t survive and grow into the nation’s largest primary care network without challenging public health orthodoxy, medical sovereignty, and entrenched bureaucracy” (2007, 147). What mechanism then could organize the efforts of the hundreds of Care Center employees that I saw packed into the wedding gala venue? What does bureaucracy even mean to organizations struggling with the “jarring disconnect between the rich, emotional legacy of health centers and their need to compete in a modern marketplace as sophisticated providers” (Ibid, 135)? Or, in the words of one veteran Care Center administrator, how do you come to terms with the fact that when you are “bigger and more mature, you can no longer act like you’re the bomb thrower because you’re in fact a bomb maker”? These are some of the contrasts and questions I struggled with during my research, and also during my working hours at Care Center, and which I ultimately fashioned into the core research question, or “problem” I describe below.

### **The Problem**

Federally Qualified Community Health Centers (aka *FQHCs*, *Community Health Centers* [*CHCs*], *Neighborhood Health Centers*, or simply *Health Centers*) - are public and private non-profit healthcare organizations funded under Section 330 of the Public Health Service Act, directed by a consumer board of directors, and complying with Federal requirements to serve medically underserved populations. In 2017 FQHCs saw more than 27 million individual patients in the United States, of whom approximately two million were seen by health centers in New York State (Bureau of Primary Health Care 2017). To put this in context, FQHCs saw more people in 2017 than the *total* populations of Denmark, Finland, Norway and Sweden combined and about three times more than the number of Veterans seen by the VA healthcare

program in 2017. Despite the volume of patients seen by FQHCs, academic literature on how these institutions actually function has been limited. Studies that do exist tend to examine the experience - mostly negative - of health center patients and providers in the context of neoliberal health policy (i.e., market) reforms (Boehm 2005; Lamphere 2005; Horton 2006; Duffy 2008; Willging et al. 2014). These studies emphasize emergent subjectivities, identities, and struggles of individual patients and healthcare providers against the backdrop of macro-level political and economic trends. As Ganti (2014) notes, anthropological engagements with neoliberalism can be divided into three broad categories: neoliberalism as a structural force affecting life chances; neoliberalism as an ideology of governance; and neoliberalism as a practice enacted at specific locations by specific actors. It is within this third “smaller body of scholarship” (96) that I intend to situate my study of FQHC bureaucracy. And while I am sensitive to the question of how neoliberal policy shapes the experience of health care, the use of this broad, macro-level construct to frame investigative study tends to neglect some of the institutional pathways that either contribute to or hinder the implementation of such policy. More to the point, existing ethnographic work about FQHCs shies away from examining the administrative and bureaucratic features of FQHCs and the ways in which health center organizational structure drives health care service delivery and policy implementation – neoliberal or otherwise. This trend in the literature reflects a general shortage of critical ethnographic accounts addressing bureaucracy generally, and healthcare bureaucracy specifically (Graeber 2015, 53). That said, neoliberalism will serve as a backdrop to some of the data I collected and analyzed during my time at Care Center.

### **The Purpose**

The general goal of this dissertation is to expand upon current ethnographic research on bureaucracies and bureaucratic practice, focusing on a specific healthcare bureaucracy (that of a



FQHC) responsible for the administration and delivery of primary care services in New York State. I will elaborate on my definition of FQHC bureaucracy in **Chapter 2: Organizational Structure**, but when I refer to FQHC bureaucracy I generally mean *a system of administration and administrative work undertaken in non-clinical office settings*. As further described in **Methodology**, I used an ethnographic approach to examine the daily life of bureaucrats and bureaucratic practice within such a bureaucracy at Care Center, a New York State Federally Qualified Community Health Center. I also used participant observation, formal and informal interviews, archival research, and analysis of a specific bureaucratic discursive object, that of “need” to conduct my research. Drawing on data I collected at Care Center and the analysis of those data, this dissertation will attempt to address the following four research aims:

**Research Aim 1: Describe the historical context in which FQHCs emerged, focusing on the relationship of this history to the concepts of health care delivery prevailing within the health center’s bureaucracy.**

The FQHC program has a long history. Its institutional antecedents, its genesis, and its subsequent development and evolution emerged from very specific historic situations: The War on Poverty in the 1960s, categorical funding sponsored by Senator Ted Kennedy in 1966, consolidation beginning with Section 314(e) of the Public Health Service Act, then morphing into Section 330 in the 1970s, the coining of the term “FQHC” in the 1980s, George W. Bush-era expansion and increases in funding, and the passage of the Affordable Care Act. But FQHCs are also tied to the broader historical trends associated with health care service delivery in the United States during the 20<sup>th</sup> and early 21<sup>st</sup> centuries. By placing FQHC history back into dialogue with these trends, I hope to show that publicly funded health centers are not only the products of heroic War on Poverty activists but also part of a longer, and perhaps more complicated set of

historical circumstances. Additionally, this aim attempts to connect the long, messy history of community health centers to the patterns of administrative styles that were replicated and practiced within the Care Center setting.

**Research Aim 2: Examine the organizational structures and logics out of which the everyday activities of FQHC bureaucrats emerge. This aim explores the way Care Center’s system of organization (or lack thereof) interacts with and impacts the way that primary care is delivered.**

In moving from historical context to day-to-day bureaucratic practice, this ethnography will contextualize the experience of bureaucrats within the institutional life of the FQHC. This aim takes up Max Weber’s theoretical writings on bureaucracy as an analytic starting point, but it attempts to offer a different logical structure underlying Care Center’s bureaucratic apparatus. I also use this aim as a way to tie some of the organizing logics I observed at Care Center to broader structural features of the FQHC program in order to illustrate the way that these structures reinforce Care Center’s system of bureaucratic organization.

**Research Aim 3: Explore the implications of Care Center’s organizational structure, specifically its “grassroots” character, within the context of substantial health center growth.**

This aim attempts to identify and analyze a specific feature of Care Center’s administrative style – that of “grassroots” - and explores the ways in which that style impacted the Care Center’s implementation of various clinical services. This aim shows how the health center’s pattern of growth interacts with its ongoing efforts to maintain this grassroots character, and some of the potential organizational and practice tensions that emerged from this circumstance. In many ways, maintaining this character in the face of growth presents a clash

between the emotionally rich history of Care Center and the present-day demands involved in managing and operating a massive corporate entity.

**Research Aim 4: Develop a case study describing how a specific organizing principle – “need” – shapes the FQHC bureaucratic setting. This proposed case study will (a) document and analyze the ascribed meanings, uses, and contextual scenarios in which FQHC bureaucrats invoke “need” as a discursive object, and (b) explore the way that the discursive object of “need” is leveraged as a currency driving health center administrative activity. Additionally, this aim will show how “need” circulates among bureaucracies external to the primary field site, specifically those responsible for regulating and establishing reimbursement for FQHCs (the Federal Bureau of Primary Health Care and the New York State Department of Health).**

This aim builds on the patterns of growth explored by Research Aim 3 and attempts to understand the vehicle by which Care Center’s growth was achieved. “Need” here is framed as a discursive object that is actively managed by Care Center’s bureaucratic processes to achieve specific ends. These processes involve inscribing and “certifying” need and fashioning it into a transactional form that can readily be exchanged for financial support. Philosophical discussions of need identify aspects of this concept that promote its consumption as a rationale for delivering health care, specifically its social character, its moral salience, and a functional tendency to linguistically “inflate” or massage the meaning of need to suit personal or organizational purposes. FQHC bureaucracy performs highly technical inscription practices that allow the concept of need to be tactically deployed in ways that do not always correlate to “empirical” facts on the ground. Need thus comes to perform a double duty, both as a required ideological

principle justifying health center service delivery and as a justification for awarding public funds to support health center activities.

In sum, this dissertation seeks to situate and describe the bureaucratic practice of Federally Qualified Community Health Centers within the historical context of the health center movement by tracing out the structural, organizational, and ideological logics of that bureaucracy as documented by ethnographic research conducted at a specific health center site located in New York State.

## **Background to the Subject of this Dissertation**

### **Federally Qualified Community Health Centers**

As noted above in “**The Problem**,” FQHCs annually serve approximately 27 million patients in the United States (and Puerto Rico) and approximately two million patients in New York State alone (Bureau of Primary Health Care 2017). Compared to the rest of patients in New York State, FQHC patients are twice as likely to receive Medicaid or be uninsured and are twice as likely to be African American or Hispanic. In addition, nearly all (89%) live below 200% of the Federal Poverty Level (Community Health Center Association of New York State 2019). These data indicate that (a) FQHCs deliver medical, dental, and mental health services to a large number of New York State residents (approximately one in nine) and (b) the population served tends to be socioeconomically disadvantaged, and therefore often has characteristics commonly associated with poor health outcomes (Capital Link 2014).<sup>3</sup>

While the size and characteristics of the patient population served by FQHCs alone justifies inquiry into the administration of care delivery, the history of community health centers

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<sup>3</sup> I have cited Capital Link 2014 because of its specific focus on the characteristics of patients seen by FQHCs. For a more general discussion of social determinants of health see Institute of Medicine and National Research Council (2013).

alerts us to the unusual breadth of practice models available to health center bureaucrats.

Historical circumstances do not necessarily explain bureaucratic practice, but they do lay out the various ideas that health center bureaucrats potentially could draw on while engaged in administrative activity. In her analysis of two competing philosophies of FQHC<sup>4</sup> management in the 1970s, Jenna Loyd offers a significant example of how this historical process can play out.

The example documents an ongoing debate between Jack Geiger, founder and director of the two inaugural community health centers (Columbia Point in Boston, MA and Delta Health Center in Mound Bayou, MS), and Howard Levy, physician and health activist. The debate pitted Geiger's assertion that health centers were radical because they changed the landscape of professional practice, transferred governing authority to community members, and met specific and immediate needs against Levy's counter-assertion that health centers, by virtue of their federal backing, constituted just another element of black oppression and subjugation (2010, 54).

Loyd characterizes the debate between Levy and Geiger as a tension between the Foucauldian conception of community health centers as a normalizing biopolitical project – that is, a project in which federal programming proceeded to exert social and political control over the lives of impoverished (often black) persons – and the ability of community-led, grass-roots efforts to resist that project by transferring power to local communities. Loyd supports the former viewpoint, but I would posit that the mere existence of such a debate shows that there were multiple philosophical currents swirling around the formation of the Delta Health Center.<sup>5</sup> Indeed, it was not a foregone conclusion that the federally sponsored community health centers

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<sup>4</sup> The term “Federally Qualified Community Health Center” or “FQHC” only came into use in 1989 and 1990 when Congress passed legislation “requiring FQHCs to be reimbursed on a reasonable cost basis for services provided to beneficiaries of the Medicare and Medicaid programs” (Koppen 2001, 4).

<sup>5</sup> Loyd demonstrates the way in which this debate unfolded during the formation of these health centers in the 1970s in a series of articles in the journal *Social Policy* (2010, 54). For the *Social Policy* articles see Geiger (1971).

would constitute the dominant version of health centers in the future. A wide array of potential models existed. Commenting on the explosion of community-based health programs during this era, Alondra Nelson notes, “this multifaceted radical health community was a decentralized aggregate of groups, collectives, and organizations with distinct missions that sought to transform medicine, institutionally and interpersonally” (2011, 81). From the perspective of this dissertation, the issue is not whether one viewpoint on health centers (as grassroots organizations or as instruments of the federal government) is more realistic than another, but rather that health centers and their administration, governance, and bureaucracy could draw on multiple philosophies, depending on the specific historical circumstances of their inauguration and expansion – and they often did. This diversity continues to characterize FQHCs, prompting some commentators to ask, “Who Governs Community Health Centers?” (Wright 2013).

**Research Aim 1** explores this question through a historical analysis of the context in which the primary FQHC field site under consideration emerged, and the potential impact that context holds for the prevailing ideas and conceptual models that bureaucrats draw on in the day-to-day operation of the health center.

## **Literature**

Several strands of literature contributed to the structure and foci of my research. Together these strands offer a rationale and a theoretical basis on which I build throughout this dissertation. Additionally, this literature clarifies and assists in defining concepts I used both during my time in the field and throughout the process of writing up my findings.

### **“Street-Level” Healthcare Bureaucracy Vs. Meso-Level Healthcare Bureaucracy**

In multiple and diverse contexts, medical sociologists and medical anthropologists have attended to Arthur Kleinman’s long ago issued directive to study the impact that organizational

systems, institutions, and bureaucracies have in shaping the character of patient care and its delivery (1980). This literature varies in terms of geographic location but consistently focuses on patient-oriented, street-level interactions between individuals and health systems. While topically gesturing at healthcare bureaucracy and its effects, this literature does not always explicitly define bureaucracy or call it out as a distinct object of analysis. Nonetheless, these studies, particularly Lipsky (1980) discussed below, do reveal the ways in which the institutional systems behind street-level interactions between clinicians and patients shape health care delivery.

A strong example of writing that attends to institutional systems and associated clinical interactions is a 2005 paper by Karen Lutfey and Jeremy Freese in which the authors attempt to uncover the causal mechanisms linking socio-economic status (SES) and health through a comparative study of routine clinic visits at two different clinic sites. They identify organizational differences, such as “continuity of care,” resources for patient education, and staffing patterns, as significant factors contributing to differences (better and worse) in diabetes treatment. Organizational structure interacts with individual patients, and with patient life contexts and chances, often highlighting the mechanisms by which SES produces negative outcomes. Without explicitly defining it as such, Lutfey and Freese’s work analyzes a specific process (“routine office visit”) commonly associated with bureaucracy (Lutfey and Freese 2005). Using similar ethnographic techniques, Wool and Messinger (2012) tease out the changes in how kin groups care for veterans resulting from their becoming enmeshed within the bureaucratic structures and logics of the Walter Reed Army Medical Center. In both instances what it means to be a patient is inseparably tied to the constitutive powers of the bureaucratic setting with which that patient interacts.

Despite working in a very different context, Vania Smith-Oka addresses a comparable bureaucratic process in her study of the “routinizing of obstetricians’ everyday practice” among impoverished populations in Mexico. She emphasizes organizational factors that contribute to a specific procedure used by physicians who manage the labor process of impoverished patients thereby connecting minute clinical practice to institutional factors as well as macro-level social trends (Smith-Oka 2013). Brotherton (2012) and Mulligan (2014), by contrast, ethnographically document top-down changes to public health systems in Cuba and Puerto Rico respectively, and analyze shifts in health-seeking strategies and behaviors accompanying these changes. Martin (1994) and Rapp (1999) have respectively advanced the study of how illness-specific and procedure-specific experiences interact with healthcare systems (bureaucracies), while Lock, Young, and Cambrosio (2000) summarize comparable work focused on healthcare systems in the context of emergent medical technologies. Collectively these authors describe a systematically coherent interactional circuit that consists of institutional and technological processes and the lives and life worlds of individual. I intend to position my research as a complementary component of this interactional circuit. Studies such as those mentioned above in “Introduction and Research Aims” contextualize the experiences of patients and frontline staff in the United States against the backdrop of policy changes (Boehm 2005; Lamphere 2005; Duffy 2008), indicating the importance of considering the environment of public policy as a macro-level participant in this same circuit.

Some studies attempt to broaden the theoretical implications of frontline experiences. Adriana Petryna, for example, explores the notion of “biological citizenship” among Ukrainians exposed to radiation following the Chernobyl disaster. Her investigation reveals the way in which individuals deploy their own “health” as a vehicle for negotiating political and social



recognition as well as specific resources and benefits (2013). This description illustrates an ongoing tension between citizens and governmental authority (i.e. bureaucracy) regarding the parameters used to define a specific biological condition and eligibility for services aimed at treating that condition. In addition, her study highlights the potential of interactions with healthcare systems to obscure and elide patient representations of illness with the language of technical and bureaucratic reporting.

A general point of thematic consistency in the studies reviewed here is an emphasis on what Michael Lipsky terms “street-level bureaucracy” (1980). Lipsky’s argument, broadly summarized, identifies the day-to-day interactions of front-line staff (police, social workers, firefighters) with citizens as the crucial moment in which (a) policy is implemented and (b) the relationship of citizens to the state is mediated. The point here is that front-line staff “create” and “generate” policy through these interactions. Although not always directly in dialogue with Lipsky, the anthropological and sociological literature concerning healthcare bureaucracy frequently adopts his level of reference. These studies are effective at painting a rich portrait of patient lives and experiences against the backdrop of day-to-day policy implementation and bureaucratic medicine, and they present a compelling critique of systems put in place to serve highly vulnerable individuals (Bourgois and Schonberg 2009; Mulligan 2014). They also allow us to understand not-for-profit agencies as emerging street-level bureaucracies, delivering public policies to citizens in service areas formerly dominated by public workers – and effectively transmuting “emergency” endeavors into de facto programmatic structure (Smith and Lipsky 1993, 13).

At the same time, the emphasis of these studies on street-level effects can obscure the complexity of meso-level operations and the social conditions at play within bureaucratic

organizations. A tendency to fall back on clichés, “byzantine bureaucratic rules” (Bourgois and Schonberg 2009, 279), or “layers of inscrutable bureaucracy” (Mulligan, 24) does little to explicate that complexity. Mulligan describes her research site, a Health Management Organization, as a “contact zone” between diverse actors and invokes Shore and Wright’s (2011) directive to “study through,”<sup>6</sup> but she acknowledges that an essential component of her research involves interviews with HMO plan members (i.e. street-level actors). The depth of her study results from life history interviews with plan members, which, incidentally, are the only interviews she describes in her methodological appendix (Mulligan 2014, 241). My **Research Aims 2-4** attempt to shift the site of investigation from the street level to what I term a “meso-level” in order to explore the density of everyday practice occluded by such terms as “byzantine rules” and “inscrutable layers” of non-street-level healthcare bureaucracy. I use the term meso-level bureaucracy to emphasize the fact that there are macro levels policies and practices that press down upon FQHC bureaucracy, in much the same way that FQHC bureaucracy in turn presses down upon street-level interactions on the front lines of health care delivery.

### **Bureaucracy, Ethnography (Institutional, Organizational, Corporate) and Practice**

In the previous section I reviewed literature focused on the impact of healthcare systems, institutions, and bureaucracies on street-level interactions. While frequently referencing bureaucracy and its effects, these works avoid categorization as studies *of* bureaucracy; often they do not define it or treat it as a distinct object of analysis. Here I draw on the classical formulation of Max Weber as buttressed by anthropological studies of bureaucracy, such as they are, to introduce the theoretical basis for this research. Additionally, this section will attempt to put those studies into dialogue with more sociologically-oriented approaches to the ethnographic

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<sup>6</sup> The term is an adaptation of Laura Nader’s term “studying up” (1972), which attempts to turn the methodological tools of anthropology to the study of persons or places that command substantial economic resources and influence.

study of organizations. Finally, I introduce the notion of an “inhabited institutions approach” to the study of bureaucracy, an approach that applies the insights of *practice theory* to the study of institutions (Hallet and Ventresca 2006). This approach allows us to assess more critically the actions, interactions, and meanings underlying FQHC bureaucratic activity.

Max Weber’s theory of bureaucracy and his description of a bureaucratic “ideal type” provides a starting point for my ethnographic research at Care Center (1946). This analytic construct, the ideal type, provides a reference point against which one can compare empirical observations collected in the field. I rely on the concept of the ideal type in a comparative sense to frame my discussion of Care Center’s organizational structure (**Chapter 2**). At the same time, and perhaps owing to the structural emphasis of Weber’s description of bureaucracy, relatively few anthropological studies (and therefore few ethnographic studies) have made bureaucracies the focus of their research. Anya Bernstein and Elizabeth Mertz have noted that anthropologists have been slow to treat “bureaucrats as participants in a complex social arena” (2011, 6). Informative exceptions include Herzfeld (1992), Gupta (2012), Hull (2012), Mitchell (2002), and Scott (1998).<sup>7</sup> Their works tease out the mechanics of mundane bureaucratic procedures and the day-to-day work of bureaucrats within the structure of Weber’s ideal type – an approach certainly applicable to the study of FQHC bureaucracy.<sup>8</sup> They also open up the study of

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<sup>7</sup> Although the Scott (1998) study is taxonomically categorized as a work in political science, his approach to the study of the state overlaps substantially with anthropological methods.

<sup>8</sup> Much of the anthropological literature I have cited here emphasizes the role of bureaucracies as a constitutive feature of “the state.” While the state is implicated in FQHC operations (FQHCs are after all *Federally Qualified Community Health Centers*), the relationship between the two does not necessarily follow an easily discernable one-directional line. Jennifer Wolch (a geographer) describes this type of relationship as a component of a “shadow state” or a “para-state apparatus comprised of multiple voluntary sector organizations, administered outside of traditional democratic politics and charged with major collective service responsibilities previously shouldered by the public sector, yet remaining within the purview of state control” (1990, xvi). This suggests that organizations such as FQHCs are responsible for implementing much of what constitutes state policy by proxy, albeit with a good deal of discretionary power. While not focusing on the connection between FQHCs and the state, I do want to indicate instances where FQHC bureaucrats and bureaucratic processes interact with broader networks and institutional forms, specifically those of New York State and the United States.

bureaucracy to traditional anthropological techniques, including analysis of symbols and language informing everyday practice (Herzfeld) and the inclusion of documents and electronic forms in ethnographic research (Hull).

Anthropological studies of bureaucracy also allow me to connect these examples of ethnography to more sociologically informed approaches, particularly those drawn from the field of institutional ethnography (IE). Codified as a subfield within ethnography by sociologist Dorothy Smith (1987, 2005), institutional ethnography examines work settings with an eye toward understanding how institutional efforts are conducted, coordinated, and codified through texts, discourses, and technical language. IE examines this type of institutional coordination in order to focus on the “ruling relations” that such arrangements promote. Within institutional ethnography, the research seeks to “take some particular experience (and associated work processes) as a ‘point of entry’” that map out the various relationships and forces that shape that experience (Devault 2006, 294). Because of its emphasis on the use of texts and objects, institutional ethnography dialogues nicely with the use of Actor Network Theory as a way to include objects, ideas, and other relevant factors within my description of life at Care Center. The move here is to extend IE’s immediate concern with “ruling relations” and to look at ties and connections that the discourses within Care Center have with a broader network of relations.

In **Methodology**, I elaborate on how I operationalized these theoretical insights during my research. Although not always specifically focused on healthcare systems, ethnographic studies in organizations and at corporations, as well as management studies, offer insights into the ethnographic descriptions I collected while working and researching at Care Center. Schwartzman (1993) provides a lengthy synopsis of ethnographic work in and about organizations, and traces the evolution and practice of this genre from the advent of the

Hawthorne Studies in 1927. Notable monographs in this tradition include Gouldner (1954), Selznick (1966), Burowoy (1979), Jackall (1988), Marcus (1998a), Ho (2009), Chen (2009), and (Reich 2014). These studies, as well as less comprehensive articles in the same vein, are well suited to “problematicize [sic] the ways that individuals and groups constitute organizations (and societies) on a daily interactional basis” (Schwartzman 1993, 46). They are also effective at in-depth analysis of specific topical aspects of corporate life.

I circle back to some of the theoretical insights these accounts offer as they present themselves in the ethnographic chapters of this dissertation. Importantly, they address a wide range of organizational subjects (occasionally complemented by business literature) on topics such as management strategies vis-à-vis the boss/CEO (Gabarro and Kotter 1980, Welsh et al. 2019), the tension between grassroots organizing and professionalism/bureaucratization (Ashcraft 2001, 2006; Eikenberry and Kluver 2004; Sanders and McClellan 2014; Maier et al. 2016; Florian 2018), organizational growth (Hess 2010), and even the zombie trope in organizations (Finkelstein 2004; Perrault 2014; Hacker 2016; Gray 2018; Lakeman and Molloy 2018). Within this dissertation they aid in contextualizing the thematic areas I pursue through **Research Aims 1 and 2**. As FQHCs, such as Care Center, continue to evolve, the awareness that this literature brings to the inner workings and tensions within organizations and corporations is invaluable in charting out practical pathways forward.

I draw on two additional theoretical concepts to support my ethnographic analysis of bureaucratic activity at Care Center. First, I understand a bureaucracy as an “inhabited institution.” This simply means that institutions are not “inert categories of meaning” but are “populated with people whose social interactions suffuse institutions with local force and significance” (Hallet and Ventresca 2006, 213). Second, a bureaucracy develops certain

structural frameworks that result from the practices of actors who internalize and embody that framework. Following Bourdieu, bureaucratic practice is conceived of as a dialectical relationship between an objective institutional field along with its associated structural rules, and the subjective individual shaped by the structures and forces of that institutional field (Bourdieu 1977). Within the context of Care Center’s bureaucracy, I intend to use this idea to point out that while objective structures do indeed inform and organize administrative work (texts for example), subjective representations maintained by bureaucrats at Care Center in turn impact the character of those objective structures. These two concepts – that of the “inhabited institution” and that of a link between subjective and objective representation of bureaucratic work - help in framing the ethnographic objectives of my research.

#### **“Need” as a Discursive Object**

**Research Aim 4** serves a double purpose within this dissertation and requires some additional introduction. The first purpose relates to a specific topical area of concern for FQHC bureaucrats (“need”) and presents the subject as a case study. The bureaucratic world of Care Center was suffused with need, but it was deployed as animating idea or rationale, not necessarily as an empirical reality. The meanings and uses of need within this context warrant attention. The second purpose looks at the manner in which need operated as a discursive object mediating the bureaucratic operations of Care Center.

In order to achieve this double purpose, I will focus on “need,” the topical focus of **Research Aim 4**, as a “discursive object.” Following Foucault, I use the term “discursive object” to mean a particular node or organizing principle within a broader network of rules and systems of reference, or “discourse” (Foucault 1970). The network ultimately establishes how, and when, the particular node is meaningful. I characterize need as a “discursive object” but I

will also depict it as a discursively developed “node” or organizing principle. I also use the term “concept” in semi-synonymous fashion when referring to need. As a discursive object “need” exhibits the characteristics of a Lévi-Straussian “floating signifier” in that it “enables symbolic thinking to operate despite the contradictions inherent in it” (1987, 63). In this latter usage I mean to convey the sense that need has an undetermined quality to it and is apt to receive many meanings. I primarily use the concept of a floating signifier to elaborate on the properties need maintains and its propensity to absorb many meanings. Frequently these meanings were conveyed by, and circulated in, texts (applications, documents, grant narratives, etc.). My use here aligns with the attention paid by institutional ethnography to “textually mediated organizations” (Smith 1990) and with Marcus’ recommendation to “follow an object” (need in this case) as a means to situate ethnographic work within a broader world system. To gain a deeper understanding of the various meanings that adhere to need, this dissertation explores the associations that the concept of need has from a philosophical perspective, but also the way that need has, from a historical and policy perspective, been used as a way of structuring health care service delivery.

I will elaborate on a specific case study within the FQHC context to flesh out how meaning(s) adhere to and anchor the theoretical concept of need as a floating signifier described above. As mentioned in “Introduction and Research Aims,” FQHCs (as well as any healthcare organization seeking to become eligible for Medicaid reimbursements under article 28 of the New York State Public Health Law) are obligated to apply for recognition by the New York State Department of Health through a Certificate of Need (CON) application (Cimasi 2005). Completing the application involves presenting the “need” for health care services (citing vital statistics, health measures, etc.) in the geographic area in which the FQHC proposes to open.

Similarly, FQHCs must complete a federal “Need for Assistance Worksheet” when applying for funding to open new service delivery locations. In both instances “need” is inscribed within an application that attempts to corral and represent several co-occurring meanings of need at the same time. This approach echoes that of Grahame (1998), who emphasized the manner in which specific funding applications for job training programs shape the organization of Asian immigrant women in the labor market. I theorize that the meanings of “need” in the applications I describe above constitute nodes interacting with the broader structural environment in which FQHCs operate. Need is at once – depending on the results of its nodal, discursive formation - capable of meaning something concerning “health” and something concerning “financial reimbursement” (Lévi-Strauss’ “floating signifier”). And it circulates among multiple actors, departments, and agencies as it animates FQHC bureaucratic work.

I have confined this case study to the bureaucracy of a single FQHC for the sake of brevity and feasibility, but it is important to recognize the artificiality of that boundary. Applications referencing, and inscribing “need” within them, move around outside the health center before entering the institutional organs of the FQHC. And they undoubtedly circulate through external bureaucracies following their sojourn there. However, what is critical about the production of such applications within the FQHC context is the way bureaucrats fashion a material representation of the competing meanings of “need” within a single artifact (i.e. the application text). The material object, its organization, schedules, and individual parts therefore become a physical instantiation of how the various meanings of need are discursively generated. Tracing out these new associations is a complementary objective of **Research Aim 4**.



## **Significance of This Study for Theory and Practice**

In investigating the ways in which FQHC bureaucrats operate, specifically focusing on diverse conceptual models informing that practice, I hope that this dissertation will open up bureaucracy to ongoing investigation and critique. As noted earlier, current literature on institutions and bureaucracy tends to emphasize a “street level” vantage point, which can obscure, and to some degree insulate, the social life of non-street-level bureaucracy, bracketing it as an obscure and impenetrable domain. Yet if, as Josiah Heyman (1995) suggests, the “anthropology of bureaucracy should address the role of organized power in orchestrating complex and unequal societies,” the mundane routines of bureaucrats must receive extensive investigation, documentation, and analysis. This study attempts to bridge the micro, or “street level” aspects of bureaucracy and those at the macro, or organizational level. Given the role that FQHCs have in providing health care to the poor, gaining greater familiarity with the administration of these institutions is a critical step in familiarizing ourselves with the organized power contributing to their persistence within the broader context of health systems in the United States, particularly as they expand and evolve.

## **Organization**

This dissertation is structured around the four major research aims I outlined in this introduction. The resultant four central chapters of this dissertation (Chapters 1-4) are preceded by two “quasi-chapters”: this introduction (**Introduction**), and a discussion of the methods I used to conduct my research and some of the ethical questions associated with researching a place where I also worked (**Methodology**). A final quasi-chapter (**Conclusion**) completes the dissertation with a brief commentary on my findings, and a provisional summary of some of the

implications these findings have for FQHCs and their role in America's seemingly endless struggle to provide health care to its poorest citizens.

**Chapter 1** addresses the historical roots of community health centers and their association with the broad sweep of healthcare history in the United States in the 20<sup>th</sup> and 21<sup>st</sup> centuries. My primary purpose in documenting this history is to capture what might be termed a community health center worldview that accounts not only for individual health center heroes, but also for the numerous political and activist voices that have contributed to the emergence of the health center program. Because health centers frequently draw on their provenance as a resource, extending our understanding of that history is a critical component of any account of life in an FQHC.

**Chapter 2** introduces my field sites and sketches out some of the ways in which Care Center was organized, contrasting a Weberian notion of a bureaucratic type with an alternate structure largely interpreted from the perspective of structural anthropology. I explore some of the implications that Care Center's system of organization has had on the way it has gone about providing healthcare services. The chapter also describes some of the structures that contribute to the persistence of Care Center's style of organizing.

**Chapter 3** introduces the idea of "grassroots" as a watchword for Care Center's struggle to balance its own history with expansion and growth. I argue that a studied maintenance of Care Center's grassroots identity does more than simply retell or reenact its history. It creates a highly informal administrative style that directly impacts how Care Center approaches care delivery.

**Chapter 4** identifies the concept of need as a vehicle promoting Care Center's growth and looks at the nature of the bureaucratic activity associated with editing and transcribing need

into transactional forms. Following an introduction that places the concept of need within a philosophical and healthcare-oriented context, this chapter argues that this activity of writing need into being in support of specific organizational work is a critical aspect of Care Center's bureaucratic life. Indeed, the process of inscribing need is an activity relatively independent from the empirical realities, whether existing or proposed, that affect Care Center's patients.

The conclusion reviews the research findings as they relate to my four research aims and reviews some of the implications those findings have for ongoing ethnographic research into bureaucratic practice. In the conclusion I also revisit some of the challenges associated with conducting research in a setting where one is also employed. A final section considers potential developments in the healthcare environment that may impact, and possibly disrupt, the manner in which FQHC bureaucracies operate.

## **Methodology**

In anthropological writing, methodological considerations, if explicitly addressed at all, often come in the form of an appendix or postscript tacked onto the end of the work (Smith 1990; Holmes 2013; Mulligan 2014). I have opted to address methods at the outset in order to explain how I generated the content that populates the subsequent narrative chapters of this dissertation. In this section I will describe some of the sources I drew on and the basic techniques I used to observe and participate in bureaucratic life at Care Center, and how I conducted and analyzed the formal interviews I conducted. Additionally, this methodological introduction will outline some of the benefits and side effects associated with conducting research where I worked.

## **History and Histories**

Although I was not formally trained as a historian, it became clear to me as I designed my research project that the topics I hoped to address within Care Center's bureaucracy required some level of contextualization within the broader arc of health care delivery in the United States during both the 20<sup>th</sup> and early 21<sup>st</sup> centuries. The most prominent FQHC historical accounts have been written by FQHC people about FQHC people for FQHC people (Lefkowitz 2007; Ward 2017). This has contributed to a peculiar cloistering effect wherein FQHCs are isolated from the broader history of medical care in the United States. And while the emergence of so-called Neighborhood Health Centers, in effect proto-Federally Qualified Community Health Centers, cannot be disentangled from the political moment driving Lyndon Johnson's War on Poverty, the broader structural context and circumstances that contributed to its uptake and expansion are substantial. One might go so far as to argue that FQHC history has intentionally been sealed off from broader conversations about health care for the explicit purpose of "flying under the radar" of political scrutiny (Jedele 2016, 31). By stitching FQHC history back together

with its programmatic and legislative antecedents, I was better equipped to recognize certain organizational tendencies within my field site, specifically the relatively conservative character of FQHC political advocacy and program development. This tangled history comes to a tidy conclusion, at least as far as community health centers are concerned, in 1966 with the introduction of an amendment to the Economic Opportunity Act that specifically funded the health center component of the law. From that point, the history can be summarized relatively easily in a more linear fashion as it underwent ongoing consolidation and legislative refinement.

In terms of sources and archives, I primarily drew on materials available at the John F. Kennedy Presidential Library and Museum as this material – particularly the Sargent Shriver papers – most directly dealt with Office of Economic Opportunity programming generally, and community health centers specifically. I also used material from The LBJ Presidential Library, the National Center for Farmworker Health (NCFH) archives, the Jack Geiger Collection at the University of North Carolina Libraries, the Medical Committee for Human Rights (MCHR) archives at the University of Pennsylvania’s Kislak Center, and the Miller Center Foundation and Edward M. Kennedy Institute for the United States Senate, the Senate Historical Office Oral History Project, and the National Institutes of Health U.S. National Library of Medicine Regional Medical Programs Collection. I identified these sources using a bit of a “rabbit hole” method. By this I mean that I dug as deeply as I could into the various threads of history that appeared to connect the emergence of community health centers with broader historical trends. To capture the tenor of the historical moment from a political perspective, I used legislative history and narrative pulled from the Congressional Record as well as several oral histories. In some instances, I have relied on interviews with historical figures who participated in the development of the Neighborhood Health Center model through work with the Office of

Economic Opportunity as well as individuals more closely associated with the founding of Care Center. I identified these individuals on the basis of their celebrity status within the FQHC community (e.g. Jack Geiger, Tom Van Coverden, Lisbeth Bamberger Schorr), or through encounters with them in archival sources (e.g. Joseph English, Noel Klores, Carol Khosrovi). I have described these interviews as “Personal Communications” and placed them in **References Cited** in order to distinguish them from the “Formal Interviews” I conducted with Care Center personnel within the field setting. These interviews forced me to consider the way that history bleeds into ethnography and how best to tell history while continuing to adhere to the conventions of assigning pseudonyms to the locations where I conducted my research. The issue here is less about ethical concerns regarding anonymization, a subject I will discuss in the section of this methodology titled **Some Ethical Considerations, and a Discussion about Pseudonyms and Anonymity**. Rather, the decision to limit the specific historical details of Care Center’s founding may limit the broader applicability or generalizability of my ethnographic findings. Additionally, this move to mask the historical details of Care Center may inadvertently contribute to distancing the field setting as a discrete “cultural garden,” isolated both physically and temporally from contemporary life (Fabian 1983). My History and Histories chapter then is my attempt to mitigate the effects of such distancing by placing Care Center’s bureaucratic life within the broader historical arc out of which the FQHC program emerged and emphasizing the consistency in the environmental dynamics informing the initiation and growth of FQHCs locally and nationally. In instances where I have quoted or summarized statements from public figures, I have done so based on my own notes and/or recordings made in public settings.

My use of history did result in one practical benefit to my fieldwork. Mary Reagan, Care Center’s CEO, showed interest in some of the more obscure historical details of the health center

program. She once commented that I was “the only one left” at Care Center who was interested in this history and would immediately respond to text messages I sent her asking for clarification about specific moments in FQHC history. I became Care Center’s informal “historian,” a role that offered me a ready-made expository statement about my project that I would readily offer to participants, colleagues, and those expressing interest in the study.

### **Ethnography at Work**

My research relied heavily on ethnographic methods within a work setting. My understanding of *ethnography* is based on the broad definition set forward by Hammersley and Atkinson. They describe ethnography as a method or set of methods that involve the ethnographer “participating in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact collecting whatever data is available to throw light on the issues that are the focus of the research” (1983, 1). The specific domain of study (i.e. the bureaucracy of an organization), the focus of the research (i.e. bureaucratic practice and conceptual models informing that practice), and the position of the researcher performing the investigation all lend themselves to an ethnographic approach. *Ethnography at work*, in the sense of receiving pay for the performance of labor within the field setting unrelated to academic inquiry, is a relatively recent development within anthropology. That said, several ethnographies have effectively used this approach to conduct research in highly corporate or organizational settings (Ho 2009; Garcia 2010; Wendland 2010; Mulligan 2014). This approach has several benefits both pragmatic and methodological.

As a purely practical matter, working while conducting my research solved the immediate problem of economic security. I used the compensation I received while working at Care Center to finance long-term research as well as ancillary components of the research

process (transcription services, travel costs, etc.). Self-funding allowed my research a certain level of autonomy from what I might playfully call the academic-industrial complex. What I mean by this is that working allowed me to avoid modifying my research aims to fit specific academic trends, grant opportunities, or pre-defined formats. Although bureaucracy has garnered some mainstream attention within anthropology (Gupta 2012; Hull 2012; Hetherington 2011), my proposed research did not appear to align with the funding priorities typically available to graduate students within my discipline.

Methodologically speaking, conducting research where I worked offered several advantages, two of which I shall discuss here. The first has to do with the level of training that I needed even to formulate some of my research questions. Specifically, my questions about the bureaucratization of “need” relied on an intense familiarity with regulatory minutiae at federal and state levels. Gaining insight into bureaucratic practice requires attentiveness to extremely technical language and associated procedures. Often the only way to master this language is by developing professional competencies within the field (e.g. through employment). Tim Diamond notes that his research on the everyday work of nursing aids required him to acquire certification, a process that added “eight to nine months... to the research ‘design’ ” (2006, 48). By conducting this “pre-fieldwork” during a leave of absence from my doctoral program in 2009, I acquired, to some degree, a professional bureaucratic competency and familiarity that lent strength to my subsequent analyses and conclusions. The process was not unlike taking preparatory academic coursework to learn a new language prior to commencing formal fieldwork in a region where the language is spoken. It was, however, a continuing challenge to find ways to step outside of my work tasks in order to view them analytically. The primary reason for this was that in order to make myself a “professional stranger” (Agar 1980), or a “marginal native”



(Freilich 1970) while working at Care Center, I often had to analyze work activities by breaking the tasks down into micro-steps and then re-reading these descriptions in completely different settings (later at night, on mini-weekend “vacations,” etc.). This process helped me to determine whether or not I could perceive something foreign in what had become relatively routine. I say that this was challenging because it made me an incredibly inefficient employee at times and created periods of frantic stress. To combat this I took periodic breaks from active fieldwork and concentrated solely on completing my responsibilities as an employee, although I do not know if I could identify a specific pattern as to why or when these occurred other than a general sense that I was burning out. This purposeful “defamiliarization” was exhausting and required a significant amount of time (de Jong et al. 2013). Although I tried to keep these descriptions separate from real-time analysis, this was not always possible. My work role at Care Center was demanding at times, and I was not always able to extract myself from the work in order to write down descriptions free from my immediate reactive analysis. I would sometimes share my notes with my wife, whose work experiences in corporate shoe design offered a strong organizational counterpoint to the corporate life in which I was immersed, and her insights helped me disengage from potentially myopic descriptions and interpretations.

A second advantage of researching where I worked had to do with gaining access to the research setting. I knew the CEO personally. I went to high school with family friends of hers, and I periodically would run into her socially or simply accidentally because we happened to live in the same town for a period of time. Additionally, prior to applying for Ph.D. programs, I had spent time at Care Center as a volunteer following my college graduation, and I had worked with Care Center staff on several programs, including one focused on service coordination and outreach to new immigrants. Following a chance encounter with the CEO while on leave from

my doctoral program, she suggested that I speak to a senior executive at Care Center who had expressed interest in some of the topical areas I had studied during my coursework. My subsequent chat with him ultimately turned into a job offer in “project management,” which turned me into a Care Center employee. For the most part I was considered a “good employee” and maintained professional relationships with several senior staff members. Midway through my research my record as an employee facilitated my application for a position as an Associate Vice President, an application that was ultimately approved.

“Rapport” or “trust” developed as part of a broader exchange in which I bartered my professional competencies for entrée to my academic project. When I initially introduced my proposed study to the CEO (about a year and half after coming to work at Care Center) she enthusiastically supported it, and we developed a very favorable research agreement. My approach to gaining access was explicitly “opportunistic” in this regard (Buchanan, Boddy and McCalman 1988). The CEO’s support helped in developing my research agreement with Care Center. This in turn made possible the recruitment of employees for participation in interviews, access Care Center’s data and archival material, and the collection of field notes and recorded observations within Care Center offices and facilities. Throughout my ethnographic narrative, Care Center institutional records on patient numbers, demographics, etc. are all generated from this level of access. I also made it clear to the CEO that my project would not really qualify as so-called “business anthropology,” in which I would perform anthropological work on behalf of Care Center for the purposes of improving work processes, assessing consumer/patient experience, etc. I very bluntly told her that my work might not produce anything of tangible benefit for Care Center. Although access is not everything, I was able to interview a broad sample of Care Center administrative and executive staff, and, if I found myself confused or

wishing I could have followed up on specific issues raised in an interview, it was possible to schedule additional time to follow up. In this sense, employment at Care Center aided my “continuous negotiation of access” (Gellner and Hirsch 2001) for as long as I maintained the dual role of researcher/worker.

While I consider the dual role of researcher/employee highly advantageous, the approach produces definite impacts on the presentation of research finding. Developing professional competencies and including information about that in my written account adds an autoethnographic element to the narrative. To a certain degree this is nothing new. As Atkinson is quick to point out, “the autobiographical has been an element in the ethnographic imagination for almost as long as social scientists have been engaged in such work (2006, 401). But I would like to suggest that my use of “autoethnography” attempts to follow the analytic version described by Anderson (2006) in contrast to more “evocative or emotional” autoethnographic forms (Ellis 2004). Although bureaucracy can generate strong emotional responses, it simply does not carry the same intensity that might accompany an autoethnographic account of an illness or conditions, for example bipolar depression (Martin 2007) or bulimia (Tillman 2009). The intent is to accept the role I played as a bureaucrat and examine some of the activities I performed in that role, while not losing sight of the broader constellation of the social world in which I participated. This goes beyond producing an emotionally striking account or offering insider secrets. Rather it attempts to leverage personal experience and expert membership within the research setting by placing that experience in analytic dialogue with the experiences of other members as well as broader theoretical understandings. I would argue that the primary benefit of such an approach is related to access – access not simply to the research setting but to a vantage point that might direct additional inquiry. For example, workplace frustration *as an*

*employee/subordinate* often opened up new types of questions I could not possibly have formulated without the actual experience of it. This type of insight is, of course, a double-edged sword. I frequently questioned whether I overidentified with subordinates and under-sympathized with Care Center figures of authority. Maintaining a fruitful balance between the academic, the biographical and the social remained a constant challenge throughout my research and throughout the process of writing up my findings. Several studies have commented on the kind of balance that is needed, emphasizing the importance of anchoring research in a “detached theoretical fundament” (Gottwald, Sowa, and Staples 2018) and a willingness to “anticipate the continuation of fieldwork relations into writing” (Mosse 2006, 952). As Jessica Mulligan affirms: “it is a situated, engaged, and compromised methodology,” but it remains “an invaluable method for learning about modern bureaucratic life” (2014, 233).

### **Artefacts, Objects and Texts**

Ethnographers have attempted to incorporate the analysis of graphic artefacts (Hull 2012), material objects (Miller 2005), and texts (Smith and Turner 2014) into their practice and final accounts. As noted in the introduction to this dissertation, this approach is a hallmark of Institutional Ethnography, which explicitly recognizes the mediating power of these data sets on organizational forms. A more robust emphasis on the inclusion of objects into ethnographic writing is, in large part, due to the emergence and popular uptake of Actor Network Theory (ANT) as developed by figures such as Michael Callon, John Law, Steve Woolgar, and Bruno Latour, among others. Although my research did not rely on strict adherence to the strategies outlined by ANT, the theory did contribute to my descriptive and analytic approach in two specific ways, which I will describe here.

The first involved ANT's investment in correcting the asymmetry between a hermetically sealed "social" world and the other types of actors (objects associated with grant applications for example). In Latour's words, these non-human actors "were explicitly excluded from collective existence by more than one hundred years of social explanation" (Latour 2005, 69). The idea here is not to equate human with non-human entities, but rather to extend the types of things included in my analysis of the bureaucratic assemblages I observed at Care Center. I wanted to offer a sense of how human action within the bureaucratic sphere of Care Center interacts with non-human actors (objects, texts, artefacts, etc.) to produce specific organizational arrangements. A lot of bureaucratic activity at Care Center could be explained by human action, but much of that action also depended on leveraging non-human objects into a broader network of associations. For Latour, this would be a critical step on tracing out connectors within a so-called "sociology of associations." My objective was simpler in that I only wanted to take seriously the idea that bureaucratic life has in large part been defined by its relationship to physical objects, documents, and applications. Consider the emphasis Weber places on "the files" as an integral feature of bureaucracy (Weber 1946, 197) or the emphasis institutional ethnography places on taking textual coordination for granted (Devault 2006, 294).<sup>9</sup> It therefore seemed important that I dedicate attention to describing the interactions FQHC bureaucracy had with objects, and how that relationship contributed to the broader patterns of organization and interaction that I observed. Harper (2000), Riles (2000), Hetherington (2011), and Hull (2012) have deployed this approach to the ethnographic study of bureaucratic processes and

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<sup>9</sup> "Texts such as medical charts, enrollment reports, strategic plans, and so on are mechanisms for coordinating activity across many different sites. Social science is sometimes a part of this coordinative apparatus, and perhaps as a result, we have tended to take this kind of textual coordination for granted, too often looking 'through' texts without noticing their power or using them, too unreflectively, as straightforward reports about social life" (Devault 2006, 294-5).

organizations thereby demonstrating forcefully the integral role that these objects have in shaping social relationships and processes. More recently van Eijk (2019) has advocated for extending the use of paperwork in ethnographic studies of healthcare institutions. Accordingly, I spend significant time trying to include, as accurately as possible, descriptions of the specific forms, spreadsheets, documents, archived institutional materials including grant applications, letters, texts, emails, and other allied objects (and actors) associated with bureaucratic assemblages at Care Center. I also include some of this material simply to help convey the various means and media through which I captured data for the project.

The second way that ANT contributed to my research approach is related to the first. Making objects a participant in my ethnographic analysis dramatically slowed down the pace of study and description. This slow-down is perhaps inevitable when using ANT, because as a theory, ANT insists on tracing the most minute connections between actors and objects since these are critical to any understanding of what is meant by “the social.” “To the convenient shorthand of the social, one has to substitute the painful and costly longhand of its associations,” says Latour (2005, 11). This “slowciology” offered the advantage of broadening my attentiveness to the wide array of actors and associations that contribute to FQHC bureaucratic systems. In turn, this added to the descriptive force of my account, but at times it caused my writing to feel ant-like, bludgeoning, and/or excessively granular. My hope is that this approach broadens the potential relationships and connections to which FQHC bureaucracy is connected, and not treat that bureaucracy as if it were an isolated and inherently stabilized whole.

### **Formal Interviews**

I use the term “formal interviews” as opposed to “structured interviews” because the diversity of work responsibilities of my informants made standardizing and sequencing questions

in the form of a rigid interview schedule ill-suited for addressing my research concerns. At the same time, I did distinguish between “formal” and “informal” interviewing in that I recorded my formal interviews and generated verbatim transcriptions from these recordings. My “informal” interviews consisted of follow-up conversations I had with formal interviewees, interactions I had in the Care Center workplace, and the slew of exchanged text messages, phone calls, emails, “coffee breaks” and after-work drinks I had with study participants during my research.

Parenthetically, some of the individuals I recruited for formal interviews offered their consent to record the interviews on the condition that we leave Care Center’s offices for more informal settings (bars, cafés, back porches, etc.). I recruited participants for my formal interviews using a purposeful sample (Patton 2002) of informants (selected on the basis of their institutional location within administrative departments). I had initially planned to conduct approximately thirty in-depth interviews with bureaucrats working within the FQHC field site; these were supposed to take 30-45 minutes each, but I rarely had the discipline to hold myself to that time limit.<sup>10</sup> I would like to suggest that I consciously selected additional interview participants on the basis of “theoretical sampling” (Glaser and Strauss 1967), in which I targeted individuals who could offer added insight into the emerging themes of the research. However, reflecting on the process, I think I developed a belief that simply adding more testimony to the record would help buttress whatever analytic arguments I ultimately produced. The added interviews actually produced diminishing returns because they began to retread previously identified themes, and if I could do the work again, I would attempt to be more aggressive in limiting the number and length of my formal interviews. I also conducted formal interviews with participants through the use of reputational case selection (Schensul et al. 1999, 240). These interviews sought out

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<sup>10</sup> See **Appendix A: Care Center Interviews** for a list of the twenty-seven formal interviews I conducted.

individuals possessing what I might term “expert knowledge” on a particular feature of the FQHC program or its history. For all of my formal interviews I included, more or less, an introductory briefing, “setting the interview stage” as Kvale and Brinkmann (2009) put it. I described the general purpose of the research, the use of a recording device, and asked whether or not the participant had any initial questions.

I have summarized my “formal interviews” as **Appendix A: Care Center Interviews**, including, when applicable, an indication of the type of work role that interviewees performed at Care Center. As previously mentioned, I have included some of the reputationally-driven and/or historically-oriented interviews as “Personal Communications” listed in **References Cited**.

## **Analysis**

“Conceptualizing our data becomes the first step in analysis”

Strauss and Corbin 1990: 63

Although not exhaustive, I did want to provide a general description of how the accumulated data from the formal interviews was processed. Coding the transcripts of the formal interviews that I conducted was the preliminary step in developing the more analytic narrative content of my project. I mostly relied on “descriptive codes” that summarized “in a word or short phrase – most often as a noun – the basic topic of a passage of qualitative data” (Saldaña 2013: 88). There were a few examples of “In Vivo Codes,” or codes formed from “the terms used by [participants] themselves” (Strauss 1987, 33), and these typically resulted in examples in my own work, such as “grassroots.” The transcripts were coded by simply adding comments to the text in Microsoft Word. As the coding became more detailed, I would occasionally review earlier transcripts and reread them to make sure any new/emergent codes were reflected if applicable. Figure ii.0 depicts a sample of some of these codes.



Right, and so the 12 staff that we had, that we did have on as we were going through this, we got money, a donation from the rotary that was in some local organization, just some local fundraising that particular group in quotes we could say "Soul Sisters" that was their name [laughs] you couldn't get no more grassroots than we were, okay.

Grassroots | January 18, 2018  
 Reply Resolve

- Cultural divide
- Work Environment
- Didn't drink the Kool-Aid
- Company unity
- Team
- Mission
  - Grassroots
  - History
  - Activism
  - Facetime
- Community Health Mentality / Community
- Social medicine
- Personal attachment to work
- Purpose
- Idealism
- Need
- Family atmosphere

**Figure ii.0. Coding Example**

Sorting these codes and placing together the portions of the transcript/narrative they summarized produced a series of thematic lists. For example:

**GRASSROOTS**

- GS- "In those same 15 years, I always made it a point, and I think quite a few other people and admin made it a point to participate in every event that – all the cultural committee, the Italian one, the Irish one, the XXXX Black History Month. Just do all those things that were celebrations of who we are. That I loved, and I just don't have time, I just can't. I feel bad; used to be a way of connecting..."
- GS- "...it was so different. To come in the back door of the health center, walk through Dental, past Internal Medicine, upstairs to the office. The chair to door with Women's Health; they could come through, periodically. Totally different."
- JS- "...we tend to talk about themes and ideas that traverse the network and not focus so much on the founding story or the founding site...What would be the point of reminiscing?"
- RT- "...we were so eager to give services that when someone came in, they could come in just saying they had a slight sniffle or they had a (splinter) in their finger. We gave them a complete physical because we were so glad to have someone come. We wanted to show them all of what we could offer and we did that."
- RT- "In this particular office, it's where our first office was when we opened on this first floor...Being able to stay close to that - it really not only has a foundation, but it makes me centered and grounded, if you will, that it is here, and making it even more to be even prouder, if you will, of where it's gone out from here."

I would tack back to the full transcript and re-listen to the recording of the interview to make sure I had not missed something from the tone or context from which I had pulled this type of quotation.

Once I had a good set of broader themes, I sifted through my more formally “written up” fieldnotes to look for specific instances where they might have been expressed. I would compare the themes against what I had participated in and observed. Many of these were themes I had been sensitized to during my “pre-fieldwork.” These resulted from my initial review of literature in preparing my dissertation proposal and from my initial period of employment at Care Center prior to the commencement of IRB-approved fieldwork. Others emerged during my formal interviews, and I followed these up with targeted observation and informal interviews. The three ethnographic chapters of this dissertation are based on themes I identified in this way. Here is an example of how the code “grassroots” finally entered my narrative:

Ms. Thompson’s reflections on the foundation of the health center exemplify the primary features of a grassroots style or mentality commonly referenced by Care Center staff. And although her account frames this in historical context, these same qualities were described, exhibited, and observed throughout my time in the field. Here I loosely define “grassroots” as a philosophy that emphasizes front-line, hands-on efforts that directly and personally inform the actions taken by health center staff and to connect those actions to specific community-level circumstances and input.

Howard Becker asserts, “the analytic trick consists of seeing in the physical object before you all the traces of how it got that way, of who did what so that this thing should now exist as it does” (1998, 50). If I made use of such a “trick,” to use Howard Becker’s term, it was to always ask how these themes might correlate to the way Care Center physically delivered health care services. Themes that were more pertinent to this question were the ones I decided to pursue more vigorously.

I do not want to suggest that my approach was more scientific than it was, and I often departed from more formalized approaches to ethnographic data analysis. I think I was as

methodical and systematic as I could be in the moment, but I also read practical and theoretical materials while I processed the data. For example, I periodically collected articles, primarily journalistic, that addressed aspects of “bureaucracy” throughout the course of my research. Occasionally these prompted me to consider, or direct some of my questions/observations toward specific aspects of bureaucratic life. In one instance a *Washington Post* article titled “Trump’s immigration order means bureaucrats have to decide who’s a ‘real’ Christian” (Hurd 2017), prompted me to reflect on aspects of skill honing (in the case of the article – theological) that bureaucrats would undergo when faced with executive orders. At another point during my research I found myself re-reading classic works in structural anthropology – Barthes (1972), Lévi-Strauss (1969), and Douglas (1986, 1966) specifically. I applied structuralism as a method to construct a model of Care Center’s organizational features. Comparing this against Weber’s ideal type produced some of the analysis I cover in **Chapter 2: FQHC Organizational Structure and Bureaucracy at Care Center**. Context and general curiosity drove my investigative sense as much as anything, and I cannot claim to have kept a perfect record of where, when, and how each specific idea might have entered the analysis.

### **Some Ethical Considerations, and a Discussion about Pseudonyms and Anonymity:**

When I initially proposed my research, I projected that I would confront two types of ethical considerations: procedural and organic. By “procedural” I was referring to the process of acquiring Internal Review Board (IRB) approval, adherence to research protocol, adherence to the American Anthropological Association (AAA) “Code of Ethics” (2012), etc. I submitted my project for IRB approval and eventually received it. This process has, rightly in my opinion, received criticism on the grounds that the ethical problems that qualitative researchers face in field settings are often so complex that IRB processes (consent, for example) do “little to assure

our subjects or ourselves for that matter, that we will do the right thing when the situation presents itself” (Bosk and De Vries 2004, 260). I mention the IRB here because the type of procedures it required offered highly mechanical “protections” to my research subjects based on very broad understandings of “harm.” I have adhered to the IRB protocol, and anthropological convention, by assigning pseudonyms to individuals and places discussed in this ethnography. But as I began writing up my report, I realized that my thorniest ethical concerns were not fully addressed by the mechanical structure of this type of review board, or by the formalized ethical statement of the AAA. These “procedural ethics” (Guillemin and Gillam 2004) were ill-suited to prepare me for, or to address, my most difficult concerns, which grew organically and took on contours all their own.

Perhaps the most basic ethical struggle I encountered, and one with which I still am not completely comfortable, arises from the fact that mechanical “protections” for “human subjects” do not translate well into the bureaucratic arena that I was studying, particularly protections that rely on anonymity as a gold standard after which to strive. The reason for this, I believe, has to do with the historical imbalance of power between researcher and research subjects that IRBs initially sought to redress. Projects that “study up” (Nader 1972), that study “larger impersonal systems of political economy” (Marcus and Fischer 1986), or that “study through” (Shore and Wright 2011) present IRBs with human subjects who, in many instances, are more powerful than the researcher designing protocol for their protection, rather than less powerful. This became particularly evident when I would share sections of my report with co-workers. A fairly common response was: “Say - Mary’s not going to read this is she?” expressing concern for my welfare (or perhaps their own) given our shared status as corporate employees. Furthermore, my role as an employed worker and participant has produced a potentially traceable link to my field

location, and by extension to individuals at that location. As indicated in my research protocol, I ascribed pseudonyms and made efforts to mask the identity of research subjects (modifying certain details about organizational role/title, specifics on locations, etc.), but the shrewd guesses of my readers made it clear that total anonymity, at least for local readership, was impossible.

In retrospect this limited capacity to fully obscure participant identity should not have been entirely unforeseeable. Several authors have suggested that anonymity in ethnographic work is a virtual impossibility (Johnson 1982; Deyhle et al. 1992; Nespor 2000; Hopkins 1993, Van Den Hoonaard 2003; Tilley and Woodthorpe 2011). At an extreme level Walford (2018) argues that the growth of social media and other forms of digital communication makes it impossible to offer anonymity in ethnography and that gesturing at anonymity as an ethical principle must be jettisoned in favor of a more open model of research, a position with which I am increasingly sympathetic. Others have persuasively posited that the assignment of pseudonyms is primarily a self-serving rhetorical strategy performed to aid the perceived generalizability of ethnographic work as opposed to the more virtuous aim of protecting the identities of informants (Lutz 1995; Smith 1987). I personally might not have cared about the consequences that writing could have on my own career at Care Center, but co-workers who read some of my initial drafts expressed concern, albeit somewhat jokingly, about my being fired, ostracized, or, as one put it, “forced to continue working in a poisoned well” in which potentially unpleasant aspects of work life had been articulated in written form. As these issues became more apparent in the field setting, I felt obligated to add verbal qualification to the language I included in my recruitment materials and I began bluntly informing participants that, despite assigning pseudonyms and disguising aspects of our discussions, the nature of ethnographic description might make total anonymity difficult to achieve. The irony in promising

confidentiality and anonymity in ethnographic work is one pointed out by Bosk (2008), who writes: “We succeed where it matters least and fail where it matters most. For those far from the scene, our pseudonyms effectively disguise the location of our investigations and the identity of our subjects. But then for these readers little would matter if we named actual names, because our subjects rarely are known outside local circles. But none of this is true in the actual community where the research was done” (158). I did not reach an entirely satisfactory answer as to what more, if anything, I *ought* to do about this dilemma. This is unsurprising given the fact that relatively limited attention has been paid to the tensions between descriptive methodologies and requirements for anonymity when “studying up” and conducting research with prominent informants (Bickford and Nisker 2015). Much of what makes it a dilemma in the first place results from my decision to focus on Care Center’s bureaucrats, some of them extremely powerful, as participants in my research. This decision introduces ethical concerns about anonymity that ultimately divert attention away from more disquieting questions about whether my findings promote and perpetuate the model of bureaucratic practice I observed, and which research participants are best served (or potentially harmed) by the findings.

My concerns over who is best served by my written account, and my concerns about what model of bureaucratic organization my account may perpetuate remain problematic, at least from the perspective of confidentiality and anonymity, because developing “reciprocity” is frequently cited as a practical way to achieve "informed" consent and strategy for mitigating negative fallout from seemingly inevitable identity disclosures (Wax 1982). In ethnographic work with powerful people and bureaucratic institutions reciprocity is unrealistic because it is practically impossible for a researcher to produce a reciprocal arrangement with say, a CEO, in the same way one might in working with less prominent and/or less powerful individuals. The

struggle here is just as much about epistemology as it is about ethics - particularly when it comes to strategies for masking identity such as fictionally creating composite "roles" or scrambling the positions within the bureaucratic hierarchy. This is because what I write about in this dissertation (bureaucratic structure and organization) depends on specificity to achieve analytic power. Altering the title of a CEO or COO within the context of my study would alter my ability to draw certain conclusions about what they had said, and it would also limit the ability of external readers to do likewise. As Fassin (2006) notes, reducing ethnographic specificity in order to cater to seemingly ill-matched procedural ethics threatens the quality of the research, places useless restrictions on academic freedom, and "gives a false guarantee that ethics is respected through purely formal operations" (524). Moving beyond strictly procedural ethics has pushed me to struggle with more difficult and potentially painful questions, such as whether my account has touched on overly sensitive areas and/or potentially revealed unflattering characteristics of individuals and the institution at which they work. This has been difficult to navigate, although I have experimented with informant feedback to gauge the potential ramifications my written descriptions might have by reading sections of the work to individual informants, or sending them brief excerpts and requesting comment. But I would also push back a little bit on this issue of "insensitivity" and/or "lack of flattery" from an ethical perspective to say - as one of David Mosse's colleagues said to him when facing a similar dilemma - " 'the absence of flattery is not harm' " (2006). For some study participants any description that did not simply celebrate the achievements of FQHCs might be received negatively. Again, I do not believe that *not* writing such a description is inherently harmful or unethical. The most succinct, and perhaps most balanced, summary of my struggle with these issues came from an informant who texted me to say the following:

It's not about consent, for many ignorance is bliss. For some a wake-up call is helpful, for others they won't recognize it. If you believe more will be gained in future iterations of community health by writing the way you did then that's the ultimate justification. If it can be equally compelling without inflicting personal pain... One could argue that you are using the pretense of the thesis to convey certain truths you weren't comfortable sharing directly with interviewees.

As I have indicated, what I ultimately did do with respect to anonymity was to mask or disguise informant identity as best as I could, recognizing the potentially limited efficacy of these procedures, but also taking additional care when the content these informants gave me might generate micro-political conflict for them within the Care Center environment. I did this by following the convention of ascribing pseudonyms to all participants and geographic locations mentioned in the study, and by tweaking identifiable job titles and/or other particularly specific identifiers in interviews and/or other observations. I paid considerable attention to this when the individuals in question were, by virtue of their position within Care Center's hierarchy, more vulnerable to potential harm. My approach here draws on the insights of Edwards (2007), who notes that the purposeful inclusion of individuals at different levels of bureaucratic hierarchy is often an integral feature of a study's research questions, despite the fact that the inclusion of a diverse range of participants may inadvertently contribute to identity disclosure. This circumstance results from the fact that certain participants, particularly at higher levels of an institution's hierarchy, have more readily identifiable characteristics, more prominent online presence, etc. For these informants, complete anonymity was virtually impossible, and this remains problematic, particularly since the comprehensiveness of internet search options makes the identifiable connections of individual participants to the field setting difficult to mask or conceal. Additionally, at the executive level there were a limited number of individuals whom I might be able to interview, and no amount of masking or scrambling would put a determined inquisitor off the scent. That said, these individuals also held/hold established positions of power



within the organization and have substantial political and economic resources at their disposal to shield them from potential fall-out or harm.

### **Limitations and Positionality**

If not already apparent, my approach to studying FQHC bureaucracy bore with it several limitations. In addition to the list of limitations now common in methodological textbooks on anthropology (length of time devoted to data collection, narrative presentation format, lack of generalizability and limited sample size, difficulty of replication, etc.), my research presented unique challenges associated with its setting and my positionality as a researcher/employee. Working at Care Center and receiving a salary in return for the defined duties I performed undoubtedly affected my perception of what I observed and how I, in turn, was observed. I have worked at Care Center for more than half a decade, and I have been absorbed into the logics and procedures governing life there. Developing a “critical reflexivity” and “conveying the context and [my] place in it” remained a constant struggle while researching and writing (O’Reilly 2005, 223). My dual role caused traditionally conceived boundaries of the ethnographic field to “bleed into daily reality” (Rapp 1999, 16). This blurring effect produces problems of categorization with respect to “insider” or “outsider” status (Gellner and Hirsch 2001, 5). The CEO at Care Center, my supervisors and my colleagues were all aware that I was conducting research, and they understood that I was interviewing members of Care Center’s administrative staff as part of that research. I certainly never attempted to hide my research, and I frequently prefaced questions I had for co-workers by describing them as “work related” or “research related,” but I did not mark my role at the outset of every encounter or interaction I had while working at Care Center. In fact, several descriptions and conversations I recount happened in real time as a function of my employment without necessarily interrupting the interaction in the moment by

referencing my academic role. I have generally included data I acquired in this way because it is evocative, descriptive, and productively conveys the sense of bureaucratic work that would otherwise be unaccounted for in my narrative. I will say that toggling my roles at Care Center was disorienting. Just as study participants might not always have been able to parse out the distinction between my position as researcher vs. my position as employee, I also was not always completely aware of who I was at a given moment in time.

I hope to contextualize and situate my positionality as well as possible throughout my narrative with the understanding that I could never claim any sort of absolute “objectivity” in my research. But I would point out, echoing Robertson (2002), that to assume that I could simply flash a reductive, universally intelligible “positionality” at a moment’s notice would be simple-minded, to say the least. It is also not clear that sophisticated white-collar employees at a company boasting a multimillion-dollar global budget were necessarily disturbed, discomfited, or in any meaningful way affected by my meddling ethnographic “positionality” or presence as a researcher. That said, I frequently questioned myself while researching and writing as to whether I was offering a *fair* account of life at Care Center. By “fair” I do not mean unbiased, but rather fair in the sense that my presentation of observations, quotations, and ancillary data painted a representative picture of what was happening. In short “fairness” became a catch-all criterion for accuracy, credibility, authenticity, validity, etc. I frequently reached out to study participants to check my work against their experience. I typically did this in an informal way, for example by reading sections of what I had written to an interviewee who offered me a ride home one day or by bringing along a copy of a chapter while out for drinks after work. I would typically solicit open-ended feedback. But as Emerson and Pollner point out, requests of this type for member response are best “recognized as integral features of the very social worlds

about which they are voiced” (1988, 196). That is, member responses are not simply verifications in an objective sense, but active pieces of the interactions taking place within the field setting. As such, my use of member checks (informant feedback) certainly could not produce a definitive yes/no verification of fairness because the diversity of personalities I interacted with at Care Center offered equally diverse perspectives (sometimes competing) on the data I presented to them. These multiple viewpoints suggest that a single all-encompassing narrative of Care Center’s bureaucratic life would be impossible to construct. Taken together, however, these viewpoints suggest that a fair composite account was constructed.

### **Limits/Delimitations**

I set some fairly arbitrary limits on what I decided to include in my research, and there are several aspects of life at Care Center that I do not extensively address in my ethnographic narrative, primarily for pragmatic reasons (e.g. time). This is not because these topics were unsubstantial or unworthy of critical comment, but rather because they rested either outside the framework for my study, running parallel to it as a sort of “soundtrack” layered on top of my specific research aims, or required a level of analysis beyond what I could feasibly include in this dissertation. I will comment on a few of these topics here in order to avoid giving the impression that they were simply absent from the field setting, and to indicate that more work certainly could, and probably should, be done in these areas.

I did not focus on the Board of Directors and their role in governance matters at Care Center. Maintaining a “consumer board” is a requirement for FQHCs, but what this means in practice is highly variable.<sup>11</sup> Several studies have looked at the implications of this requirement

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<sup>11</sup> Federal requirements associated with being an FQHC require that the Board of Directors include at least 51% who are representative of the demographics of the patient populations served and limit the amount of income non-patient members can earn from healthcare-related industries.

and the various tensions it can introduce (Wright and Martin 2014; Wright and Ricketts 2013). At Care Center, the Board of Directors played a well-intentioned role in which they consistently affirmed decisions put in front of them by the CEO and allied executive staff, but they did not forcefully direct - or question- the course of Care Center activity. Alan Johnson, Care Center's former Chief Medical Officer with about thirty years of experience working with Care Center's Board, emphasized this when I interviewed him saying he could not remember the last time there was a serious debate at a Board meeting or a vote that was not unanimous. I observed this firsthand when a Board member raised an objection to language within a resolution presented to them that would have removed a service delivery site from Care Center's Federal Scope of Service. The resolution stated the removal would "in no way result in the diminution of the Health Center's total level or quality of health services currently provided." The Board member suggested that the change would, in fact, reduce the level of services provided for patients living in the immediate vicinity of the site. Care Center's Chief Operating Officer explained that the Federal Scope process required the language and that it needed to remain in the resolution, which it did. It was adopted unanimously. This phenomena of "rubber stamping" has been extensively reviewed from a legal perspective as it relates to the governance of not-for profit organizations (Dent 2014) and been explored qualitatively using participant observation (Parker 2007). I risk oversimplifying the role the Board played, but in any case, the bureaucratic activities I focused on were largely unrelated to formal Board proceedings.

Another topical area that I did not emphasize in my research has to do with the concept of socially constructed gender and its relationship to Care Center's organizational and bureaucratic structure. This is unfortunate because FQHCs tend to buck broader trends in employment that systematically produce asymmetries in terms of pay and executive status associated with gender.

Working with data from 2016, Mercer Consulting, a group conducting annual surveys of FQHC executive compensation, determined that women make up more than 50% of all FQHC CEOs. At Care Center, approximately 65% of executive staff identified as female. That said, among the largest FQHCs (those with higher executive compensation), females account for less than 30% of CEOs (Ura 2016). Against the backdrop of Care Center's growth this trend bears consideration, particularly as this relates to the concept of a "grassroots" organization. What I mean by this is that grassroots efforts to found FQHCs were primarily associated with bringing health services into areas passed over by mainstream healthcare systems. The contrast in the gender make-up of executive leadership between FQHCs and, say, a large hospital system therefore warrants critical analysis because the contrast might say something about gender-based hierarchies as they map onto contrasting types of healthcare institutions and the various barriers or opportunities to leadership presented by them. This would require additional data, which I have not collected. Likewise, it is worth understanding the interplay between gender, particularly of FQHC founders, and the militaristic characterization of their "fight" to initiate these programs. I would theorize that this interplay results from rhetorical emphasis on "war" as a symbol for the antipoverty efforts that initially funded the health center program (Zarefsky 1986). This connection has been maintained by several grassroots accounts of the War on Poverty, most notably Annelise Orleck's *Storming Caesar's Palace: How Black Mothers Fought Their Own War on Poverty* (2005), but accounts of more recent grassroots, anti-poverty activism have emphasized the emergence and galvanizing effect of an "oppositional consciousness" (Katz 2017). I try to be mindful of this as I describe and critique Care Center's "grassroots" character, out of a concern that such a critique might inadvertently promote organizational forms that systematically perpetuate gender inequality.

Another potential blind spot in my discussion of Care Center bureaucracy involves race and ethnicity. Care Center was founded by African-Americans, and African-American women and men have historically held significant administrative and executive roles there. The interplay between organizational history and race certainly existed at Care Center and accompanied my observations of bureaucracy there. I have attempted to offer a sense of this interplay in my historical discussion about how race and the development of healthcare infrastructure in the early part of the 20<sup>th</sup> century intersected and consequently preceded the fusion of civil rights effort with War on Poverty programs focused on the expansion of health services. The changing demographics of the health center's patient population (only 15% identified as Black/African American at the time of my research as opposed to 60% identifying as Hispanic/Latino) presents rich opportunities for additional inquiry.

At a departmental level, I did not focus heavily on the inner workings of Care Center's Quality Assurance and Quality Improvement apparatus nor on the functions of Care Center's billing and IT departments, although these are certainly part of Care Center's bureaucracy. Institutional perspectives, particularly as they relate to quality, have been addressed in the literature (Mol 2008; Mulligan 2010). I would also argue that "quality" within Care Center was primarily associated with baseline levels of compliance rather than with actively developing new mechanisms for evaluating outcomes, performance, etc. To some degree this limited focus was confirmed by Care Center's receipt of only the most basic level of supplemental quality payments provided to it by the Health Resources and Services Administration in 2017. That in and of itself might be worthy of attention, but it departs somewhat from my initial desire to focus on bureaucratic practice. This, along with more pragmatic concerns (i.e. the impossibility of

being everywhere at once, and the hope of ultimately concluding the study) provided a reason, if not an excuse, to leave these departments outside the framework of my research.

In some instances, I used limits as a conscious methodological strategy. For example, I consciously tried to avoid prying into various Care Center “secrets.” It was not then, nor is it now, my intent to produce a gossipy “tell all” revealing salacious details of personal rivalries, amorous relationships, monetary compensation, and the like. I did hear and find out about such things at Care Center, but as Liisa Malkki eloquently observes, “Too often, the anthropologist takes on the role of police detective, discovering what is ‘hidden’, assembling ‘evidence’ to make a strong ‘case’, relentlessly probing for ever more information.... It may be precisely by giving up the scientific detective’s urge to know ‘everything’ that we gain access to those very partial vistas that our informants may desire or think to share with us” (1995, 51). In any event it is unlikely that including every bit of hidden or secretive information would add much to the persuasiveness of my account. In fact, doing so would assume that something “interesting” was also somehow powerful and important, when more often than not “the power of bureaucracy shows just how often exactly the opposite is in fact the case” (Graeber 2015, 57). FQHC bureaucracy is not overly secretive, and it is not necessary to discover the darkest secrets of a community health center to demonstrate the effect that administrative structure has on the delivery of health care services. Setting in relief the most transparent, almost pedestrian, aspects of Care Center’s bureaucracy demonstrated its power more effectively than accumulating titillating and deeply buried secrets.

## **Chapter 1: History and the FQHC World in Context**

### **Introduction**

Daily practices and activities in an FQHC bureaucracy do not take shape according to a rigid, well-defined set of prescriptive policies or legislative actions. Many of the themes that emerged from the data I collected while conducting research and working within FQHC bureaucracy reflect the accumulation and incorporation of the long history of the health center program. But there are also aspects of FQHC bureaucracy that extend beyond the strictly linear development of community health centers as part of the War on Poverty. In the following chapter, I intend to put FQHC history back into dialogue with the broader history of health care service delivery in the United States in the 20<sup>th</sup> and 21<sup>st</sup> centuries.

In writing such a history, I will review some of the institutional antecedents of community health centers and outline several significant changes in healthcare legislation that ultimately created space in which FQHCs could flourish. This history looks at the broad sweep of federal policy and critical legislative moments that precede, and then run parallel to, the specific institutional history of my research site. My purpose in writing this history is threefold. First, FQHC history warrants attention in and of itself and has decidedly maintained an isolated, exceptional status as compared to other systems and methods of health care delivery in the United States. FQHC history offers a unique vantage point from which to observe the evolution of healthcare policy throughout the 20<sup>th</sup> century and to the present. And although FQHC history has been separated from these overarching trends, its development can be reintegrated into the context of federal healthcare legislation during that timeframe. Second, I would like to preserve some of the recollections and perceptions of individual content experts who lived through that history. This goal aims to capture the voice and tenor of some of the participants contributing to



the establishment and ongoing success of FQHCs. And third, an understanding of what FQHC bureaucracy does and why, especially as it relates to personality-driven systems of organization and the mechanization of necessity as a rationale for service delivery, must explore what came before. This history casts a long shadow, and it looms over the bureaucratic activities I observed and participated in at my field site. This effort hopes to focus an anthropological lens on the role that history plays in crafting contemporary health center bureaucratic practice. This attention to what the Comaroffs have termed “historical imagination” will enable the subsequent ethnographic analysis of FQHC bureaucracy to “penetrate beyond the surface planes of everyday life” (Comaroff and Comaroff 1992, xi)

## **History Part 1: Pre-History**

### **Antecedents: Dispensaries**

Federally Qualified Community Health Centers - aka *FQHCs*, *Community Health Centers (CHCs)*, *Neighborhood Health Centers*, or simply *Health Centers* - have definite antecedents in the 18<sup>th</sup>, 19<sup>th</sup>, and early 20<sup>th</sup> centuries. Although this dissertation specifically focuses on the creation and evolution of federally recognized health centers, earlier eras in which attempts were made at providing community-based outpatient services share similarities with the period in which federal community health centers emerged. I would argue that the dispensary is the most illustrative of these proto-health center models, particularly as dispensaries relate to primary care service delivery.

Dispensaries were first developed in England, where they provided a stand-alone, independent organization that offered the urban poor a “medical soup-kitchen” in which medicines and medical services were distributed to metropolitan “needy” (Davis and Warner 1918, 2). Dispensaries emerged in the United States toward the end of the 18<sup>th</sup> century in

metropolitan areas including Philadelphia, New York, and Boston (Ibid, 3). The general organization of the dispensary included a central building, and one full-time employee (either a physician or apothecary) who would attend to vaccinations, pulling teeth, minor surgical procedures, and filling prescriptions (Rosenberg 1974, 33). Most dispensaries were funded by private contributions, although some received municipal support, and many subsidized their expenses by renting some of their space to commercial tenants. Additionally, many dispensaries filled a “pedagogical void” by providing formal clinical training opportunities for attending physicians hoping to acquire necessary clinical experience (Ibid, 34).

Dispensaries as a model of service delivery declined precipitously at the turn of the 20<sup>th</sup> century. In response to dwindling economic prospects for private medical professionals, several of these professionals took the lead in coordinating the opposition of state medical societies and the American Medical Association to these charitable institutions (Markowitz and Rosner 1977). The lasting impacts of the panic of 1893 had limited discretionary income among urban poor and new immigrant populations and had driven them in large numbers to the dispensary system as opposed to private physician practice (Ibid, 89). An intensifying belief that the medical profession was suffering from “overcrowding” coupled with the uptick in dispensary use led many private practitioners to view “consumers” “using these alternative services ... as lost clients. The services themselves were viewed as a type of competition which was stealing away potential income” (Ibid, 91).

Medical societies began to campaign against these perceived threats by publicizing accounts of the way the dispensary model was being abused by wealthy citizens capable of affording private practice (Burrow 1977, 111). *The Forum*, run by noted musicologist and chess patron Isaac Rice, carried a sweeping critique of the dispensary system and its abuses in 1897.

Titled “A Propagator of Pauperism: The Dispensary,” the article claimed that “fully 50 per cent of the patients who apply for free medical aid are totally undeserving of such charity.... It would appear that charity is monopolized in the same way as any other marketable commodity that is ruled by money” (Shrady 1897, 420). The article continues to document eye-witness accounts of the patients at the so-called “diamond dispensary” on New York City’s west side:

The reception-room held about two hundred at a time. Nobody was turned away. Fully 50 per cent of the applicants were well dressed, and 10 percent of them were finely dressed. Three women wore fur coats that had not been handed down from somebody else. There was an attractive display of fine millinery; and the men, more than half of them, bore no evidences of poverty. But all obtained free treatment supposed to be given to paupers – ‘poor persons’ (Ibid).

Despite the relatively weak evidence supporting claims such as those made in *The Forum*, pressure to “reform” the dispensary system mounted and in New York ultimately resulted in the enactment of a new dispensary law on October 1, 1899 (“The New Dispensary Law” 1899, 431). The law required that every patient at a dispensary be obligated to sign a card stating their inability to pay for medical treatment. Following their initial visit, all applicants would undergo investigations to assess their ability to pay (Ibid). Legislation such as this clearly segmented the provision of primary care into two tiers: one for those “deserving poor” who qualified for dispensary services because of documented poverty, and another for those wealthy enough to afford payment to private physicians. The institution of a “sliding fee discount program” wherein charges for service are calculated according to demonstrable income would later constitute an obligatory component of FQHC program.

Some reformers such as the Columbia-trained Michael M. Davis still looked to the dispensary model throughout the 1920s as an effective means to provide primary care, and several of these second-generation dispensaries emerged in urban areas throughout the country. Davis, along with his colleague Andrew Warner, valorized the dispensary model in their 1918

publication (Davis and Warner 1918). Arguing that increasing specialization and fragmentation of the practice of medicine may limit efficient medical service delivery, Davis and Warner argue that the dispensary as an institution differs from the “slightly tempered individualism of private practice” and can organize “the professional equipment and special skill of physicians for the diagnosis, treatment, and prevention of disease among ambulatory patients” (27). Unlike the dispensaries of old, however, this new model would rely on salaried physicians and fees paid according to consideration of the patient’s income, family responsibilities, and the probable cost of the medical treatment required by the patient (67). This innovation, coupled with a philosophical emphasis on preventive medicine and a recognition that provision of medical care required cooperation from many community partners, represents a major break from previous models of service delivery (Pumphrey 1975, 463). Community participation in outreach and governance of these sites foreshadows the creation of “community boards” that constitute an integral part of FQHC organization. Despite the power of Davis’ model as a system of primary care, pay clinics (or modified dispensaries) did not expand. The rise of hospital-oriented educational programs, medical specialization, and the increasing claims of hospital authority to treat all patients eroded the viability of a dispensary model (Rosenberg 1974, 50).

Dispensaries prefigured many of the elements that would come to characterize the community health center model. The dispensary model represents a *community-based approach* to service delivery that emphasizes geographic and financial *accessibility* and a *social commitment* to providing medical care as an overall social good. Although the dispensaries were local, the bureaucratic organization of the actual dispensary sites sought to bring together community-wide welfare and social service agencies (Stoeckle and Candib 1969, 1389). Subsequent challenges to the dispensary model (e.g. New York’s dispensary law of 1899) placed

an emphasis on *demonstrating a lack financial means* as a precondition for receiving health care. All these features would eventually have a familiar ring once the institutional form of community health centers emerged. But the dispensary model does more than simply foreshadow subsequent institutional (read here “bureaucratic”) forms. As Charles Rosenberg puts it: “the social logic implicit in their rise and fall underlines permanent and significant relationships between general social needs and values and the narrower world of medical men and ideas” (1974, 32). But a final point should be made regarding the failure of these proto-health centers. Their decline seems not to have resulted from a lack of efficacy but rather from a lack of political support from the various local municipalities in which they operated (Stoeckle and Candib 1969, 1387). Lack of a clear political constituency capable of advocating for the dispensaries left them vulnerable to the interests of medical professionals and local politicians alike.

### **Hiatus I: “Necessary Preliminary”**

Following the decline of the dispensaries and pay-clinics it might appear that the community-based model of primary care lay dormant until enactment of the “Great Society” programs during the Lyndon Johnson administration. I have opted to characterize this period, and periods like it, as a hiatus to emphasize the fact that it was more akin to a pause in the overall emergence of community health centers rather than a total rupture. While no major pieces of federal legislation advanced models of care resembling community health centers during the intervening time, several preliminary experiments with medical care during this period created the stage on which Johnson’s domestic policies would perform.

David Blumenthal and James Morone have noted that historians “have largely granted FDR a bye on universal health coverage” (2009, 54). Because such an assessment measures Roosevelt’s influence on health policy strictly in terms of “success” in enacting universal health

coverage, it tends to miss the possibilities that he opened for federal involvement in health policy. In a similar assessment, Funigiello (2005) emphasizes FDR's failure to enact universal coverage beyond other health-related efforts. FDR's Committee on Economic Security (CES) was concerned with health care and devoted a technical subcommittee to health insurance, but the immediacy of economic security, unemployment benefits, etc. consistently had top priority. Political resistance to health insurance from traditional sources (the American Medical Association among others) ultimately stifled universal health insurance legislation. As such, FDR's health initiatives suffer in comparison to other pieces of New Deal legislation, social security most prominently.

Yet hidden within the New Deal's financial reforms, public works projects and relief efforts were two programs that pushed health system innovation forward. The Federal Emergency Relief Administration (FERA) of 1933 and the Farm Security Administration (FSA) of 1937 both experimented with mechanisms to redress the failures of American health care that the Great Depression had exposed. The FERA (subsequently WPA) authorized grants for federal relief funding to individual states and subsidized "physician care, emergency dental services, bedside nursing, prescription drugs, and emergency appliances" (Haeder and Weimer 2015, 754). Significantly, the program delivered these services to the general category of "able-bodied" unemployed through grant funding (as opposed to loans). Despite the extraordinary circumstances under which the program was enacted, FERA demonstrated a government willingness to assume responsibility for health needs and to appropriate and dedicate resources for addressing them (Fox Piven 2011, 64). Direct federal involvement in distributing categorical grants in collaboration (and sometimes tension) with individual states would prove to be a hallmark of subsequent community health center struggles.

Whereas FERA programs often focused on addressing specific medical needs, the FSA experimented with cooperative funding plans designed to pool and share the costs of medical care among participants (Grey 1999). The program depended on five basic features: free choice of physician, group prepayment, family contributions based on average incomes, voluntary participation, and collaborative agreements with state medical associations (U.S. Department of Agriculture 1941, 16). FSA cooperatives relied heavily on grassroots support and eventually expanded to cover more than 650,000 poor farmers as well as a million migrant workers through Agricultural Workers Health Associations (AWHAs) (Grey 1994, 1678). Although FSA cooperatives ultimately declined following World War II, this intervention by the federal government focused on reducing barriers to medical care for the underserved by using local organization instead of centralized financing would ultimately be replicated by the community health center movement. This model points to a distinction between perceived federal support and perceived local control, and it would prove highly effective in balancing political perspectives on the role of government in the provision of health care. Indeed, Leslie Falk, an FSA veteran, would go on to oversee an OEO (Office of Economic Opportunity) grant for a community health center in Nashville TN; and Lisbeth (Lee) Bamberger Schorr, first health division director of the OEO, worked closely with several administrators of the FSA programs, including Fred Mott, the former Chief Medical Officer (Grey 1999, 225). Another offshoot of the FSA programs that would intersect with, and ultimately join, community health centers involved the population-specific concern for migrant workers. Specific legislation authorizing grants for family clinics for domestic agricultural migratory workers would predate the War on

Poverty, being signed into law by John F. Kennedy on September 15, 1962 (Public Health Service Act 1962).<sup>12</sup>

In his final State of the Union address in 1945, Roosevelt referenced health and medical care as a fundamental component of his “economic bill of rights,” for which he had campaigned in 1945:

I said then, and I say now, that these economic truths represent a second bill of rights under which a new basis of security and prosperity can be established for all- regardless of station, race, or creed. Of these rights the most fundamental, and one on which the fulfillment of the others in large degree depends, is the "right to a useful and remunerative job in the industries or shops or farms or mines of the Nation." In turn, others of the economic rights of American citizenship, such as the right to a decent home, to a good education, to good medical care, to social security, to reasonable farm income, will, if fulfilled, make major contributions to achieving adequate levels of employment (Roosevelt 1945).

And later:

An expanded social security program, and adequate health and education programs, must play essential roles in a program designed to support individual productivity and mass purchasing power. I shall communicate further with the Congress on these subjects at a later date.

Although he did not specify the details, this address made one thing crystal clear: as a public policy and legislative matter, health care and economic opportunity were joined at the hip. Roosevelt’s death in April of 1945 left any major development of such legislation unfinished. Harry Truman soon picked up the cause.

Truman’s special message to congress on November 19, 1945, recommending a comprehensive health program, summarizes the broader issues he hoped to address. These included: 1. Construction of health facilities, 2. Expansion of public health and maternal and infant health services, 3. Assistance for medical education and research, 4. Expansion of prepaid health insurance, and 5. Expansion of sickness and disability insurance (Truman 1945). The

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<sup>12</sup> Migrant Health Centers would operate quasi-independently from Neighborhood Health Centers/Community Health Centers until the passage of the Health Centers Consolidation Act (P.L. 104-299) in 1996.



struggle to enact a national prepaid health insurance program (so-called “socialized medicine”) against the lobbying efforts of the AMA has received significant attention on the part of historians and public policy analysts (Greenberg 1993; Schremmer and Knapp 2010; Morone 2011; Warner 2013). But as with Roosevelt, the emphasis of these accounts on a system of national health insurance obscures other developments in the broader environment of healthcare policy and service delivery – developments that would have a lasting impact on health center development. In the following section I will dedicate substantial attention to the emergence of one specific piece of Truman’s approach, the Hill-Burton Hospital Survey and Construction Act, because it ultimately produced structural outcomes that offered community health centers ample space to grow when they emerged some twenty years later. One structural outcome has to do with the creation of a healthcare infrastructure disproportionately focused on hospital-based care (as opposed to primary/outpatient care). Another has to do with the preservation of Jim Crow language in the law that introduced a racial aspect to this infrastructural imbalance. In addition, the law introduced several bureaucratic features to health facility planning that are echoed in the work I would ultimately observe at my field site.

On January 10, 1945, a full eight months prior to Truman’s address, two senators, Harold Burton from Ohio and Lister Hill from Alabama, had introduced S.191: A bill to authorize grants to the states for surveying their hospitals and public health centers and for planning and construction of additional facilities, and to authorize grants to assist in such construction (the “Hill-Burton Act” or “Hospital Survey and Construction Act”).<sup>13</sup> The bill offered a preemptive response to the first component of Truman’s health plan while remaining silent on the other four,

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<sup>13</sup> William McClure, the Chief Clerk for the Senate Committee on Labor, Education, and Public Welfare, commented later that “Senator [Harold] Burton, Republican of Ohio, had nothing to do with that bill. In fact, when it was on its way through Congress he went to the Supreme Court. But Hill wanted a Republican name on there, and this was a good one; he was a decent fellow and willing to go along” (McClure 1983, 79).

thereby avoiding the messy politics associated with them. When signed into law, the Hill-Burton Act would appropriate \$3,000,000 in grants to states for hospital construction planning and \$75,000,000 for construction of public and other non-profit hospitals. The act also created a bureaucratic process for assessing and funding new facility construction and included language to provide for adequate hospital facilities for persons “unable to pay therefore” (Hospital Survey and Construction Act of 1946).<sup>14</sup> Its passage on August 13, 1946, marked the most substantial insertion of federal funding into the field of health policy and planning to date.

Committee hearings on Hill-Burton characterized it as an incremental approach to broader healthcare problems. In his explanatory opening statement to the committee discussions of the bill, Senator Hill expressed his “firm conviction that adequate hospital and public health facilities, properly distributed, were the first step in finding a solution to our national-health problem” (Committee on Education and Labor 1945, 7). American Hospital Association president Donald Smelzer expressed the belief that “the steps provided in this legislation are a necessary preliminary in the better distribution of hospital and medical care” (Ibid, 10). Similarly, a statement from B.C. MacLean of the New York State Commission on Medical Care references the bill’s incremental nature: “I trust that the bill, if enacted, will be considered as a first step toward, and not a complete solution of, the general problem of providing adequate medical care” (Ibid, 228). Dorothy Boulding Ferebee from the National Nonpartisan Council on

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<sup>14</sup> The act’s language preserved the doctrine of “separate but equal” indicating that hospitals funded by the program “will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.” Only two of the hospitals constructed in Alabama using Hill-Burton money would allow black patients entry (Smith 1999). The language of Hill-Burton would quite literally color the development of healthcare infrastructure and inextricably link OEO health center programs and civil rights. Despite his commitment to healthcare legislation, Lister Hill retreated from supporting, or even discussing economic opportunity programs, in response to the fierce segregationist views of his constituency. The case of Lister Hill is in many ways indicative of the gridlock Congress faced in the years immediately prior to Lyndon Johnson’s election in 1964.

Public Affairs of Alpha Kappa Alpha Sorority's also addresses the stepwise character of the legislation: "Gentlemen, we urge that this first step be taken for the preservation, the conservation, and for the fulfillment of the basic need, that of the health of our greatest resource - our human resources" (Ibid, 320). So, while the bill was intended to address healthcare infrastructure problems through dedicated hospital planning and construction, it made no attempt to address questions about broader service provision (health workforce, health insurance coverage, etc.). Senator Robert Taft from Ohio openly questioned this separation in committee hearings saying: "There is one other question I would like to raise. In other words, the doubt I have in mind is whether we should just consider the construction of hospitals alone without considering the general health plan" (Ibid, 26). Taft would ultimately play a major role in drafting the final version of the legislation, so that the autonomy of hospitals over federal authority was secured and that allocation formulas were distributed based on state population and per capita income (Feshback 1979, 320).

Because the Hill-Burton Act limited aid to states with a ratio below 4.5 hospital beds per 1,000 people this number became a target (as opposed to a "not-to-exceed" figure) for hospital expansion (Starr 1982, 35). This limit was never reached in the history of the program, although a massive hospital-centric building boom ensued (MacNay and Merry 1994, 7). The program likely accounted for a 17% growth in total hospital beds from 1948-1975 (Chung et al. 2016). Only 11% of Hill-Burton grants went to outpatient facilities before 1980 (Feshback 1979, 314). The Hill-Burton Act made a general effort to rationalize the distribution of constructed facilities by mandating that individual states survey the necessity of health facility services and develop a comprehensive plan for hospital construction (see flowchart in Chung et al. 2016). Lister Hill would later reflect on the planning component of the act saying: "the word 'survey' was in there.

It wasn't to be a haphazard, grab bag proposition" (Hill 1967). But despite the initial requirements for planning, the act did not require *subsequent* coordination of funded hospitals and "retarded integration in the [health services] industry" (Starr 1982, 351).

Some commentators have celebrated the Hill-Burton Act for its lasting contribution to healthcare infrastructure and the bi-partisanship that ensured its passage into law (Schumann 2016; Mantone 2005; Raske 2008). But Hill-Burton also left a legacy of bureaucratic structure with respect to facility planning that would permanently impact the development of community health centers. First, the act included explicit service provision requirements to all patients regardless of ability to pay. Although this provision was largely ignored until indigent persons who had been denied services filed suit against a Hill-Burton funded facility, the act substituted discussions of health insurance for a poorly defined "uncompensated care obligation" (Maryland Law Review 1979, 317). Community health centers are required to maintain similar obligations to this day.

Second, Hill-Burton reinforced the position of dominant hospital facilities over all other healthcare facilities. More specifically the formula for allocating funds within states was based on a relatively nebulous concept of "need" (Feshback 1979, 327). This was largely intentional and in response to the wishes of hospital representatives. Consider the statement John G. Martin, former president of the American Protestant Hospital Association, made during Hill-Burton committee hearings:

Both the surveys of need and the programing of new construction would be the responsibility of the State.... Any definition of need would have to be sufficiently elastic to be adapted to a large number of varied situations. In connection with hospital facilities, past occupancy, and the ability of existing institutions in the area to meet all needs for service, together with the condition of their physical plant would constitute a more significant index of need than any standard of so many beds per thousand population. Some concrete criteria, however, would be established for use as general guides (Committee on Education and Labor 1945, 50).

This “elasticity” of need for hospital beds ultimately resulted in a circumstance where utilization or demand (as opposed to need) dictated future financing (Feshback 1979, 327). And although hospital infrastructure expanded, this ultimately had little impact on costs since hospitals merely dedicated their effort to filling as many beds as they could in a process known as “Roemer’s Law” (Roemer and Shain 1959). Opportunity emerged, and fulfillment of need followed. Structurally, then, no real mechanism existed to cap the expansionist tendencies of Hill-Burton recipients. The National Health Planning and Resources Development Act (1974) would attempt to address these structural features of the law with an eye toward curbing expenses and duplicative facility creation. This ultimately led to the creation of Certificate of Need (CON) laws within individual states receiving federal funds for health facility projects.

Third, the Hill-Burton Act highlighted the substantial impact that passionate individual politicians have on development of healthcare legislation. This type of life-long commitment (and tenure) is echoed within the leadership structures of several FQHCs in which individual leadership and the individual leader becomes intertwined with the institution itself. With the introduction of the Hill-Burton Act, Lister Hill would embark upon a two-decade commitment to the health field in the Senate. Hill often referenced the lasting influence of his father (a doctor and surgeon who performed the first successful heart suture surgery by the light of kerosene lamps) on his life and career (Hill 1967, *passim*).<sup>15</sup> This deeply personal connection to health care would lead Hill to sponsor more than sixty pieces of healthcare legislation (Lipscomb 2002, 109). He would also head the Health Subcommittee of the Committee on Labor and Public Welfare and the Senate Appropriations Committee from 1955 until his retirement in 1969 (Ibid).

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<sup>15</sup> Consider for example: “Of course the man who influenced my life more than anybody else was my father, and he was a doctor and a surgeon... Then the example he set for me – see, a man of real dedication! He not only went to his hospital every morning, again every afternoon, but he went to his hospital every night between ten or eleven o’clock just as regularly, by golly, as he went there in the morning, or afternoon” (Hill 1967, 2).

This afforded Hill incredible power to enact and appropriate funds to support legislation that piqued his interests. His close relationship with Mary Lasker and Florence Mahoney would result in a massive influx of financial support for NIH research, which grew from \$4 million in 1947 to \$46.3 million in 1950 (Starr 1982, 342-3). And although he opted for political expedience in matters of healthcare legislation too closely aligned with civil rights, Hill's passion for the subject was undiminished. Personal passion, care, and intercession on behalf of health centers would deeply shape their development and evolution throughout their history.

### **Hiatus I: Coda**

In terms of content, the “Legislative Reorganization Act” (1946) could not seem more thematically removed from Hill-Burton despite being signed into law a mere eleven days prior. Upon signing the law, Harry Truman emphasized the updates to the “procedural traditions that have burdened the Legislative Branch” and offered special praise for a provision in the bill raising the salary of members of Congress from \$10,000 to \$12,500 plus an expense allowance of \$2,500 (Legislative Reorganization Act of 1946, presidential signing statement by Harry S. Truman). Truman made no explicit mention of Title IV of the bill: the Federal Tort Claims Act, which waives, with certain limitation, governmental immunity to suit in tort and permits suits on tort claims to be brought against the United States. The act would prove equally as impactful in the fate of community health centers as Hill-Burton.

### **Hiatus II: Internship in South Africa**

As World War II wound down, and Roosevelt and then Truman struggled through the thickets of healthcare policy, developments in health services a continent away were emerging that would leave an indelible mark on health care delivery in the United States. Dr. H. Jack Geiger is renowned within FQHC circles for his application of a South African model of primary

care delivery (Community Oriented Primary Care) in the United States, so it is worth taking time to review what exactly it was Geiger did during his sojourn there. The failure of Community Oriented Primary Care to spread as a national model in South Africa demonstrates how political circumstance, as much or more than effective programs, ultimately constricts the diffusion of health care delivery models.

In South Africa in 1942, a National Health Services Commission had been appointed to advise on the provision of an organized national health service. Chaired by Dr. Henry Gluckman MP, the commission made several recommendations regarding the reorganization and implementation of a new, rationalized, integrated system (Marks 1997, 452). The commission's report, released in 1944, de-emphasized large hospital-oriented approaches, characterizing hospitals as objects of only secondary importance to comprehensive health service provision (Ibid).<sup>16</sup> Instead of basing the system on hospitals the report recommended that "a network of local health centers linked with a nationalized hospital system" form the foundation of a national health service (Susser 1993, 1040). The model for this network would be a health center located in Pholela, a Zulu reserve in southwest Natal province set in the foothills of the sweeping Drakensberg escarpment (Kark and Kark 1999, 22). The health center in question resulted from the pioneering efforts of Sidney Kark and Emily Jaspan (later Emily Kark).

Four years prior to the formation of the National Health Services Commission (1938), Dr. Harry Gear, the then Deputy Chief Health Officer of South Africa, recruited Sidney Kark from the University of Witwatersrand Medical School to conduct a survey of nutrition among Bantu children in 1938 (Susser 1993, 1039). The final report on the study noted widespread

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<sup>16</sup> In the words of George Gale Secretary and Chief Medical Officer of the South African Department of Health from 1946-1952: "The outstanding merit of the Gluckman Report was that it made a clean break with the view, which had become almost a dogma, that medical practice must revolve around hospitals – the institutions which sought only to restore health which had been lost" (Gluckman 1970, 501).

malnutrition and infectious disease and lamented the fact that these conditions were preventable. The report concluded: “Science has given the necessary knowledge to eradicate, or at the very least to considerably reduce the occurrence of these diseases. The ravages following upon rapid soil erosion, overcrowding, ignorance, and poverty are all within the bounds of control, but it is beyond the terms of reference to consider the social application of this abundance of knowledge” (Kark and le Riche 1944 in Kark and Kark 1999, 13). In 1940 this attentiveness to the potential for social intervention as a basis for disease prevention would stick with Kark, as Harry Gear assigned him and his now wife Emily to a new task: heading, initiating and planning a new health center at Pholela.

At Pholela the Karks sought to move beyond a restrictive medical model and incorporate health promotion, prevention, and educational notions of health care. Such a model would “be responsible for the total health of both the individual and the community” (Marks 1997, 453). The Karks envisioned a model of community medicine that would bridge the gap between community medicine and primary care (Kark 1981, vii). This model demonstrated a concern not only for demography and epidemiology (although the Karks were certainly skilled practitioners of these disciplines) but also attentiveness to ethnographic, sociological, and psychological components of health. To prosecute the model effectively the Karks would recruit health workers from the community in which the health center was located, availing themselves of the lessons and insights these “bearers of parochial knowledge” added to clinical care (Susser 1993, 1040). As Sidney Kark would later summarize: “there is a strong case for enlarging the traditional horizons of the primary care practitioner from the strictly clinical to the epidemiologic and community aspects of care. It is this to which I refer as community-oriented primary health care” (Kark 1981, vii).



Members of the National Health Services Commission would visit the Karks' health center at Pholela as they formulated their recommendations, and the final report not only recommended the Pholela Health Center as a model but also enthusiastically endorsed Community-Oriented Primary Care (COPC) as the philosophical basis for healthcare reform (Susser 1993, 1040). By 1948, 44 health centers of the 400 initially proposed by the commission had been founded, but a changing political climate and the rise of the Afrikaner National Party would curtail further implementation of the health centers. The Karks would continue to support the work at South African health centers until leaving for a professorship in epidemiology at the University of North Carolina Chapel Hill in 1958 (Kark and Kark 1999, 199). Before their departure, however, the Karks would receive a visitor whose experiences with them at two of the South African health centers would serve as the inspiration for the creation of community health centers in the United States.

By the time he reached his final year of medical school in 1957, Jack Geiger (**Figure 1.0**) had already lived an eventful life. As a 14-year-old runaway, Geiger had lived with Canada Lee in Harlem, meeting the likes of Paul Robeson, Langston Hughes, Richard Wright, and Adam Clayton Powell (Geiger 2013b). At 16, he enrolled in the Journalism School at the University of Wisconsin and worked with Jim Farmer to form a local chapter of the Congress of Racial Equality (Ibid). During World War II, he enlisted in the Merchant Marines because "it was the only branch of anything military, quasi-military, or whatever that wasn't racially segregated" (Ibid, 12). For his participation in a student-faculty strike protesting racist admission policies at the University of Chicago, Geiger drew the ire of the vice-president of the American Medical Association, who sent a letter to the deans of every medical school in the country condemning Geiger's actions (Ibid, 20). Nevertheless, Geiger was admitted to an experimental integrated



**Figure 1.0: Jack Geiger at his home in Brooklyn, NY. August 8, 2017. Photo by David J.B. Erickson**

program at Case Western Reserve in 1953 (Ibid, 23). While serving on the American Association for the Advancement of Science (AAAS) Geiger so impressed Warren Weaver (a former president of AAAS and vice-president at the Rockefeller Foundation) that he offered Geiger a job as science editor for the Rockefeller Foundation (Ibid, 26). Instead, Geiger explained he wanted to explore social medicine, unaware that social epidemiologist John Grant of the Rockefeller Foundation had been backing “community clinics” in China as well as the work of Emily and Sidney Kark (Birn 2014, 136).<sup>17</sup> According to Geiger:

I knew instantly that if social medicine was real, because after Virchow and John Simon in London and some of the other great figures of the nineteenth century, the American literature, such as it was, that touched on this was all touchy-feely, talking about the whole man and the whole person and this and that. And social medicine, it seemed, wasn't anything specific that you did; it was just an attitude you had. And here {South Africa} was this place that seemed to me to be really doing it” (27).

Weaver forwarded Geiger some information about the Karks, saying “I supposed you better know about this,” and Geiger immediately set about getting approval from Case Western Reserve to combine the final four and half months of his senior year of medical school with work with the Karks in South Africa (29).

Upon his arrival in South Africa, Geiger first spent time in Durban at the University of Natal Medical School and began his internship at one of the Karks' health centers at Lamontville, a Durban suburb and Zulu housing project (Pers. Com. 2/9/18). Of the Karks, Geiger would remember how receptive they were to him and his interest but also how personally involved they were in the projects and the lives of people working on them. In describing Emily Kark, Geiger noted:

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<sup>17</sup> According to Geiger John Grant “could lay claim in a way to being the great-grandfather of community health centers, because he had tried to fund one at the University of Peking, as it was then called, a rural health center that had failed because nobody in Peking wanted to go out into the boondocks. But he tried” (Geiger 2013b, 27).

She was a pillar of maternal warmth; she really was underneath, which was a steely determination to get the whole project done.... both parts of that were true, the maternal warmth. She took care of all kinds of folks including me, that was what – really - she was like, a personal concern. And underneath that, as I wrote their son after Emily had died, she just drove everybody's work and made sure that the whole thing was going to happen. In other words, she could be very tough and determined in all of those professional relationships and tasks. And he wrote me back and said, "You have described her exactly" (Ibid).

During weekly two-hour tutorials with Sidney Kark, Geiger began to explore the ideas of cultural differences in medical practice (Ibid). Kark and a collaborator (Guy Stuart) had just that spring produced an article exploring the differences in how specific medical services might be applied in a manner “highly sensitive to such factors as the community’s interpretation of the nature of health and disease, and what it expects of a service” (Kark and Stuart 1957, 132). An example of this sensitive service delivery involved Geiger’s experience with the patient file system at Lamontville:

Mrs. N, the Zulu family that I was working up, a mother and four kids, I think. And -uh something that had never happened at Western Reserve or any other place I knew in the States, um you couldn't pull out an individual file on any member of the family. The only way - they were all hooked together, every family member's medical record and file and you had to look at all of them at once. It really was family health care. And I was working them all up and reading them all, and Mrs. N. got typhoid fever and had to be hospitalized. And I was doing all of that in what would have been in the US a fairly standard way.

We gave it to Sidney and he said, "Well, this is just fine but it's incomplete," and I said, "What do you mean?" He said, "You haven't dealt with the mother's absence." All those other individuals in the file, the kids, who's going to feed them? Who's going to cook for them? Who's going to clean the house? What is that going to do for their school? Attendance in school with that kind of workload; how is the whole family going to survive in the absence of the mother? She was divorced or separated, I don't remember which. I had to go back and figure that out. And find the family members in question who are two girls, about 12 and 14. There was another boy - two other boys, I think. And I had to go back and figure out how to find a neighbor that would teach them to cook more than they might have already known. Make sure that family sustenance was provided for. That was their idea of a complete workload (Pers. Com. 2/9/18).

The recognition that the services medical personnel have to offer may not in fact be responsive to the wants or perceived needs of the people receiving them would foreshadow some of the challenges Geiger would face at the Delta Health Center in Mound Bayou, Mississippi.

After Lamontville, Geiger would travel to Pholela and marvel at what was then a Zulu tribal reserve including thatched huts, cattle kraals, very rural and “some of the poorest, most miserable-quality land in South Africa” (Geiger 2013b, 29). The startling range of conditions were eye opening – malnutrition, syphilis, tuberculosis, diarrheal disease – often the result of the political economy driving migratory labor. Guided by community health workers recruited by the Karks, Geiger would observe community gardens, pit latrine, infant and school-age feeding programs and rationing of skim milk to patients (Geiger 2013a, 110). The distribution of milk in particular raised the ire of the South African government, which labeled the Karks communists (Ibid, 115).

Conceptually, the health center model in South Africa would give Geiger very clear practical knowledge of how a community health center could function. He would bring that knowledge with him upon the completion of his internship and incorporate this learning into his senior thesis (“Family Health in Three Cultures: Implications for Medical Education”), which would serve as the blueprint for later community health center proposals (Geiger 2005, 313).

The Karks’ model for community health centers clearly had a substantial impact on Jack Geiger’s personal familiarity with the model of care, and most accounts of the “origin” of U.S. community health centers point to Pholela as the source from which all American health center sites descend (Lefkowitz 2007; Ward 2017). But the history of the Karks’ health center program in South Africa also points to something frequently missed in the romantic story of Jack Geiger “bringing learnings home” and implementing them as OEO-sponsored health centers. By the time Geiger visited, the Karks’ experiment had almost fully run its course. Within a year the Karks would leave South Africa, Hendrik Verwoerd would be elected prime minister, and apartheid policies would completely erode whatever advances had been made by the Community

Oriented Primary Care model (Phillips 2014). The political moment that gave rise to the National Health Services Commission in 1942 would wither away as quickly as it had emerged. Despite the advocacy and support of people such as John Gale (Secretary of Health and Chief Medical Officer of South Africa and subsequently dean of Durban Medical School) and Harry Gear (Deputy Chief Health Officer), the South African health centers ultimately failed to live up to their national aspirations. Gale grimly noted that if the program simply focused on the poor, its ability to promote broader systematic change would be limited. As Yach and Tollman suggest: “change in the healthcare system cannot develop out of a program solely limited to the poor” (1993, 1047). Perhaps more to the point: political circumstances contribute as much to the development of innovative models of care as do individual experiences and efforts.

## **Hiatus II: Coda**

Despite the romance of Geiger’s internship in Pholela and Lamontville, an equally important - yet undeniably less exciting strand of health center pre-history was emerging in New York City. The story of the Gouverneur Health Services Program on Manhattan’s Lower East Side received immediate attention following its implementation in 1961 (Brown and Alexander 1964; Light and Brown 1967; Madison 1969; Kovner et al. 1969). Only recently, however, has it received critical assessment within the context of the War on Poverty (Chowkwanyun 2018). In brief, the decline of the Gouverneur Hospitals in the 1940s and 1950s led to the loss of both its hospital and teaching accreditations. Dr. Ray Trussell, the commissioner of hospitals in New York, ordered an intensive study of the hospital by a panel of consultants (including Frank Van Dyke, Professor of Administrative Medicine at Columbia University) who recommended that Trussell close the facility and transfer patient care to neighboring hospitals (Trussell 1962, 229). In response, the Lower East Side Neighborhoods Association, consisting of approximately eighty

social, religious, and civic groups, held multiple rallies and generated petitions in order to prevent the closure of the facility in its entirety, maintaining that “the neighborhood had special needs and must have its own hospital to meet these needs” (Brown and Alexander 1964). The city still moved to close inpatient services, but on December 1, 1961, the city entered a contract with Beth Israel Hospital to staff and operate the Gouverneur Ambulatory Care Unit, an outpatient unit (Ibid). The bureaucratic administration of the newly opened unit would reflect the programs dedication to local needs and grassroots involvement. Howard Brown, the director of the Gouverneur program, “stressed the importance of efficient operations through staff participation in finding solutions to administrative problems” (Shenkin 1975, 16). The first item in the health center’s statement of purpose also recalls the population health concepts of the Kark model: “To provide comprehensive medical care of high quality in a way that will best meet the total needs of the Lower East Side” (Brown and Alexander 1964, 1663). By September 1964, the health center was seeing 550 to 600 patients per day (Ibid, 1665).

Gouverneur reflects four pieces of the context in which community health centers emerged. First, the explosive advances in medical research and a focus on hospital construction since the enactment of Hill-Burton meant that physical capacity outstripped workforce availability and overmatched the demand for inpatient services. Second, the result of the hospital-centric expansion meant that the construction and development of outpatient facilities was retarded, thereby exacerbating the imbalance between inpatient and outpatient care. In the words of Rosemary Stevens: “Comprehensive, primary health centers were a casualty of the Hill-Burton interests” (1989, 226). Third, developments in medicine and medical research had dramatically shifted the type of illness an individual was likely to face. Whereas infectious disease had previously been the scourge of urban life, chronic conditions now began to emerge

as the most prominent threats to well-being. Health professionals such as George Silver (1963) were experimenting with changing service models to provide “supervision in a continuous fashion, not episodically or only when grave illness occurred” in response to shifting needs. And fourth, New York, as much if not more than any similar urban setting, typified these shifting trends as well as an emerging district-level demand from locally organized groups for institutional responsiveness. It is not surprising then that the relatively straightforward concept of a community health center would be put forward as a solution to these challenges in many different settings. The question was not whether a model for services existed (it clearly did) but rather what the significant effects of implementing such a model would have on social and medical systems, provided that such a model would receive financial and political backing.

### **Pre-History: Conclusion**

Although the origin of U.S. community health centers is traditionally associated with the passage of the Economic Opportunity Act in 1964 and the subsequent development of the Office of Economic Opportunity, several factors converged to produce the broader constellation of political and social circumstance into which they emerged. Prototypes such as the dispensary program and New Deal health programming were available as a point of reference for politicians and government officials, while large-scale healthcare legislation such as Hill-Burton created a mechanism for hospital-oriented (and later other healthcare facility) infrastructure driven by a specific formula based on a malleable concept of “need.” By bowing to the pressures of the Jim Crow South, Hill-Burton made healthcare infrastructure legislation a prime target for civil rights advocates, and instilled new legislation with the double purpose of healthcare rights and civil rights. The well-timed internship of Jack Geiger in South Africa opened American eyes to the awesome potential of community-oriented primary care, even as the political window for its full-



scale implementation in that country drew to a close. These antecedents, preliminary steps, and unique personal experiences were all part of a tinder-box waiting for its spark. Lyndon Johnson's War on Poverty would provide it.

### **Health Center Formation and Struggles**

There is a tide in the affairs of men,  
Which, taken at the flood, leads on to fortune;  
Omitted, all the voyage of their life  
Is bound in shallows and in miseries.  
On such a full sea we now afloat,  
And we must take the current when it serves,  
Or lose our ventures.

- Julius Caesar: Act 4, Scene 3.

What we'd struggled for through November of 1963 was an organizing theme. To the extent we got one, I would say it was the Community Action Program, which we viewed as a device to focus many different federal and local programs to match the needs in particular localities.

- William Capron, Senior Staff Member, Council of Economic Advisors

### **The War on Poverty > Economic Opportunity Act > Community Action Program**

Most conventional histories of Community Health Centers trace their origins to the War on Poverty (Lefkowitz 2007; Sardell 1989; Ward 2017). They do so with good reason: Jack Geiger and Count Gibson founded the first *federally* sponsored health center. This health center was funded through Title II of The Economic Opportunity Act (1964) and administered by the OEO (Office of Economic Opportunity), the bureau created by Lyndon Johnson to design, implement, and manage a wide array of antipoverty programs through the executive branch. Most if not all CHCs retell and celebrate the story of this founding and are oriented to it by the continued presence of Jack Geiger at health center events such as conferences of the NACHC (National Association of Community Health Centers). In Geiger, CHCs found an exemplary journalistic voice that could tie together the War on Poverty, the Civil Rights Movement, and the foundation of the first health center in a tidy, well-defined narrative. But not unlike the messy picture of human evolution told by fossil remains, the family tree of health centers, and indeed

the entire War on Poverty, more closely resembles “a wayward bush with stubby branches” (Borenstein 2007). Much of the character CHCs would eventually develop reflect the “messiness” of this history. The fortunes of CHCs cannot be disentangled from the evolving nature of legislation supporting the War on Poverty generally and the Office of Economic Opportunity specifically. Nowhere is this more evident than in the fact that the origins of the Economic Opportunity Act, Johnson’s first legislative achievement in the War on Poverty, were mingled with the efforts of his predecessor. The intellectual currents informing the Kennedy administration’s interagency task force, Lyndon Johnson’s adoption and personal connection to the development of the poverty program, and the administrative structure of the agency governing the implementation of the program as part of the War on Poverty constitute the three durable watermarks underlying contemporary community health center organization and structures. Throughout this section I hope to emphasize a broad distinction between Kennedy as a tactical thinker on the matter of poverty and programs that might address it, and Johnson as a personally committed, strategic actor on poverty issues.

John F. Kennedy had begun to “discover” poverty through visits to Appalachia during the 1960 presidential primary. Impressed and moved by Michael Harrington’s 1962 publication *The Other America*<sup>18</sup>, Kennedy favorably responded to the request of Walter Heller, his chief economist, to begin researching the nature, dimension, and extent of poverty in the United States. As chairman of the CEA (Council of Economic Advisors), Heller would convene a series of informal learning sessions and Saturday “brown bag” lunches to further explore and discuss poverty during the summer of 1963. CEA staff member Robert Lampman would later describe these sessions in the following way: “It was almost an academic sort of seminar. Indeed, it was

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<sup>18</sup> Kennedy aides indicate that it is more likely that JFK read a *New Yorker* review of Harrington’s book by Dwight Macdonald, not the book itself (Lemann 1992, 130-1).

interesting how many people there were Ph.Ds. or were backed up by a scholar who was associated with the work” (Gillette 1996, 6).<sup>19</sup> One gets the impression that these sessions had an almost salon-like feel to them in which the various philosophical intricacies of poverty were scoured over and debated in what Daniel Patrick Moynihan would term “the professionalization of reform” (1969).<sup>20</sup> Given the composition of the interagency task force Heller put together later that summer (cabinet insiders including secretaries from HEW [Health Education and Welfare], Agriculture, Labor, Agriculture, the Bureau of the Budget, etc.) Moynihan’s assessment appears to hit the mark. Staff member William Capron would later describe the interagency task force in disparaging terms:

The primary purpose of this kind of informal task force was to get the departments and agencies to come up with suggestions for items that might be included in a program should Kennedy decide to go ahead and make this part of his 1964 program. The results were perhaps predictably disastrous. That is, Heller got a lot of junk. These were warmed-over revisions of proposals that had been around for a long time, coming up out of the bureaucracy, programs that had been already rejected by the Congress. Very little imagination. (Gillette 1996, 12).

The readily available bureaucratic and intellectual environment did not yet support a coherent or innovative approach to the issue of poverty. Perhaps more alarmingly, the interagency task force’s call for ideas had only brought forth crusty leftovers from New Deal civil service lifers, which only served to advocate for the advancement of their individual bureaucratic empires. Capron and Lampman would later express a fundamental skepticism about the effectiveness of a program held captive to the internal interests and motivations of entrenched government bureaucracies (Poverty and Urban Policy 1973).

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<sup>19</sup> Gillette’s “Launching the War on Poverty: An Oral History” is an invaluable resource on Johnson’s anti-poverty programs. It compiles 48 oral histories of the War on Poverty archived at the LBJ library and organizes them in thematic and chronological order.

<sup>20</sup> Moynihan’s view is often contrasted with that of Piven and Cloward (1977) in a debate as to whether the War on Poverty was primarily driven by “top down” reform (Moynihan) or “bottom up” reform (Piven and Cloward 1977).

The stiffness of the initial academic studies and the subsequent agency-oriented task force required an imaginative approach to startle it into action, and fortuitously the President's brother had a rough and tumble chum from his days at Milton Academy experimenting with just such a thing. Born in Dedham MA in 1926, David "Dave" Hackett had befriended Robert F. Kennedy in 1942 and the two would remain lifelong friends. Hackett would eventually work for RFK's campaign in 1968, serving as director of correspondence and manager of the campaign's delegate-tracking operation known as "the boiler room" (Hevesi 2011). Although Hackett is occasionally caricatured as an oafish intellectual lightweight compared to other Robert Kennedy insiders, his bullish approach to dealing with social ills (specifically juvenile delinquency) would offer the interagency task force a pathway out of the well-worn bureaucratic paths it had been treading.<sup>21</sup> Based on the results of Hackett's initial fact finding, and at Robert Kennedy's urging, John F. Kennedy created and then appointed Hackett director of the PCJD (President's Commission on Juvenile Delinquency) formally under HEW (Department of Health Education and Welfare) in May 1961 (Unger 1996, 60).<sup>22</sup> Hackett had one overwhelming talent in terms of leading this effort: he effectively and accurately channeled the sentiments and wishes of Robert Kennedy. In the words of RFK's press secretary Wesley Barthelmes:

There was a great correspondence of attitude between Dave Hackett and Robert Kennedy. Someone I know once said--and it was not meant uncomplimentarily at all - "When the Attorney General itched, why, Dave Hackett scratched." What they were simply saying was, when you went into a staff meeting, Hackett had the uncommon quality of being able to speak for the Attorney General in a way that was so precise that there was almost no disjointment, no inconsistency at all (1969, 148).

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<sup>21</sup> "He batted around ideas as he had once shot hockey pucks, never holding onto them for detached or deep speculation, but outpacing many other Kennedy aids in shrewdness, dexterity, and guts" (Blumenthal 1969, 134). In an amusing exchange on March 13, 1963, President Kennedy interrogates Hackett on the U.S. hockey team's 17-2 loss to Sweden with the president saying: "Christ, who are we sending over there, girls?... So it obviously, uh, we shouldn't send a team unless we can send a good one. Would you find out about it and let me know." (Kennedy 1963).

<sup>22</sup> Another program that evolved in parallel to the PCJD efforts include the Ford Foundation Gray Areas projects initiated by Paul Ylvisaker. For a more extensive discussion of these efforts see Halpern (1995).

Soon after the formation of the PCJD, New York School of Social Work (Columbia) sociologist Lloyd Ohlin and Brandeis-trained Ph.D. Sanford Kravitz signed on to the commission with Hackett (Moynihan 1969, 65). Lloyd Ohlin, then an assistant to HEW secretary Abraham Ribicoff, was particularly active on the commission, building on his research with Richard Cloward, in which the two argued that limited alternative opportunities and not individual irresponsibility produced delinquency among youth. Using this underlying philosophy, Ohlin aided in redrafting of an Eisenhower era bill on delinquency which John F. Kennedy signed into law on September 22, 1961 (Juvenile Delinquency Act of 1961). The law authorized the Secretary of HEW to make approximately \$10 million/year in grants to state/local/other agencies to establish pilot projects addressing juvenile delinquency. Such grants would have two components: a study phase and a demonstration phase, and would focus on relieving the structural impediments to opportunity through building and supporting community organizations with their input, consultation, and leadership – “community action” (Unger 1996, 61). Importantly, these programs were modest in size and scope, not massive large-scale efforts. Dave Hackett summarized the “lessons learned” from the work with juvenile delinquency programs in a memo to Robert Kennedy:

In our work on the Juvenile Delinquency program, we have learned that programs for the prevention and control of delinquency must deal not only with the delinquent, but also with disadvantaged youths who may become delinquent unless there is substantial intervention on their behalf. Such an approach is broad, encompassing many young people, and concentrating on their environment – the family, the school, the local labor market, etc. This comprehensive approach precludes the use of traditional concepts and plans which call for dealing merely with the delinquent in uncoordinated programs (Hackett 1963).

The memo goes on to encourage recognition of the intimate relationship between poverty and crime, the value of local planning in addressing these problems, and the need for stronger coordination of federal bureaucratic programming. It recommends development of a series of

task forces to study and then conduct demonstration projects on poverty in key areas throughout the United States (Ibid). There is a philosophical congeniality between this summary and the tenets of COPC (Community Oriented Primary Care) as articulated by the Karks in South Africa and absorbed by Jack Geiger during his time there. For Hackett and company, juvenile delinquency, like health, could not be addressed at an individual level. “The word ‘comprehensive’ was one we used a good deal those days; a ‘comprehensive’ approach to it” (Hackett 1970, 70). But whereas the Karks had begun their journey to create a cohesive, nationwide system, the PCJD sought to reform one through an attack on the structural barriers and institutional roadblocks that were the fundamental causes of poverty and delinquency.

Dave Hackett, perhaps because of his closeness to the executive authority of John and Robert Kennedy, saw siloed bureaucratic interests as a contributing factor to the ineffectiveness of government programming. The target of the PCJD would therefore be the very “conventions of institutional practice itself” (Kravitz 1969, 33). Despite its generally anti-bureaucratic stance, funding “community action” projects still would require the support of established government agencies. After cultivating a like-minded group of “guerillas,” Hackett waged a subtle insurgency against bureaucracy to secure ongoing financial resources for his projects from various agencies without oppressive administrative oversight (Matusow 1984, 114). Of Hackett’s approach Moynihan would write:

The concept of the ‘guerillas’ – living off the administrative countryside, invisible to the bureaucratic enemy but known to one another, hitting and running and making off with the riches of the established departments – was attractive, but also romantic. Simply as a matter of firepower, God was on the side of the big battalions (1969, 75).

In 1969 Moynihan may have lacked a certain distance from the ongoing guerilla warfare in Vietnam to fully appreciate the intensity of the anti-bureaucratic guerilla warfare metaphor. And although Hackett’s guerillas “could not deliver the goods” neither did they fail in opening up

new conceptual pathways for an ongoing effort to combat poverty. Moreover, the cognitive connection between “guerrillas” and “grassroots” would follow several of these warriors – Sanford Kravitz in particular – as they eventually “infiltrated the tactically significant middle level of the American bureaucracy where programs are actually carried out” (Wood 1993, 73). The persistence of a “grassroots” style of organizing this type of programming would become a fundamental characteristic of FQHC bureaucracy in the field site where I conducted my ethnographic research.

While Hackett’s guerillas were in the weeds testing out community action in the form of small-scale projects, Walter Heller was struggling. After a bomb of an initial meeting with White House aide and speechwriter Ted Sorensen on the preliminary proposals his task force had come up with, Heller was running out of time to get something together for Kennedy’s 1964 platform. Serendipity would send him a lifeline. In late October 1963 Bill Cannon from the Legislative Reference Office referred a member of Heller’s task force, William Capron, to Dave Hackett’s band. In addition to Hackett the group included his aid Dick Boone and Paul Ylvisaker from the Ford Foundation. After an extended meeting about some of their projects for the PCJD and the Ford Foundation Gray Streets program, Heller “got sold on the idea of community action as being the organizing principle” (Gillette 1996, 17). Finally, the economist had a fresh, innovative idea that could match the optimism of Kennedy’s “New Frontier” rhetoric. A mere three days before his fateful trip to Dallas, President Kennedy sounded pleased with Heller’s progress: “Yes, Walter, I am definitely going to have something in the line of an attack on poverty in my program. I don’t know what yet, but yes, keep your boys at work and come back to me in a couple of weeks” (Ibid, 15). But some have viewed Kennedy’s embrace of a poverty initiative as less than passionate, suggesting that his briefing on the upcoming 1964

election with census director Richard Scammon convinced him that a new poverty program “wouldn’t do him very much good at the ballot box” and that he ought to focus instead on doing something for the middle class (Lemann 1988). Heller himself would also recall hearing from Ted Sorensen “some rather disquieting comment about, well, you know, ‘We may have to put more emphasis on the suburbs’, or something like that” (Heller 1970, 20). Regardless, it seemed clear that Kennedy had thought about poverty programming extensively during the autumn of 1963, although the outcome of his musings would be left unfinished. JFK’s notes from his final cabinet meeting on which he had scrawled and circled the word “poverty” six times underneath a sketch of a placidly moored sailboat are a haunting reminder of his unfinished thinking on the subject. Jacqueline Kennedy would have them framed as a gift for Robert F. Kennedy, who hung them on his office wall at the Department of Justice and then the Senate (Schaap 1967, 194).

On November 23, 1963, Johnson’s first full day in the White House following Kennedy’s assassination, Walter Heller relayed the initial findings of those efforts to him, as well as the message that Kennedy himself had hoped to develop a CEA plan to address poverty (Johnson 1971, 69). Johnson would adopt the antipoverty cause as his own and later reflect:

Before me now was a call for action, a call for a revolutionary new program to attack one of the most stubbornly entrenched social ills in America. My perceptions of America persuaded me that three separate conditions were required before social change could take root and flourish in our national life – a recognition of need, a willingness to act, and someone to lead the effort... So the *need* for action was there. The need was more apparent every day (Ibid, 70).

Johnson’s pursuit of antipoverty legislation would not only capitalize on Kennedy’s legacy, but would also define the moral framework and administrative basis on which the cause would be pursued. Johnson’s January 8, 1964 State of the Union address and his subsequent Economic



Report fired the opening salvo in “the War on Poverty”<sup>23</sup> and would outline the scope of initiative. The President’s Economic Report, developed by the Council on Economic Advisors, presented research on poverty, characteristics and causes of poverty, and a strategy for attack (Johnson 1964a, chapter 2). Recalling the language of the New Deal, the report described the task at hand: “to focus and coordinate our older programs and some new ones into a comprehensive long-range attack on the poverty that remains. A new federally led effort is needed, with special emphasis on prevention and rehabilitation” (Ibid, 73). The report also cast the fight against discrimination as an integral part of the effort, one that would “open additional exits from poverty,” and stressed the need to expand opportunities for jobs, education, and improving health (Ibid, 74).

Significantly for the history of Community Health Centers, Johnson battled poverty in a decidedly different style than his predecessor might have done. An administrator who had served under Kennedy noted the difference between the Kennedy and Johnson approaches to the poverty program immediately, saying “The President [Johnson] has a great feeling for this program. It’s close to his roots. Where Kennedy may have had only an intellectual appreciation of the need to eradicate poverty, Johnson had a ‘gut’ reaction to the basic idea” (Schiff and Goodell, 19). As details in the legislation for funding the War on Poverty (Economic Opportunity Act) came into focus, Johnson emphasized the need for a first-hand connection to poverty as a prerequisite for the administrative positions within the program. Speaking to his aide Bill Moyers, Johnson described an ideal candidate in the following way: “Well, what I want is, I want somebody that—I don’t ... Bill Bennett’s<sup>24</sup> outfit don’t appeal to me much—but I want

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<sup>23</sup> For clarity, I adopt Bailey and Danziger’s definition of “the War on Poverty” as “the full legislative agenda laid out in the 1964 State of the Union and in the eleven goals contained in chapter 2 of the 1964 Economic Report of the President” (2013, 7).

<sup>24</sup> Television personality Bill Bennett, host of the “The Bill Bennett Farm Show.”

somebody that's really come up competitively and born on a farm and knows something about poverty himself. And, you know, that's got ... that's had a little hockey (horse manure) between his toes.” (Johnson 1964c). Famed Johnson biographer, Robert Caro, would similarly describe Johnson’s approach as something more than simple political calculation:

In some of the things that he did, there was...something more, something that had to do less with strategy than with memories. And I think that driving him was not only the political calculation to make himself more palatable to liberals, to put his own stamp on the presidency because he was going to be running for re-election; there was also the memories of his youth and what poverty meant to him, and how it hadn’t been his fault that he that he was in poverty (NPR Staff 2014).

Deeply personal, the War on Poverty carried with it an almost messianic vigor at the heart of which stood the belief that “a program that eliminated poverty – or even reduced it – would strengthen the moral and economic fiber of the entire county” (Johnson 1971, 72). He re-emphasized the justness of the cause in his State of the Union address, saying: “Let us carry forward the plans and programs of John Fitzgerald Kennedy--not because of our sorrow or sympathy, *but because they are right.*” (Johnson 1965, my emphasis).

Regardless of the personal and moral intonations informing his approach, Johnson was only able to wrangle about one billion dollars for the War on Poverty through negotiations with Senator Harry Byrd and the Senate Finance Committee.<sup>25</sup> This austere budget was matched by an equal scarcity of programmatic ideas for the effort. As William Capron called it “the glimmering possibility dimly seen” of a community action program was the single thread holding the initial planning discussions together (Gillette 1996, 22). These discussions would therefore focus on how to channel the President’s limited budget into the creation of a full-scale War on Poverty. Several agencies – Labor, Health, Education and Welfare (HEW), etc. – sought

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<sup>25</sup> To put this number in perspective, FDR’s New Deal programs totaled about fifty billion dollars thirty years before the War on Poverty began.

to latch onto Johnson's vision as a way to extend their jurisdictional authority: "The big debate... was whether or not you did some restructuring of programs and agencies, within particularly Labor and HEW, or whether you needed something bureaucratically separate from those," said Capron, expressing a concern he shared with some of the President's economic advisors. "Nothing was going to happen if you put particularly the small number of dollars we were talking about into existing agencies. [The money] would just get gobbled up in the usual bureaucratic crap. It would get tied into the categorical programs with these very strong bureaucratic links between the feds, the state, and the local governments. You wouldn't be able to see anything happen" (Gillette 1996, 23). Members of the Bureau of the Budget (BOD), Kermit Gordon, Charles Schultze as well as Walter Heller, met with Johnson on January 30, 1964. They described their vision for the poverty program as being run by a director appointed by the President who would be responsible for approving "comprehensive Community Action Programs" and allocating funds to various agencies to supplement existing programs. They went on to recommend Sargent Shriver for the directorship in a memorandum sent to Johnson's top aide Bill Moyers (Shriver "Personal Papers", Box 41). John Kenneth Galbraith, Keynesian economist and author of *The Affluent Society*, a "liberal bible" of the late 1950s, expressed a similar viewpoint the next day in a memo to the President:

I have been over the poverty program. It is good. It will take more money in later years; perhaps it could do with more now. But the agent should be "This is the beginning." And it is a good beginning for which you will be justly remembered.

I urge the following: Do not bury the program in the Departments. Put it in the Executive Offices where people will hear what you are doing, where it can have new staff and a fresh man as Director. The Director will, of course, work on Congress for a bigger effort next year. Have the money appropriated to the Director to insure cooperation from the Departments. Nothing wins assistance like cash. Support the Director with a Cabinet Committee (Galbraith "Personal Papers").

Johnson agreed and endorsed a model for the poverty program that created an independent cabinet-level agency independent from existing government departments. The principle was likely tied to the philosophy of New Deal policy that “a new bureaucracy has more energy, more willingness to innovate, than an old one” (Goodwin 1988, 286-7). To do this would require more than a simple infusion of cash, it would also involve a legislative and public relations effort that went beyond the strictly mechanical.

On February 1, 1964, Johnson named Sargent Shriver to direct the War on Poverty, a person in many ways uniquely qualified to oversee the effort. In directing the Peace Corps, Shriver had obtained, as Johnson put it, “a measure of congressional respect not always given to a bureaucrat” (Johnson 1971, 76). Shriver’s generalship in the War on Poverty would reflect an attunement to “spirit” and “idealism” rather than existing bureaucratic structures. This approach is written into the very DNA of War on Poverty programs. Johnson’s selection of Shriver reveals something else about how the programs would develop. Despite Shriver’s insistence that he did not know anything about poverty, Johnson told Shriver that it was not a question of the availability of “competent” candidates for the job: “it’s a question of just getting accustomed to what’s going on down here and how to operate in Washington. We don’t have a year, this thing has to work. And it has to (a) get through Congress, and then (b) it has to work right away” (Gillette 1996, 31). The selection of Shriver had less to do with expert knowledge or training than it did with Shriver’s personal characteristics and social ease with national-level politicians. This is not to say that the appointment was “political” in a traditional sense, but rather to emphasize that individual characteristics trumped technical talents when it came to fighting the War on Poverty. “Selling” the program, lobbying for the program, and a personal (and in

Shriver's case religious) commitment to it would be just as valuable, if not more valuable, than rigid methodical skills.

In the months following his appointment, Shriver developed various task forces to help translate the broad concept of the War on Poverty into actionable legislation. Members of the working group would include Daniel Patrick Moynihan, Wilbur Cohen, Edgar May, and Michael Harrington among others (Zeitz 2018, 80). Most of the participants in these sessions recall the informality and unstructured, almost chaotic format they took. Of the sessions Harold Horowitz, assigned from the Department of Health, Education and Welfare, would say: "There were some true wild brainstorming sessions, just what kinds of programs could be dreamed up" (Gillette 1996, 50). Shriver himself decided that "in the brief time we had, we would read everything that had been written about poverty; listen to anyone who had anything to say; accept advice from any source" (Stossel 2004, 360). At one point the task force was joined by James Patton from the National Farmers Union who exemplified the basic approach saying "I don't really care what you do, how you do it. The important thing is that you're doing something and you're different and you're new. I know this goddamned bureaucracy; I know this government. They get stale. So you have to have somebody new come in and just kick them in the ass and make them aware of a new problem and have them do something, compete with them, create a new entity" (Gillette 1996, 41). Experience with "newness" and "innovation" would guide the efforts of the task force.

Shriver had received an executive order that allowed him to recruit people for his various task forces from existing government agencies, and those agencies would be required to pay the existing salary and benefits. Attorney Noel Klores exemplified this recruitment pattern. After working for the atomic energy commission in New York he traveled to Washington with his recently married wife to work at NASA's division of manned spacecraft. Fred O'Reilly Hayes

contacted Klores and asked if he would like to come work on the poverty program. Thinking it sounded interesting, and not negatively impacting him financially, he took the job. Usually beginning their work in the late afternoon and continuing throughout the night, Shriver's group worked out of an old hotel, using bathtubs as filing cabinets<sup>26</sup>. Klores would go on to work as "director of special programs," particularly those for migrant farmworkers, Indian affairs, and activities in the various territories and Puerto Rico (Pers. Com. 4/6/18). Lisbeth Bamberger also noted that the bathtubs were really quite multi-functional, as the group had boards that they could lay across the bathtubs allowing them to double as desks. The task force leveraged whatever resources were available. "The story was told," she recalls, "that when a messenger came in very often he was asked if he could type and stay for a while" (Pers. Com. 4/13/18).

Despite the relatively free-form organization of the task force, they still had to produce the basic structure to the program that could translate into legislation. Sargent Shriver and Adam Yarmolinsky, on loan to the task force from the Department of Defense, assigned specific pieces of the bill that would eventually fund the War on Poverty to different members of the task force<sup>27</sup>. Other than "community action" and its associated emphasis on "maximum feasible participation," the task force generally followed the template of New Deal programs focused on work and training initiatives to fashion the various parts of War on Poverty legislation. Shriver would repurpose several existing bills (Youth Employment, from the Department of Labor) and proposals (Community Work and Training, from Health, Education and Welfare; rural grants and loans from the Department of Agriculture) as part of the poverty bill, including community

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<sup>26</sup> Most of the task force participants were housed in the "New Colonial Hotel," but since it was at that point about fifty years old many referred to it as "the old Colonial Hotel" at the corner of M Street and 15<sup>th</sup> (Gillette 1996, 141).

<sup>27</sup> Yarmolinsky would ultimately be excluded from joining Shriver in implementing the EOA as a concession to the North Carolina delegation in the House. Yarmolinsky had restricted military personnel from entering segregated facilities during his time at the Department of Defense, drawing the ire of southern conservatives (Clark 2002, 30).

action, thereby presenting the final product as a broad, bold, new, initiative. This met Johnson's requirement that the program "be large and impressive" yet "frugal" (Blumenthal 1969, 165). Given that "community action" was the offspring of the PCJD, Richard Boone, Sandy Kravitz, and Fred Hayes were enlisted from the PCJD staff to draft Title II ("Urban and Rural Community Action Programs") of what would become the Economic Opportunity Act.<sup>28</sup> The final version of the law, which kept virtually the entire original language of the task force draft intact, would define community action in the following way:

The term "community action program" means a program –

- (1) Which mobilizes and utilizes resources, public or private, of any urban or rural, or combined urban and rural, geographical area (referred to in this part as a "community"), including but not limited to a State, metropolitan area, county, city, town, multicounty unit, or multicounty unit in an attack on poverty;
- (2) which provides services, assistance, and other activities of sufficient scope and size to give promise of progress toward elimination of poverty or a cause or causes of poverty through developing employment opportunities, improving human performance, motivation, and productivity, or bettering the conditions under which people live, learn, and work;
- (3) which is developed, conducted, and administered with the maximum feasible participation of residents of the areas and members of the groups served; and
- (4) which is conducted, administered, or coordinated by a public or private nonprofit agency (other than a political party), or a combination thereof.

The proponents of community action and community participation generally agreed with the basic underlying principle and concept. Task force participant and Peace Corps administrator Christopher Weeks suggested that the "guerillas" viewed structural barriers created by existing institutions as particularly detrimental to impoverished groups: "[they] felt that one of the major problems with government programs oriented toward the poor, urban redevelopment, and so on, was that most of the planning had been done by agencies in Washington or by city bureaucrats sitting in city offices: that in a lot of cases things had been done that simply didn't make sense in light of what was actually going on in a particular neighborhood" (Gillette 1996, 67). The

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<sup>28</sup> The Economic Opportunity Act (1964) would consist of seven titles: I "Youth Programs"; II "Urban and Rural Community Action Programs"; III "Special Grants to Combat Poverty in Rural Areas"; IV "Employment Investment Incentives"; V "Work Experience Programs"; VI "Administration and Coordination"; VII "Treatment of Income for Certain Public Assistance Purposes."

solution was to decentralize the effort, and to cede influence on it to local groups – thus “community action” and “maximum feasible participation.” Among the guerillas, however, there were various shades of difference regarding the aspect of community action that appealed to them most strongly. There were differences, not on the basic theory perhaps, but certainly on the emphasis each individual placed on the direction the underlying concept might take (Blumenthal 1969, 140).

Critiquing community action some five years after the fact, Daniel Patrick Moynihan suggested that four separate and mutually incompatible definitions of the concept were to blame for the eventual conflicts that arose from the enactment of community action programs (1966, 5). Although I review these definitions here, the important point about community action is that it fundamentally *worked* from an FQHC-perspective. The *first* supposedly incompatible definition drew on a budget-oriented idea that stressed the efficiency of using local organizations to deliver government services, the *second* drew on a revolutionary idea that emphasized the acquisition of power on the part of the poor, the *third* invoked a Peace Corps/service provision concept, and the *fourth* simply looked at community action as an expedient means to achieve a politically effective outcome both in the passage of the legislation and the ongoing support for President and party (Ibid, 6-7). Moynihan would go on to suggest that the discrepancy between these definitions, and the potential for conflict resulting from that discrepancy indicates a lack of intellect and familiarity with the social science theory informing the “community action” idea (1969, 169). “This is the essential fact,” writes Moynihan: “The Government did not know what it was doing” (Ibid, 170). Of course, this assessment ignores actual congressional debate on the subject in which various congressmen described their understanding of community action



programs, and how they would work.<sup>29</sup> Nevertheless, Moynihan continues his argument suggesting that the diversity of interpretation created “a varying impact of the program on localities” that was “unsatisfactory to almost everyone involved” (1969, 7). Worse than that, according to Moynihan, is that by wasting effort on the confused and bungled implementation of community action the Johnson administration failed to institute permanent social changes, including fixed full employment and guaranteed income (1969, 193). This second point simply ignores the fact of the matter that Johnson did not have sufficient money allocated to the Poverty Program (nor indeed would he ever, following the escalating costs of the Vietnam War) to bring about such a result. Moynihan’s first argument, however, warrants closer attention. In essence, Moynihan argues that a failure to precisely define the concept of community action equals a failure to define the intent of the program in its entirety. This view, and others of its ilk (Glazer 1988, 5; Murray 1994, 63) interpret community action as poor planning, meaningless conflict, and obscene federal meddling in social processes. If only the purpose and theory governing community action programs had parsed out the distinction between anti-poverty goals and socio-political activist goals everything would have worked better – or so the argument goes. But given how closely intertwined poverty and political disenfranchisement have been historically, distinguishing between the two for the purposes of describing an approach to anti-poverty efforts in legislation seems like an academic exercise at best and a fool’s errand at worst. Moynihan’s

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<sup>29</sup> Attorney General Robert Kennedy explicitly described community action in testimony to the Congress: “The institutions which affect the poor – education, welfare, recreation, business, labor – are huge, complex structures, operating far outside their control. They plan programs for the poor, not with them. Part of the sense of hopelessness and futility comes from the feeling of powerlessness to affect the operation of these organizations. The community action programs must basically change these organizations by building into the program real representation for the poor. This bill calls for, “maximum feasible participation of residents.” This means the involvement of the poor in planning and implementing programs; giving them a real voice in their institutions (Economic Opportunity Act of 1964 U.S. House of Representatives, 306). Also: “I think the key to this program, and I think it has been the key to the success of this country, is people coming up themselves and deciding what needs to be done, and then the rest of us who are in a more advantageous position helping. I think that is a key element in this bill” (Ibid, 308).

suggestion that “the origins of the community action programs of the war on poverty will be found first of all in intellectual history” simply ignores the fact that Johnson’s visceral response to poverty and a burning desire to do something, anything, prompted the enactment of the War in the first place, not the various academic experiments with social science theory. Speaking to Congress on March 14, 1967, Johnson would frankly admit confusion and mistakes in implementing anti-poverty efforts, but he emphasized the point that Moynihan would later fail to grasp: “America could not wait for a decade of studies which might not even show precisely what should be attempted. A New Program had to begin in our cities and rural communities, in small towns and in migrant camps. America had to pull the drowning man out of the water and talk about it later” (Johnson 1965, 333).

Community action, then proved incredibly seductive not because of its clarity, but because of its power to do *something*. It is unlikely Johnson knew of, or would even care about the complexities of social science theory, but he certainly valued the management of bureaucratic processes and he recognized that he had to discipline them if he was to implement any of his domestic program. The strength of the community action concept was not so much in its practicality (*vis-à-vis* conflict and political outcry) at the local level, but rather “as a political and administrative strategy to tame the federal bureaucracy, and pacify Congress,” thereby churning out “successful” programming with urgency and speed (Flanagan 2001, 593). The primary drafter of the legislation, Norbert Schlei summarized this strategy:

I think the dominant element was the idea that if you left it up to local government it would never get done. There had to be an element of pressure on the local government stemming from the fact that if they didn’t go along at all, you could just do it without them. With that pressure, you would be able to involve them in the job and wind up probably with their support. But if you were totally subject to their veto, in many places nothing would happen (Gillette 1996, 76).

Given the limited resources and the pressures Johnson felt to make the program as visible and as widespread as possible, the manipulation of the delivery system, not the content, was paramount. Community action itself was in the broadest sense a strategy for channeling programs into an area as quickly as possible. The specifics of how that happened were to some degree irrelevant and bore the potential for misunderstanding.

In his memoirs Johnson would indicate, directly contradicting Moynihan, that he was fully aware of the political risks of community action and that “some shaking up might be needed to get a bold new program moving,” but he completely misunderstood the specifics of how community action would work (Johnson 1971, 75). Consider this remarkable conversation with Bill Moyers on August 7, 1964 (Johnson 1964c):

**Johnson:** But now, we've got to get ... And I don't want to commit—I see—I'm going to rewrite your poverty program. You-all, you boys got together and wrote this stuff, and I thought we were just going to have [another] NYA [National Youth Administration]. As I understood it—do you know what I think about the poverty program, what I thought we were going to do?

**Moyers** What?

**Johnson:** I thought we were going to have CCC [Civilian Conservation Corps] camps.

**Moyers** We've got that.

**Johnson:** And I thought we were going to have community action [programs] where a city or county or a school district or some governmental agency could sponsor a project—state highway department sponsor it—and we'd pay the labor and a very limited amount of materials on it but make them put up most of the materials and a good deal of supervision and so forth just like we used to have.

**Moyers:** We've got that.

**Johnson:** I thought that we'd say to a high school boy that was about to drop out, "We'll let you work for the library or sweep the floors or work in the shrubs or pick the rocks, and we'll pay you enough," so he can stay in school.

**Moyers:** We've got that.

**Johnson:** I thought you'd let a college boy do the same thing.

**Moyers:** We've got that.

**Johnson:** And college girl. Now, I never heard of any liberal outfits that's where you could subsidize anybody. I think I'm against that. I just—if you-all want to do it in the Peace Corps, then that's your private thing and that's Kennedy. But my Johnson program: I'm against subsidizing any private organization. Now, if we had a hundred billion, we might need to, but with all the governmental agencies in this country, I'd a whole lot rather Dick Daley do it than the Urban League. ... And he's got heads of departments and he's got experienced people that are handling hundreds of millions of dollars. In every one of these places, I'd make them come in [and] sponsor these projects. And I just think it makes us wide open, and I don't want anybody to get any grants. Now you got the grants out for farmers, didn't you?

**Moyers:** Altogether.

**Johnson:** All right. And ...

**Moyers:** And I got that thing out on handicapped that I mentioned to you last night. Everybody has to work.

In a more direct statement to Walter Jenkins on the subject the following day, Johnson says, “Looks like to me it would be awful dangerous sponsoring something through the YWCA, Urban League, NAACP, and I really didn't know that was in the bill” (Johnson 1964d).

Some have suggested that these exchanges shows “a President who never saw the potential of such federally backed grassroots action” and as such “never knew how to fight for it – had he been so inclined” (McKee 2010). That may be so, but at another level, it reveals Johnson’s ultimate willingness to disregard the potentially negative political consequences of the law’s final impact if its passage would help him distinguish *his* program from the groundwork laid down by his predecessor. Johnson’s combustible relationship with Robert Kennedy, who could justly claim ownership to the originating idea of a poverty program, meant that he would invariably push the program with his own distinctive flair. Just that April he had harangued Bill Moyers and Richard Goodwin to “use the Kennedy program as a springboard to take on the Congress, summon the states to new heights, create a Johnson program, different in tone, fighting and aggressive” (Goodwin 1988, 270). Moyers would later suggest that Johnson was simultaneously of two minds when it came to poverty: one traditional, and one that flirted with the radical. “You can’t take a poor kid and turn him around just by getting Congress to pass a

bill and the president to sign it and one of those agencies in Washington to run it,” Johnson said. “You have to experiment and keep at it until you find what it takes” (Moyers 2011, 169). The willingness to try something, to innovate, without concern for getting it perfect, characterizes many of the most successful community action programs. Johnson’s perspective also captures something critical to the organizational structure of War on Poverty programs: a fundamentally conservative principle stressing local control and the mandated participation of anyone receiving benefits from the programs (“Everybody has to work”).

Financial constraint could not develop a program of the scope and size envisioned by Johnsonian bombast, but by maintaining the structural innovation of “community action” Johnson fused together the martial tone of the War on Poverty with a rhetoric of moral certitude and the anti-bureaucratic, guerilla-like character of its historical development. Johnson sought to stamp the poverty program as his own version of the New Deal: as a massive and wide-ranging “War” that would eventually translate into a “Great Society.” The Economic Opportunity Act (EOA) would create the institutional systems by which he could pursue that double vision. The paradox is that in his commitment to large-scale intervention, Johnson would take the relatively small-scale experiments in community action of Dave Hackett and infuse them with Johnsonian grandeur: “He felt instinctively (and perhaps somewhat resentfully) that he must not allow the ideas of aides of the dead president to dominate his administration,” noted Richard Blumenthal (1969, 151). Possibly without fully realizing it, his insistence on a large and impressive approach would expand the reach of a Kennedy idea, only to suffer political fallout from it when the results failed to match the rhetoric deployed to enact it. That said, Johnson might very well have been taking a calculated gamble, one that used the EOA as a building block in the implementation of additional pieces of the Great Society.

The debate over community action and maximum feasible participation would be of critical importance to the development of community health centers, particularly because the broadness of its definition and the flexibility of potential applicants would allow truly unique projects and sponsoring agencies to gain access to Office of Economic Opportunity funding. The defined geography of a “community” is unlimited (“any urban, rural, or combined urban and rural, geographical area... including but not limited to a State, metropolitan area, county, city, town, multicounty unit, or multicounty unit”), and there are no specifics as to what these organizations must provide other than “services, assistance, and other activities of sufficient scope and size to give promise of progress toward elimination of poverty.” This broadness left incredible discretion in the hands of the “communities” applying for such grants, and also in the authority of the director to administer them. To respond to Johnson and Shriver’s demands for rapid scale-up and implementation, the bill emphasized “action” as opposed to assessment and planning. But even so, section 207 of the act allowed the OEO to authorize grants (no more than 15% of total annual appropriations) to “enter into contracts with institutions of higher education or other appropriate public agencies or private organizations for the conduct of, research, training, and demonstrations pertaining to the purposes” (The Economic Opportunity Act of 1964). The first health center applications to the Office of Economic opportunity would zero in on this provision of the law as a path to funding support.

The legislative process and the intricacies of the congressional maneuvering involved in the passage of the Economic Opportunity Act (EOA) is beyond the scope of this dissertation, but one aspect of that process warrants attention insofar as it captures a sense of the environment in which health projects sponsored under Title II (Community Action Programs) would be

implemented<sup>30</sup>. The introduction of the EOA coincided with the drawn-out fight over civil rights, and the basic lines of opposition to the EOA reflected those drawn over civil rights. Senate opposition from Southern Democrats reflected distrust of federal intervention on state policy particularly when it came to Title II, which allowed the federal government to bypass local governments entirely by offering grants to a “local coordinating body” including non-governmental nonprofit organizations. Senator Strom Thurmond (D-SC) voiced the segregationist objections in the following way: “Under the innocent sounding title of ‘Community Action Programs’, the poverty czar [Sargent Shriver] would not only have the power to finance the activities of such organization as the National Council of Churches, the NAACP, SNCC, and CORE, but also a SNOOP and a SNORE which are sure to be organized to get their part of the green gravy” (The Economic Opportunity Act of 1964 U.S. Senate Congressional Record). Senate Republican dissenters complemented this type of objection by hammering on the authority of the OEO director. Senator Simpson (R-WY) called the act a “legislative monstrosity” and argued that “the Director of the war on poverty will become a little dictator who will be restrained by few, if any, congressional directives and be almost immune from statutory provisions” before summarizing that “a socialized dictatorship is now a reality” (Ibid). Selecting appropriate sponsors for the bill would be necessary to confront such challenges.

As chair of the Senate Labor and Public Welfare Committee and because of his heritage as a “New Dealer,” one might have expected Lister Hill to sponsor the bill in the Senate. But Hill was soon to be assigned as a “platoon” captain on one of Richard Russell’s three teams whose sole purpose was the effective filibuster against civil rights legislation. The captains would have to hold the floor and debate specific sections of the law for up to ten hours at a

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<sup>30</sup> For a general history of the EOA and the titles and various programs created by them see Clark 2002.

stretch (Zelizer 2015, 104). "Being a team captain . . . was a 'much, much greater' task than simply serving in the ranks of the filibusterers. He must keep debate going, try to spread speaking assignments equally, serve as 'back-up' man to relieve his teammates by asking questions, as well as deliver his own lengthy speeches," Hill told Barret Shelton of the *Decatur Daily* (Van der Veer Hamilton 1987, 269). As with the Hill-Burton legislation, he would not "sacrifice himself on the altar of civil rights" (Ibid, 268). In retrospect, it seems self-evident that Hill, who had nearly suffered a senate defeat at the hands of James D. Martin, a militant, race-baiting, segregationist Republican endorsed by George Wallace, would never come anywhere near a law containing provisions for community action. In recalling Hill's retreat from sponsoring OEO legislation, Stewart McClure, Chief Clerk for the Senate Committee on Labor, Education, and Public Welfare, would say:

Well, he foresaw what did happen, that these community action agencies in every city in the country and every town in the country would come into clash with the existing institutions, welfare, relief, education, school systems, medical provisions, hospitals, and so forth, all of whom thought they were doing a great job for the poor, but they were not. They were being challenged by the organizations representing the poor, the people left out. People who never could find the clinic or didn't know it existed, had a voice. He could see that this was going to just bring into frightful clash the very structure that elected him--the political structure - with the common people.

The program never was a great success in the South, except where they had tremendous battles, in Atlanta and places where they won, in fact, and elected their own mayors. But it was a tremendous struggle in the '60s, and Lister foresaw this. It wasn't that he was anti-black; he wasn't. But he could see that any federally financed organization going in and rounding up the poor people of Alabama to confront the established order was going to be agony for him, and any other Southern senator. And, indeed, it was. But none of the other Southern senators was chairman of the Labor Committee! But he never stayed out of any of the health and education legislation (McClure 1983, 190).

To distance himself as much as possible from EOA legislation, and the potentially problematic community action clause, Hill devised a subcommittee consisting of every member of the Senate Labor and Public Welfare Committee except himself.<sup>31</sup> Replacing him at the helm was the

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<sup>31</sup> For a comprehensive history of the War on Poverty in Alabama see Ashmore 2009.



efficient and conventionally liberal Patrick McNamara. This substitution required Johnson to find strong conservative support for the bill in the House. He did so by enlisting the aid of Phil Landrum (D-GA). Despite his segregationist views, Landrum proved a strong promoter for the bill, particularly in gaining southern support. Chatting with House Speaker Carl Albert (D-OK) about the likelihood of passing the EOA in May 1964, Johnson declared: “Well, we’ve got to watch those southerners, though. I would guess we’d get a good many from Georgia on account of... the author, won’t I?” (Johnson 1964b). Landrum shored up the conservative *bona fides* of the bill, delivering his district along with five other Georgia house districts (totaling six out of ten) voting in favor of the legislation. Johnson repaid Landrum’s stewardship of the bill with a call to United Auto Workers President Walter Reuther asking him to limit UAW support for Landrum’s opponent in his primary election contest (Ibid). Despite his historical opposition to “liberal” causes,<sup>32</sup> Landrum committed substantial effort to passing the EOA. Of Landrum’s support, Johnson aide Larry O’Brien would later speculate: “I think it’s like anything else. We were talking about Lyndon Johnson in that regard. I guess if you’ve been exposed to this [poverty] directly in the context of representing people, you probably have a soft spot in your heart, and the day is going to come when the spark will be there and you feel comfortable. It’s hard to figure that out in terms of his opposition to labor, but maybe not that hard. Talking about poverty is different than talking about organized labor and its power” (Gillette 1996, 118). Together McNamara and Landrum represent a fascinating duo insofar as they touch on something that would become a hallmark of community health centers: broad levels of congressional support spanning divides between rural and urban constituencies, and liberal and conservative ideologies.

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<sup>32</sup> The Landrum-Griffin bill increased government control over internal union affairs.

Pat McNamara adopted the testimony from the House whole cloth and whipped the bill through the Senate. This was likely the only way it would gain approval. As Counsel to the Senate Subcommittee on Poverty, Donald Baker would recall: “I told Pat McNamara once – I think after the first reading of the bill – ‘If the members read community action and understand what it means, it’ll never get through.’ But they didn’t of course.” (Gillette 1996, 124).

McNamara’s distaste for hearings in general, and on this bill specifically, limited interrogations about the potential pitfalls of the community action provision. At the same time McNamara’s blue-collar credentials (he had previously worked as a pipe fitter, a semi-professional football player, and a union president) gave the bill plenty of liberal credibility. One amendment to the bill introduced in the Senate is worth noting. In response to concerns such as those raised by Strom Thurmond, who argued that the law would ultimately deliver “arbitrary and discretionary grants of power” through a non-elective Federal official (the OEO director), the Senate adopted a resolution from George Mathers (D-Florida) to allow governors to veto grants made to private organizations within thirty days<sup>33</sup>. At its core, the veto amendment crystalized a fundamental debate over mechanics of how the War on Poverty would be fought. McNamara summarized the matter in the following way:

The philosophy behind the bill is to place the control of the situation, so far as the alleviation of the impoverished people is concerned, at the lowest possible level of government. The assumption is that the government level closest to the people understands the problems best. The amendment of the Senator from Florida would establish bureaucratic control above the local or State officials, officials who are just as much elected as are Governors but who are closer to the problems, more familiar with the required solution, and more familiar with the necessity for doing something to eliminate them in the first place, than the Governors are likely to be (The Economic Opportunity Act of 1964 U.S. Senate Congressional Record, 16767-8).

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<sup>33</sup> Having won a Senate seat in Connecticut in 1962, Abraham Ribicoff, for whom Ohlin Lloyd had been an assistant during his time as HEW Secretary, voiced vigorous objection to the governor’s veto amendment saying: “We are dealing with a different philosophy. In a sense we are dealing with problems that are not State problems, but problems which, time after time, are pinpointed into one community. The plans of the mayor and the common council should not be vetoed by the Governor of the State” (The Economic Opportunity Act of 1964 U.S. Senate Congressional Record).

Although the amendment would be adopted, the underlying question of how best to channel federal anti-poverty funds to local communities would persist. The amendment would be modified in 1965 to allow the OEO director to override a governor's veto if the proposed program was deemed to be consistent with the purpose of the law (Clark 2002, 51). It is easy to interpret discussion of the governor's veto as a familiar question about states' rights. But it also introduces a fundamental change in how the federal-local relationships are viewed, specifically in light of Johnson's increasing emphasis on "creative federalism." Regardless of how "grassroots" OEO programs were in their origins, the nature of their funding meant they would consistently orient themselves to the federal cues before all others.

Having concluded the legislative debate, President Johnson signed the Economic Opportunity Act into law on August 20, 1964, and moved into its implementation phase. The establishment of the Office of Economic Opportunity gave incredible power to the Director, Sargent Shriver, who made the critical decision to emphasize the operational aspects of the program as opposed to its oversight/interagency coordinating functions. "It was utterly impossible for Sarge to conceive of himself as part of a bureaucracy," recalled OEO chief counsel Don Baker, "He saw himself as being part of a monumental effort at innovation, of helping to find new ways of charting new routes, and with a lesser emphasis placed on resources as such." (Gillette 1996, 147)<sup>34</sup>. The War on Poverty's main assault unit would simultaneously wage a pitched battle against bureaucratic structure itself.

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<sup>34</sup> The impossibility of considering oneself a part of the bureaucracy was echoed by interviewees at Care Center. Bill Meisner, director of Care Center's billing operations (and quite possibly the most bureaucratic of Care Center's departments) was particularly vociferous in his condemnation of bureaucracy:

**BM:** I consider bureaucracy red tape where you can't actually get to the answer. One question moves to another question that circles back to the first question that goes to the third question that circles back to the first question and there's no end in sight, no one's accountable for finishing the [crosstalk]

**David:** Finishing something-- unfinishable tasks is the salient characteristic?

**BM:** Yes, red tape and barriers to completion. I look at myself as one of those enablers who break the barriers [laughs].

## **War on Poverty, EOA, CAP: Conclusion**

The passage of the Economic Opportunity Act heralded Lyndon Johnson's first legislative success distinct from previous Kennedy era initiatives. Yet the law would inevitably include input from Kennedy staff, who continued through the transition between administrations. Several of these, including a number of Dave Hackett's "guerillas," would carry on their approach within the newly created Office of Economic Opportunity. Johnson's willingness to promote and support the War on Poverty from a personal, moral, and political standpoint lent the effort a sense of urgency and (albeit exaggerated) grandiosity. But Johnson assiduously avoided details on how the War would be waged. With few truly "new" ideas at their disposal, the architects of the War on Poverty had to rely heavily on Community Action Programs both to brand the program as more than a simple repackaging of stale New Deal programs and also to funnel the financial resources secured by the passage of the EOA on a massive scale. The passage of the EOA coincided with the fight for civil rights legislation, and it was being debated even as volunteers descended on Mississippi as part of Freedom Summer. With Johnson's landslide election victory in November, the Economic Opportunity Act was poised for enactment at a wild pace in 1965.

## **Medical Segregation and An Experimental Next Step for the Medical Committee for Human Rights**

Medicaid, Medicare, and even FQHCs are so heavily ingrained into the collective understanding of the United States healthcare system that it is difficult to imagine the healthcare landscape prior to 1965 before the enactment of these programs. However, in the pre-1965 state, health care was generally not accessible to and affordable for all people. It is within this context,

that advocates for health equity, particularly racial equity in health care, would take the critical step of civil rights efforts into medical service delivery through a community-based model.

The Hill-Burton Act (The National Health Policy Hospital Survey and Construction Act) was, for all intents and purposes, the most substantial healthcare law enacted at the federal level in the first half of the 20<sup>th</sup> century. It carried on the legacy of Jim Crow and was the only major piece of legislation since Reconstruction to contain language specifically sanctioning segregation. This limp accommodation made by Lister Hill meant that despite adding hundreds of health facilities in Alabama, few if any were accessible to blacks. *Brown v. Board of Education* had barred separate but equal provisions in education in 1954, but the language of the law instructing district courts to desegregate at the local level “with all deliberate speed” had enabled delays and resistance. Nearly twenty years of hospital construction programming under Hill-Burton had built not only a hospital-centric model of care, but also a thoroughly segregated one.

The chair of Howard University’s Department of Preventive Medicine and Community Health, Paul Cornely, surveyed the extent of hospital segregation in 1956. While approximately 83% of hospitals in the north offered some level of integrated service, only 6% in the South offered unrestricted services to Blacks. More than a third refused to admit Blacks under any circumstance at all (Reynolds 2004, 711). Little change had occurred by 1961 when George Simkins, Jr., a North Carolina dentist and president of the local branch of the NAACP, petitioned two hospitals (Moses H. Cone Memorial Hospital and Wesley Long Community Hospital) to desegregate (Gamble 1995, 188). The hospitals ignored his request, and the following year he filed suit arguing that as recipients of federal Hill-Burton funds they were subject to equal protection guarantees. Specifically, the lawsuit argued that the public funding associated with the Hill-Burton hospital program constituted state action even though the hospitals were private

institutions. As such they would then be obligated to abide by the fifth and the fourteenth amendments to the Constitution guaranteeing equal protection. Upon appeal to the U.S. Court of Appeals for the Fourth Circuit, the court overturned the ruling of the District Court and found that the hospitals had in fact violated constitutional equal protection guarantees. The ruling struck down the “separate but equal” components of Hill-Burton, but the Supreme Court refused to hear an appeal on the part of the hospitals, thereby limiting the impact of the ruling to the Fourth Circuit’s geographic district.

*Simpkins v. Moses H. Cone Memorial Hospital* often draws comparison to *Brown v. Board of Education* in terms of its impact, and indeed a vast number of references to the case, over 260 in legal decisions between 1963 and 2001, reflect its prominence (Reynolds 2004, 714). But unlike *Brown v. Board*, the ruling did not play out in highly dramatic confrontations at the doors of various institutions in quite the same way as the fight over school desegregation did. In addition, the enactment of the Civil Rights Act and Medicare together moved hospital desegregation forward with remarkable speed in comparison to the same process in schools (Smith 2016). But at the time of the *Simpkins* ruling on November 1, 1963, Kennedy’s civil rights bill was hopelessly stalled in Howard Smith’s Rules Committee, and broader structural changes were not assured by any means.

By February 1964, planning had begun for Freedom Summer, and medical professionals in the North had begun to take note. Among the activists who traveled to Mississippi was a group of physicians and medical students who sought to provide informal health care services to these activists while simultaneously mounting a challenge to hospital segregation and the exclusion of black physicians from the American Medical Association. Organized in New York in the spring of 1964, these doctors and students referred to themselves as the Medical

Committee on Human Rights (MCHR) and traveled through Mississippi providing such “first aid” and medical care for civil rights workers as was permissible given the unwillingness of arch-segregationist Archie Gray, head of the Mississippi Department of Health, to issue them appropriate licensure (Dittmer 2014, 745)<sup>35</sup>. The first field coordinator would be none other than Leslie Falk from the Farm Services Administration (FSA) program, who would strike up a working relationship with Art Thomas, Warren McKenna, and Bruce Hanson from the Delta Ministry, one of the largest civil rights organizations in Mississippi (Dittmer 2009, 38-9). According to Jack Geiger, who joined in August of that year:

It really got organized person to person. People who had this idea that they (civil rights workers) should be prepared for by physicians, and civil rights-oriented people called other people who, in turn, called other people. It wasn't like there was a meeting to set up the organization or the board... or 'would you help fund this'? The guy who called me in was a New York internist called Charlie Goodrich and I knew there were others from California and so on.... They were a very varied group from very activist and committed to people. I remember one guy illustrative of a considerable number of the rules were. If you came down, you stayed with black families in Jackson or wherever you went on to go. Taught in the schools or provided informal medical care, what was called 'medical presence' to the people doing voter registration and were at risk to visit people in jail and the like. Those were the rules, the way you're supposed to do (Pers. Com. 8/8/17).

A 1966 publication orienting potential MCHR volunteers to the program described the purpose of “medical presence” as a tool for “allaying apprehensions about disease and injury in the Civil Rights workers – there is a certain security in knowing that even if they do get hurt, professional help is available” (Medical Committee for Human Rights 1966, 4). The concept of “medical

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<sup>35</sup> Although no explicit provisions had been made for the medical care of Freedom Summer civil rights activists, Harvard University's Robert Coles and MIT's Joseph Brenner took it upon themselves to write to white southern doctors requesting their support in treating civil rights volunteers in the hope that “a clear separation between social upheaval and medical need” would be maintained (Dittmer 2009, 41). The condescending tone of the letter did not necessarily help MCHR doctors and volunteers engage the white medical community in Mississippi, but it did reveal a specific strategic angle many physicians sought to pursue in the South. Leveraging a particular notion of medical necessity would offer doctors a certain amount of “cover” for their broader interests in racial equality and human rights.

presence” reflects a sense of “co-suffering” or compassion (*compassio*) more than a mechanical execution of professional practice.

The murders of civil rights workers James Chaney, Andy Goodman, and Michael Schwerner in late June galvanized support for MCHR. (Geiger’s wife Nicole Schupf Geiger had been a schoolmate of Andy Goodman’s mother.) They also enormously increased recruitment potential (Ibid)<sup>36</sup>. As part of the recruitment process Geiger reached out to Count Gibson from the Department of Preventive Medicine at Tufts Medical School. Gibson had previously attempted to recruit Geiger to come to work at Tufts. Deeply committed to civil rights, Count Gibson likely authored the earliest letter of criticism to Dr. Sidney Olansky regarding the ethics of the Tuskegee experiments (Reverby 2009, 70, 535). Unlike some of the volunteers, Gibson “wasn’t subject to rescue fantasies and the like, and participated thoroughly” (Geiger Pers. Com 8/8/17). All in all, approximately one hundred doctors, nurses, dentists, psychologists and social workers volunteered in Mississippi.

Although the initial efforts of the MCHR had been directed at supporting civil rights, they soon witnessed tremendous need for medical services among black populations throughout the state. This was not surprising given enforced segregation and the fact that fewer than three percent of all United States medical students were African American. Barely fifty black doctors were actively practicing in Mississippi in 1964 (Dittmer 2009, 5, 31). MCHR volunteers did not explicitly consider themselves tasked with treating the health problems of Mississippi’s black population, but the need and demand for their services was inescapable. The poor health conditions in predominantly black areas were staggering. Infant mortality for Mississippi whites

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<sup>36</sup> Charles “Charlie” Goodrich, MD, along with Alfred Kogan, MD (both MCHR physicians) would be asked by Michael Schwerner’s family to be present for the autopsies of the three men. Goodrich was refused permission, but he contacted New York pathologist David Spain, who performed an independent autopsy that revealed the extent of bodily harm done to James Chaney as opposed to his white companions (deShazo et al. 2014, 473).



was 23.6/1,000 live births compared to 49.9/1,000 among blacks (Geiger 1966, 12). Perhaps not surprisingly 97% of white births took place in a hospital compared to 53% of black births (Ibid).

MCHR founder Dr. Robert “Bob” Smith, would describe the conditions as educational in the sense that they showed what it truly meant to be black, underprivileged, poor, and without medical care in Mississippi: “People by the hundreds and really thousands go without medical care. [I] saw, what I call, a third-world country. Worms. Everything. Anemia. Requiring of deposits. Some hospitals wouldn’t admit blacks at all. Others, a dingy, segregated ward (Smith 2000, 10). The enforcement of “cash up front” (requiring of deposits) policies for medical care often served as an exclusionary tactic for poor blacks. Said one Mississippi doctor: “If there is a nigger in my waiting room who doesn’t have three dollars in cash, he can sit there and die. I don’t treat niggers without money.” (Cobb 1992, 262, quoted in Dittmer 2009, 7). Overcoming financial barriers to care became a hallmark of OEO-sponsored health projects. Sargent Shriver would later comment on the financial barriers to care and the formation of the Watts Health Center:

In Watts, the ghetto area near Los Angeles, in Watts they had a saying. They said, "Are you ten dollars sick?" And this is what they meant. They meant, and let me say ten dollars is a lot of money for them, they meant that unless you were sick enough to want to spend ten dollars; seven dollars for round-trip taxi fare to get to the nearest medical center which would receive you, that was a one-hour round trip, no public transportation available, unless you wanted to spend seven dollars for that and three dollars for the minimum clinical fee, you were not sick enough to get medical attention. Ten dollars sick: It was a sad, tragic commentary on the state of American medicine (Shriver 1974).

With the limited resources they had, MCHR volunteers did what they could to address the basic health needs of the black families they encountered. They helped prepare meals, demonstrated and distributed basic health supplies (toothbrushes, thermometers, etc.) and helped to build basic sanitation infrastructure. But these efforts in large part only revealed how severe the problems were and how massive they were in number (Dittmer 2009, 51).

As the summer came to a close, the members of MCHR gathered back in New York City to consider how best to establish medical services to address the needs of the poor black families they became familiar with in Mississippi. With Count Gibson and Jack Geiger attending from their academic posts in Boston, the meeting sought to plot out a strategy for the organization's next steps. Specifically, they sought to respond to criticisms from the Student Non-Violent Coordinating Committee (SNCC) and the umbrella civil rights coalition, the Council of Federal Organizations (COFO), that the MCHR ought to have spent more effort attending to the needs of the local people (Dittmer 2009, 63). They promptly dispatched Geiger to Mississippi to scout out the situation, and he found that several MCHR volunteer nurses had continued to work at different sites throughout the state. One of these, Josephine "Jo" Disparti, had been working out of a community center in Mileston, a tiny town in the state's poorest county. She reached out to Geiger and described some of the work she had been doing, whereupon Geiger immediately asked her to work with MCHR to develop the Mileston site into a potential long-term clinic (Ibid, 75). With the help of approximately \$30,000 in private donations and the support of the Delta Ministry and its parent organization, the National Council of Churches, the leaders of MCHR announced that a rural health center "aimed primarily at improving Negroes' health would soon be started 'at the crossroads in central Mississippi'" on October 7, 1964 (*New York Times* 1964). They went on to say that they "hoped it would be the forerunner of a number of such health centers" (Ibid). Despite these initial steps, the severity of local needs outstripped MCHR presence, and the Delta Ministry soon called for a meeting to explore the direction the program would take. On December 11, 1964, MCHR and various members of local civil rights organizations met in Greenville MS, with Drs. Geiger and Gibson, co-chairs of MCHR's program committee, in attendance (Ward 2017, 3).

Although some have characterized the mood of this meeting as “let down” and “demoralized” (Lefkowitz 2007, 7; Ward 2017, 3), Jack Geiger suggested that the participants were more “on edge” than anything else, and that they were looking to write the next chapter in their efforts:

Let me set a broader context for Mississippi and for the meeting. You mentioned in Greenville, in December, sponsored by the Delta Ministry [of] the National Health Council of Churches, which was probably the biggest of any of the civil rights organizations in Mississippi, and a bunch of ministers of one faith or another. The reason for the conference was not despair but uncertainty - that is Freedom Summer had come and gone - it had obviously had an impact but there was equally obviously an enormous amount still to do. And the question was really "What do we do now?" rather than one of outright despair. There was, "How do we continue this? What do we do next? We can't let this be just a single summer and a single episode" (Pers. Com. 8/8/17).

What happened next is well known in the Community Health Center world. Bob Smith spoke to the group about his MCHR experiences at the Mileston clinic site. He told them that the only next step he could think of would be “to create a new institution which we had not had, and didn’t know how it could be funded, and didn’t know of any model of that kind of institution in the whole country. But an institution that brought not only direct medical service, but an institution that would combine some of the other social service skills, literacy skills. The whole nine yards.... That didn’t exist, and there was no model in the country” (Smith 2000, 15). At that moment, Geiger had the sudden realization: “For the first time, I had no idea why it was so blocked in me until then. I remembered Pholela, and said something to the effect of, ‘There *is* a model, it’s called Community Health Centers. This is what it is.’” (Pers. Com. 8/8/17). He went on to explain the Karks’ innovation, the use of defined populations, epidemiological surveillance, and community involvement and engagement. Bob Smith responded favorably saying “I didn’t know anything about South Africa. I knew what Mississippi needed, and from that meeting we came up with the idea of trying to put together a comprehensive package which we had no idea how it would be funded or who would sponsor it, or what have you. But out of

that grew the concept of neighborhood health centers, of comprehensive health centers, really, [out] of the Mileston experience that the medical committee had had, beginning with the summer of sixty-four” (Smith 2000, 15).

### **MCHR Coda: Other Branches**

The drama of Freedom Summer and the work of the MCHR is rightly celebrated as a critical moment in the development of community health centers. At the precise moment that the MCHR was contemplating Geiger’s description of Pholela at the Holiday Inn in Greenville, MS, the Gouverneur Ambulatory Care Unit was already up and running on Manhattan’s Lower East Side. Other communities were contemplating similar projects. A thousand miles away in Colorado, Denver’s War on Poverty Inc. was approving a proposal for creation of a neighborhood health center to deliver comprehensive medical care to approximately 20,000 poor black and Mexican-American residents on Denver’s east side (Hollister 1970, 146). Denver’s Department of Health and Hospitals (DHH) had been working with Mayor Thomas G. Currigan and his Deputy Manager of DHH, Phil Frieder, to address urgent health needs throughout 1964. Almost immediately after passage of the Economic Opportunity Act in August, Denver’s War on Poverty, Inc. (WoP) was incorporated. By September a study group headed by DHH’s director of public health and preventive medicine, Dr. Samuel Johnson, presented a proposal to WoP for the neighborhood health center. With its approval, WoP sent the proposal to the Office of Economic Opportunity to request funding (Cowen 1969, 1027). The WoP had sent eleven proposals to the OEO, all which had been rejected previously “because they were terrible,” but the health center proposal had potential. With OEO support, the proposal evolved into “something that was a good bet to fund” (May et al. 1980, 113). Dr. Julius Richmond, who

reviewed the Denver application at the OEO, would comment on the proliferation of health centers originating from diverse sources:

I might just historically go back and say if one goes back and looks at the report that the Committee on Costs of Medical Care talked about earlier, one can find essentially the paradigm for this kind of development recommended in that report that had never come to fruition. I think that's an interesting point to have on the record because as neighborhood health centers programs developed, various people were beginning to try to establish credit in terms of priority for the idea, the notion, and I would always just point to the fact that in 1932 the Committee on the Costs of Medical Care had essentially recommended that kind of development. So, I don't think anybody at a later point could truly claim priority (Richmond 1981, 37).

### **“Pitching” the Health Center Idea**

Even though there “was some agreement” that the health center idea should be a big part of MCHR’s agenda, it took some bad weather on the flight back to Boston to take the project to the next level. “We were flying back to Boston together,” said Geiger. “We got grounded in Atlanta by weather and went to a motel the airline provided us. And at supper Count said of the Community Health Center thing, "If you can find the money, Tufts will sponsor it” (Pers. Com. 8/8/17). With the outlines of a strategy in place, Geiger began seeking out a funder who might get the project off the ground.

There is an irony associated with Jack Geiger’s initial pursuit of federal funding for community health centers. Early in 1965 Geiger approached Dr. William “Bill” Kissick, assistant to the Surgeon General in the U.S. Public Health Service (PHS) perhaps the most ancient health-oriented agency in the United States. Signed into law by John Adams in 1798, the Public Health Service attempted to alleviate the burden of treating sick merchant marines through the creation of marine hospitals in various ports of call (Mullan 1989, 17). These hospitals were eventually placed under the authority of a “Supervising Surgeon” (later Surgeon General) and gradually took on a military model of organization (Ibid, 20). This old-line bureau, which had formally been placed under the authority of the newly created Department of Health,

Education and Welfare during the Eisenhower administration, did not seem like a natural fit for an innovative idea.<sup>37</sup> Moreover, the PHS was actively sponsoring the Tuskegee syphilis experiments that Count Gibson had criticized.

But as Bonnie Lefkowitz has noted: “Ideas are translated into government programs in several ways, not the least of which is serendipity” (2007, 8). Kissick himself had only been assigned to the office of the Surgeon General after an assist from what he called “The Princes of Serendip” led to the misfiling of his application to work at the National Institutes of Health (Shaddox 2005). Selected to join the President’s Commission on Heart Disease, Cancer, and Stroke, Kissick and his colleagues had worked tirelessly to produce the first of two reports to the President in December of 1964. This report would inform the creation of Public Law 89-239 authorizing the establishment and maintenance of Regional Medical Programs. Kissick would go on to participate in the drafting of Medicare legislation and would serve as director of program evaluation at PHS. When Geiger showed up at PHS, Kissick knew his ideas would not find a home in the rigid environment of the PHS. But he had an acquaintance from the AFL-CIO, Lisbeth “Lee” Bamberger Schorr, who was just about to begin working at the Office of Economic Opportunity, and he called her up. “Hey Lee, there’s a wild man in my office and he’s got some ideas we can’t do much with over here, but I think you people in the War on Poverty would find him pretty interesting. I’m sending him right over” (Schorr and Schorr 1988, 130).

Bamberger was still working out of her AFL-CIO office when Geiger dropped in to visit and, fortunately for Geiger and community health centers, she had been working on healthcare issues for the previous decade. In 1952, she had organized a union education project sponsored

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<sup>37</sup> Sar Levitan notes that as OEO health programs were proposed, officials at the U.S. Public Health Service initially recommended “that if OEO became involved in the health field, it should merely support programs that would fill specific loopholes in existing community services” (1969, 193).

by the Ford Foundation and operating out of the Institute for Industrial Relations at UCLA. Unions had just begun to enter into collective bargaining negotiations for healthcare benefits, and they all expressed an interest in having the Ford Foundation project educate them on the critical issues. Despite having no background in health care, the “motley crew” working on the project learned what the issues were pretty quickly, and they traveled throughout the United States, making numerous contacts with labor representatives. UCLA’s chancellor short-circuited the project after a couple of years when he decided to put money into a medical school. The local medical community supporting that project vigorously opposed the work that the Ford Foundation project was doing with organized labor. When that work wound down, Bamberger got in touch with some of the contacts she had made with the United Auto Workers (UAW) and expressed an interest in working on some of their healthcare programming. Unfortunately, her move to the UAW would be delayed until 1955: hiring a woman in their social security department was not permitted, as the role would also include work on bargaining negotiations from which women were categorically excluded. The conclusion of the 1955 Ford and General Motors union contracts included a broader employer-financed health security program, and Bamberger worked with UAW and Walter Reuther to translate this benefit into what amounted to a proto-HMO (Health Maintenance Organization) program. Just as the program had matured to the point where it would require a physician at its head, Bamberger was contacted by Lane Kirkland, who oversaw the healthcare portfolio for the AFL-CIO. Kirkland was moving over to be director of research and education for the International Union of Operating Engineers, and he asked if Bamberger would like to take over his spot.

At the AFL-CIO Bamberger spent much of her time working on legislative affairs, specifically testing out ideas for a medical program for the aged, which would ultimately become

Medicare. Bamberger's boss and Farm Services Administration veteran Nelson Cruikshank was well connected to Wilbur Cohen and heavily invested the AFL-CIO's efforts to support the work on medical legislation being done by the Department of Health, Education and Welfare. "We were able to finance the National Council of Senior Citizens for HealthCare, we provided a convening place, and it was still a time where you had to reproduce things with a mimeograph, and it was our mimeograph machines that were doing that and copying different versions of the bills that were circulating. So, a lot of the back office "shadow government" was headquartered at AFL-CIO" (Pers. Com. 4/13/18). Bamberger also did a lot of work setting up the physician's committee, a group of doctors who supported insurance proposals that ran counter to the long-time AMA stance. "We felt for a long time the terrible lack of having any recognized voice for physicians who didn't share the AMA's position... And the question was: Since the American public, when it heard from physicians at all, only heard on one side of this issue, what could you do about it?" (Schorr and Lesser 1967).

Personal connections also formed an integral part of the AFL-CIO's efforts. At one point, Wilbur Cohen set Bamberger up for a date with Kennedy advisor and speechwriter Ted Sorensen, and she attended a White House dinner with him and Myer "Mike" Feldman. Cruikshank, Bamberger, and Leonard Lesser (general counsel for the AFL-CIO) would work with Feldman and Sorensen on drafting John F. Kennedy's amendment to Kerr-Mills legislation that would have delivered hospitalization insurance to all Social Security beneficiaries over the age of 68. Bamberger would later recall the terrible rush of putting it together with a stapler and scotch tape at the Industrial Union Department library. Although the proposed amendment was voted down, Kennedy used its defeat to promote his presidential candidacy, saying, "This vote demonstrates that if we're going to have effective legislation in this and other fields, we're going



to have to have an administration that will provide leadership and a Congress that will act." (Kennedy 1960). As work on Medicare began again in earnest following Kennedy's election, Bamberger would continue to connect with critical administrative staff in the various departments that would ultimately be responsible for implementing the program: Social Security; Health, Education and Welfare; the Public Health Service, etc. Among those Bamberger would get to know was Bill Kissick, who was then one of two physicians responsible for drafting Medicare legislation.

By early 1965 it had become clear that the AFL-CIO effort on Medicare was winding down, and Bamberger became increasingly interested in joining the rapidly developing poverty program:

Everyone I knew was talking about it, and half the people I knew were leaving their jobs on a temporary leave or permanent leave to work on it. It was what so many of us dreamed of. It was where the action was. It was pretty wild, but all under the umbrella of people knowing that they had an opportunity to do good that might not come so often again. That part I didn't realize yet. It was a very misleading orientation to what government could be like. There's been nothing like it really since then, where if you had a good idea there was usually money to try it out. And support to flesh it out and make something out of it. That is not the usual atmosphere in government (Pers. Com. 4/13/18).

Nelson Cruikshank only agreed to let Bamberger leave when Medicare legislation had passed one house of Congress, but the OEO was working out of the New Colonial Hotel only two blocks away, and things usually got started there in the late afternoon when work at the AFL-CIO was winding down. Bamberger therefore was able to work at both places until Medicare passed the House by a vote of 313-115 on April 8. Bamberger's familiarity with macro-level aspects of healthcare programming and her experience with developing consumer-oriented support for such programming would push the OEO's interest in health toward system reform and redesign.

"What we were hearing was from people who wanted us to plug little holes," Bamberger said of the initial proposals coming into OEO. "You know, they were finding that when they

were setting up training programs, people couldn't pass the physicals, and couldn't we do something about free physicals. It was very unimaginative what we were being asked for money for, and there was no strategy there at all. And we knew that we wanted a strategy and we wanted a strategy that would change health care for poor people" (Ibid). In fact, one of Bamberger's first assignments at OEO was a direct request from Sargent Shriver to somehow turn a dry and unimaginative proposal from the Chicago health department into something he could fund. No doubt because of political pressure, Shriver's cover letter simply said, "Fund it please" (May et al. 1980, 113). With the help of Jule Sugarman, who had connections to Joyce Lashof at the Department of Preventive Medicine at the University of Illinois College of Medicine, the OEO commissioned a "study of health needs" that ultimately led to the opening of the Miles Square Health Center in 1967. This type of request likely made Bamberger's first meeting with Jack Geiger all the more refreshing. "When I said, 'a wild man appeared in my office'<sup>38</sup> he *did* seem pretty wild and was over the top on everything, but what he said made so much sense, and it was such a great fit for what we were hoping for. It was the first time someone from the outside was suggesting something that would make fundamental changes" (Pers. Com. 4/13/18). After listening to Geiger describe his health center plans, Bamberger set up time for Geiger to talk with Sandy Kravitz, a veteran of Dave Hackett's "guerillas" who had recently taken charge of community action research and demonstration and training programs.

Sandy Kravitz, whom Shriver came to refer to as "Doctor Strangegrant" for the peculiar projects he would recommend, offered a receptive ear for Jack Geiger's proposal. It met all the criteria Kravitz and community action advocates had developed in response to the burning question the planners for the War on Poverty had: "What kind of program can be developed that

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<sup>38</sup> (Schorr and Schorr 1988, 130)

provides a counterattack across the total spectrum of need at the local community level?” (Kravitz and Kolodner 1969, 34). Kravitz also understood the urgency of program implementation from his experience with the PCJD (President’s Committee on Juvenile Delinquency). “The waiting for a group of professionals to study the problems for a year and then to generate action programs had evoked great impatience in most communities.” To counter this concern, he “labeled planning as ‘program development’... This meant that without waiting for a fully developed ‘conceptual framework’ for its anti-poverty effort, the community could begin immediately to implement a program, provided it could justify its relevance to the problem of poverty” (Kravitz 1969, 60-61). Funding the centers through the research and demonstration division of the Community Action Programs offered an additional advantage: it would leave the potential number of health center sites open-ended and would encourage health center development to cover broad geographic areas to appropriately “demonstrate” the positive impact of the program (Hollister et al. 1974, 8). Geiger would describe how these ideas played out during his first meeting with Kravitz in late January 1965:

Everybody needs to have this experience at some point in life. I came with a yellow pad and talked non-stop for the better part of an hour. Making notes on this yellow pad to describe what a community health center was and should be, and how and what the models were, and so on. At the end, Kravitz said, “Well how much do you want?” I did the classic academic sidestep shuffle and said, “Well, I think the smart way to go would be to have \$30,000 for a year’s feasibility study.” Total bullshit. I mean, you know, this is the way to temporize rather than do it. He said, “You can’t have it.” And I said, “Why not?” He said, “You’re going to take \$300,000 and do it now.” I had no idea what a real budget would be. I went back to Boston and met with Count, and I think it was at that point to sit down and do a real budget that we realized that, if Tufts Medical School was going to do a project 1,500 miles away in Mississippi – that predictably, there is going to be two sources of screaming and protest. One - the whole power structure in Mississippi. Two - poor people of Boston. Count, as part of his department, had already had a small program at Columbia Point Housing Project for training students in chronic care. So Columbia Point immediately came to mind. It was this isolated project on a peninsula sticking out into Dorchester bay separated by a big railroad line and a big highway from getting into Boston. Columbia Point immediately came to mind, and we realized we had to add Columbia Point. I did a budget. I can’t remember the initial amount, but it was on the order of -- Exactly, but it was on the order of a million, 1.2 million for the two health centers (Pers. Com. 4/13/18).

Gibson recalled Kravitz's reaction to the presentation of their "planning grant" slightly differently: "Sandy stared at us after we went through this routine. And he paused and said, Well, we don't believe in planning grants around here very much. There is a war on! A war on poverty! If you would agree to open a health center in a year, would you take a million dollars?" (Gibson quoted in May et al. 1980, 115). Despite the enthusiasm of Bamberger and Kravitz, the debate over emphasizing comprehensive health services as opposed to plugging specific gaps was hardly decided. The costs associated with such a program were considerable, and recruitment of health professionals into impoverished areas was a daunting task. The Public Health Service recommended simpler, more focused programs that might address specific, narrowly defined health concerns such as vision or hearing (Levitan 1969, 193). Additionally, Sargent Shriver still had the final say over all the OEO grants and viewed the "motley crew" of Bamberger and Kravitz with some suspicion. "Shriver was a very personal kind of manager, and if he didn't know you personally he didn't see any reason to trust you," says Bamberger. "Eunice Shriver sat in on staff meetings when we finally did get our own building. He [Shriver] put some sculptures from his home into the lobby. There weren't a lot of boundaries for him. But of course, once you were in the "in-group," which I ultimately became part of, it worked nicely. It's just not the way the textbooks tell you that large agencies should be administered" (Pers. Com. 4/13/18). To advocate for the project Bamberger sought out the support of Dr. Julius "Julie" Richmond, who had recently joined OEO from Syracuse Medical School to direct Head Start. He would lend her "an aura of legitimacy." Together they persuaded Shriver that the ideas behind Geiger's health center warranted a major dedication of resources (Ibid).

At Richmond's memorial service, some forty-three years later Bamberger would emphasize how critical his support of the program was: "It took me about five minutes to

discover that with this man's help, there was a real prospect of making the poverty program into an engine for fundamental reform of health care for the poor" (Schorr 2008). Dr. Joseph English, who had transferred from his position as medical director for the Peace Corps to OEO in 1966, remembered Richmond similarly. At one point, he managed to arrange an appointment with Ladybird Johnson, and as he was describing the wonders of the Head Start program she began to doze off. Changing tactic, Richmond mentioned one of the terrible illnesses he had encountered in some of the Head Start children. This immediately got the First Lady's attention. Her elder daughter had apparently experienced the same illness in her youth. "What does a poor woman do if her child has this illness? Wrecking her school? And what does this program (Head Start) have to do with that? If you tell me that, then you have all my support," she told him. "Well," said Richmond, "first discover it and then treat it early." The encounter generated about 200 million for the Head Start program (Pers. Com. 1/26/18). With Richmond's support, OEO eventually funded the health center proposal for \$1,168,000 on June 24, 1965 (Gibson and Geiger 1965, 18).<sup>39</sup> The Denver War on Poverty, Inc. proposal would be funded for \$850,000 in August of that same year (Institute of Medicine 1982, 88).<sup>40</sup>

The final "Tufts Comprehensive Community Health Action Program" proposal put together by Drs. Gibson and Geiger identified two sites: one at Columbia Point in Boston and one in "an unnamed southern state" (Lefkowitz 2007, 9). It sought to "intervene in the cycle of extreme poverty, ill health, unemployment and illiteracy by providing comprehensive health services, based in multi-disciplinary community health centers, oriented toward maximum

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<sup>39</sup> A Poverty Program Information guide published by the OEO describing the status of programs as of January 1, 1966 lists the funding date for the Tufts CAP Demonstration Grant as April 2, 1965 (U.S. Office of Economic Opportunity 1966).

<sup>40</sup> The Gouverneur Health Services Program would receive a grant for \$661,000 on February 1, 1966 (Light and Brown 1967, 387).

participation of each community in meeting its own health needs and in social and economic changes related to health” (Geiger 1972, 164). The outline of the proposal runs to almost five pages. It covers clinical services, environmental health services, community health action programs, training and education services, programs operated by the local health council, special programs jointly sponsored by the health council and the health center, local hospital services, and town-specific services (Ibid, 159-64).<sup>41</sup> Institutional transformation lies at the heart of what Gibson and Geiger were proposing: “the need is not merely for the provision of more preventive and curative health services, but also for the development of new organizational patterns to make the distribution of such services uniquely effective for severely deprived populations... The need is not for the distribution of services to passive recipients, but for the active involvement of local populations in ways which will change their knowledge, attitudes and motivation...” (Ibid, 165). But more to the point, Gibson and Geiger sought to change a narrow understanding of health to a broader one. To do so, they did not redefine “health” but rather focused on the more elastic concept of “need.”

While Geiger worked through revisions to his final proposal, he was teaching the staff at OEO to speak this evolving language: “As he was writing his proposal, he was informing our description of what our neighborhood health center program would be,” commented Bamberger (Pers.Com. 4/13/18). By October of 1965 Bamberger would be able to describe new relationships between existing health departments and community agencies, in which increasingly “we will see needs filled by laymen – needs which we have assumed could only be served by professionals, but which cannot wait until we have enough professionals to get to them” (Bamberger 1966b, 598). Through continued work with Gibson and Geiger, the CAP

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<sup>41</sup> For a full outline of the proposal see Geiger 1972.

office at OEO would produce a relatively consistent four-point model for what neighborhood health centers would look like. First, they would consist of a one-door facility in which virtually all ambulatory health services would be available. Second, they would maintain close coordination with other community resources. Third, they would develop relationships with professional physician groups (hospitals). And fourth, they would include intensive participation from the population to be served, who would “help plan the center’s program and make sure it [was] responsive to the needs of residents” (Bamberger 1966a, 1143). But looking back on the matter in 1972 she would write that the number one characteristic of the neighborhood health center was a “focus on the needs of the poor” (Schorr 1972, 140). In Bamberger’s assessment, “needs” supersede the more narrowly understood concept of health. As the program continued to develop, the emphasis on need as the driving force behind the program would continue.

Gibson and Geiger had decided on Columbia Point as the site for their first health center in large part because of its existing ties to Tufts. Through its affiliation with the Home Medical Service of the Boston Dispensary, the university had a long history of experience with urban health problems like those present at Columbia Point and could readily establish a health center in a renovated apartment housing unit, sponsored in part by the Boston Housing Authority (Gibson and Geiger 1965, 18). Gibson’s program with the Housing Authority was already sending fourth-year medical students to do home visits at the housing projects in Columbia Point, so the process of rapidly implementing the program had the potential to go more smoothly. In addition to these practical advantages, Geiger would note, “the population seemed to fit the need profile” (Lefkowitz 2007, 52-3). So, on a foggy snowy Saturday, December 11, 1965, the Columbia Point health center celebrated its opening with a well-attended ribbon cutting ceremony. Following a performance of the Star Spangled Banner by mayor John Collins’

daughter Patricia, and an invocation by Episcopalian bishop John Burgess, Dr. Gibson proceeded to introduce several notable guests including Sanford Kravitz, Lisbeth Bamberger, and Julius Richmond from the Office of Economic Opportunity. Drs. Gibson and Geiger both offered remarks. Gibson quoted from Psalm 127 and asked that the Lord watch over the city of Boston and help the program in its watchful vigilance. Geiger noted that the attendees were opening more than a building, but also “launching an idea.” He continued to expound upon the “ideas and beliefs” that informed the development of the program, explaining the \$3 dues for joining the health center association as a reflection of the costs that residents might otherwise incur from a taxi ride to the emergency room in the middle of the night. “We think of hope not really as a matter of illness or the lack of it, not merely as a matter of having doctors and nurses and facilities. We believe hope involves how people live, what they do, what they feel and think, what they eat and their environment inside the home and out.” He concluded by emphasizing the role of community participation in the program: “Now, a department store doesn’t ordinarily invite its customers to help run the store, why do we? Because this is not a store but a community program. Because you are not customers and not just patients, but partners with important ideas, skills, and knowledge of your own lives and needs and communities to contribute.”

The event also offered insight into the hopes the OEO staff had placed on the program. Dr. Richmond spoke to the audience about the confidence they had in the program’s capacity to serve as a model for other communities to follow: “We think that all of you in this community will be kept busy in the next few months and years showing visitors around. We know that in the tradition of health workers everywhere, the staff of your center will be happy to have your work observed and duplicated in other communities.” (Geiger n.d.). His confidence was well-founded, for the event was attended by several luminaries of Boston’s political establishment



including the majority leader of the Massachusetts House, Robert Quinn, and the Speaker of the U.S. House of Representatives, John McCormack. McCormack had become familiar with the proposal to establish the program when Jack Geiger and Sandy Tredinnick Jr. (Vice President of Development from Tufts) visited the Speaker at his office in Washington. Speaking to the attendees of the ribbon-cutting, McCormack indicated that the health center would serve the residents of Columbia Point, but that its existence had “far greater meaning and significance” (Ibid). McCormack also emphasized the fact that while the medical center was new, it would become permanent, and was experimental only in the sense that “the advances made therefrom in the field of medical research [would] be given to all mankind” (Ibid). He praised the work and vision of Tufts University and referenced with pride his receipt of an honorary degree from the school, and his first-hand knowledge of “sub-economic standard conditions.” As Speaker, McCormack was well positioned to press the political advantage of a project that hit close to home. Robert Quinn lavished praise on McCormack in his comments on the opening of the health center, saying: “You’ve done it again, Mr. Speaker, here with the health action program just as you did it a generation ago when Boston was one of the first with a public housing development to replace slums. You’ve done it again and again, and I think we fail to appreciate you because we’re so accustomed to your excellence, but I thank you profoundly on behalf of our neighbors at Columbia Point” (Ibid).

The opening ceremony at Columbia Point reveals the idealism of its founders, but it also marks a turning point in national-level political recognition. It placed the health center program in the district of the most powerful person in the U.S. House of Representatives. That very fall John McCormack’s nephew, former Massachusetts Attorney General Eddie McCormack, had been testing the waters for a gubernatorial run in Massachusetts in the fall of 1965. Eddie had

been defeated in a brutal senate primary with Edward “Ted” Kennedy in 1962, and the upcoming 1966 race would pit Kennedy insider Kenny O’Donnell against McCormack. Such a race had the potential to reopen the wounds of a smoldering political feud between the two most prominent political families in Massachusetts. Just three months prior to the opening of Columbia Point, John McCormack had reached out to the youngest Kennedy to garner support, or at least keep him neutral, in the gubernatorial race. McCormack went so far as to take the unorthodox step of testifying in a Senate committee on behalf of Ted Kennedy’s shortsighted nomination of Francis Morrissey as a Massachusetts district judge.<sup>42</sup> *Washington Post* columnists Novak and Evans took note of McCormack’s unusual support noting in October of 1965 that “Speaker McCormack is bending over backwards to be nice to Teddy Kennedy and keep him neutral – maybe even pro-McCormack. He opposed President Johnson earlier in supporting Kennedy’s anti-poll tax amendment” (Evans and Novak 1965). McCormack would continue to cultivate Kennedy’s support on behalf of his nephew throughout 1965 and 1966. This ultimately resulted in a Kennedy-McCormack “unity” session in the summer of 1966 (Nelson 2017, 697). The dissolution of the feud may also have drawn Ted Kennedy’s awareness to local matters occurring within McCormack’s district.

When the Columbia Point health center opened in December of 1965, Senator Ted Kennedy had already held the junior seat from Massachusetts for three years. In that time, he had mostly remained focused on local Massachusetts business issues and cozying up to senior southern senators who held the keys to various committee assignments (Clymer 2009, 46-7). From June until December of 1964 he was hospitalized from injuries he sustained in the crash of his private plane in Southampton, MA. His convalescence gave Kennedy uninterrupted time to

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<sup>42</sup> Morrissey was a Joseph Kennedy loyalist whom the younger Kennedy felt a duty to support despite his failure to pass the bar exam and his graduation from a dubious “diploma mill” law school (Clymer 2009, 71-2).

become more familiar with economics and political science (receiving seminars from Kenneth Galbraith and Samuel Beer respectively). He also gained direct insight into healthcare issues and the hardships of illness and disease, coming to the realization that “access to health care was a moral issue” (Kennedy 2009, 225). All that remained was to find a vehicle to channel his newfound passion into legislative action.

### **1966: Turning Point(s)**

1966 would be a momentous year for community health centers. By early spring the health centers at Columbia Point and in Denver were up and running and the response, at least in terms of utilization, was overwhelming. At Columbia Point some two hundred patients a day were streaming into the health center (Lefkowitz 2007, 53). Amendments to the Economic Opportunity Act were introduced and referred to committee discussions in Congress in April, and at in June Lisbeth Bamberger received a phone call from David Burke, Ted Kennedy’s chief aide, expressing interest in learning more about the OEO’s neighborhood health centers. How Ted Kennedy first learned about the health center at Columbia Point is not entirely clear. Speaking at the center’s first anniversary on December 11, 1966, he would indicate that he had followed the efforts “closely over the past year” (Kennedy 1966). That timeframe makes it entirely possible that his ongoing relationship with Speaker McCormack introduced him to the local matters developing at Columbia Point, especially given McCormack’s work with public housing projects on Boston’s South Side. In his posthumously published memoir *True Compass* Kennedy would indicate that Drs. Gibson and Geiger had attended “one of the semi-regular policy dinners” that he held in 1965, in which they discussed a plan for community health centers (304). But Geiger recalls meeting Kennedy for the first time in 1966 (Pers. Com. 8/8/17). The easiest guess is that he would have learned everything he could want to know about

the OEO from his brother-in-law (Sargent Shriver), and the two certainly worked together on various legislative initiatives including the special Senate Committee on Aging in early June 1966. What is certain is that Kennedy had familiarized himself sufficiently with the OEO and the Columbia Point health center to ask Mitchell Svidoff from the National Association for Community Development about the program during his testimony on June 22:

Finally, the House bill decreases from 15 to 5 percent the amount of community action funds allocated for research and development. I know that there have been many innovations which have been achieved from these research funds. We see this in the Columbia Point Health Center in Boston, which I believe you are familiar with. From your own knowledge, would you say that these research and development funds have been extremely productive, or would you give us at least some comment on the usefulness of this kind of research and development and any recommendations you may have (The Economic Opportunity Act Amendments of 1966, 180).

It is telling that Kennedy's question speaks closely to the nature of the Title II (Community Action Program) funding stream. The house bill had not only reduced available funding to title II, but had also placed restrictions on how the money should be spent. At a later point in Svidoff's testimony Kennedy decries these changes saying, "to limit large sums of money to fixed categories will deal a grievous blow to the principle of local determination and local flexibility" (Ibid, 187). The general thrust of the inquiry is whether or not the flexible programs funded by Title II (demonstration activities at OEO among them) warrant continued funding without categorical restriction. The discussion about Columbia Point has more to do with the relative merits of innovation coming out of Title II's R&D arm, than a more clearly articulated concept of health care service delivery.

The Title II projects (Community Action Program) were controversial from their very inception. Southerners either aggressively rejected them for their association with civil rights activities (Strom Thurmond) or carefully avoided any association with them for fear of political repercussion (Lister Hill). Lyndon Johnson was startled when he realized what they were, when

they were included in the Economic Opportunity Act (EOA). Local political figures from across the political spectrum (mayors in particular) feared that the projects would create militant politically active groups. Chicago's Mayor Daley bitterly protested an OEO grant that bypassed the Chicago Commission on Opportunity, a CAP he had founded at the outset of the War on Poverty. Backlash against CAPs resulting from racial resentment were also not uncommon. Robert Clark recalls working for a CAP in Mississippi called STAR, Inc. that provided job placement and education services for predominantly black low-income residents. The complaints at the offices headquarters mostly came from white middle-class families bemoaning the loss of readily available maid services to the employment opportunities that the CAP was providing (2002, 91). When the 1966 EOA amendments came up for debate in the Senate later that year, some of the most heated discussion focused on the inclusion of an amendment offered by Harry Byrd (D-VA) prohibiting payment, assistance, or services to "any individual who incites, promotes, encourages, or carries on, or facilitates the incitement, promotion, encouragement, or carrying on of, a riot or other civil disturbance..." (The Economic Opportunity Act Amendments of 1966 Congressional Record, 25146).<sup>43</sup> Johnson staff assistant James Gaither noted that people working on the poverty program tended, over time, to de-emphasize the community action label: "Community Action struck most people as a violent kind of movement. I think if you look through the presidential messages, you might find Community

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<sup>43</sup> In a remarkable rebuke to Jacob Javits's opposition to the amendment (who argued that it was fundamentally unfair to place authority to determine violation of the restriction in the hands of the OEO director) Richard Bevell Russell, Jr. (D-GA) stated that he would formerly have agreed with Javits, but that with the advent of civil rights legislation the nature of administrative authority over local programming had been fundamentally altered: "the Congress has now passed laws which put in the agencies of this country the power, administratively, if they find that any school has an improper proportion of teachers as to races, or hospitals as to races, to deny them any funds without any legal action being taken at all other than administrative findings" (The Economic Opportunity Act Amendments of 1966 Congressional Record, 25147).

Action mentioned once. In fact, we described what was happening in the program but we didn't use labels" (Gaither 1980, Interview V).

Sargent Shriver became worried that criticisms related to the implementation of the CAPs would overwhelm the hugely popular and successful programs such as Head Start, which had successfully been implemented with lightning speed for an eight-week summer session in 1965, serving approximately 560,000 children (Vinovskis 2005). Shriver also faced pressure to obligate its entire appropriation by the end of the 1965 fiscal year, and he had begun to prepare program applications on behalf of CAPs in order to dispense its funds more rapidly (Clark 2002: 51). So as Congress prepared to debate the 1966 EOA amendments, Shriver called on Joseph English and Julie Richmond to help him strategize a way forward. On July 14 - Bastille Day - Shriver brought Richmond and English to a French restaurant not far from OEO headquarters on 19<sup>th</sup> and M and ordered a very nice bottle of champagne.<sup>44</sup> "This is the essence of what he said," recalls English: " 'The poverty program is failing,' said Shriver, the Community Action Programs were a zoo... they were getting into military actions against local governments, Congress was going out of its mind and submerging all the good that was being done. 'The problem that is pervasive everywhere is health,' Shriver continued, 'and you guys are approaching it differently. What I want you to do is to start a major health initiative in the Poverty Program. Julie, you have the seniority, and Joe will protest because he's only a couple years out of his residency and he shouldn't be doing stuff like that. But you got him covered.' You could not resist this man" (Pers. Com. 1/26/18). Shriver initially wanted to put the program under Community Action Programs, but English refused, telling Julie Richmond "Do that and I can't do it. I'm only going to do this if I can help. That place is such a disastrous bureaucracy

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<sup>44</sup> Stossel (2004) reports this as 1965, which would be unlikely given that English only came to OEO in 1966.

that will never... If the health programs are associated with that, there's not a reason to spend any time. We have to have total flexibility" (Ibid). The strategy of culling the health programs out of Community Action served the organizational demands of OEO's leadership. It also spoke to a pressing need for political support. But regardless of the rationale, the decision to move health programs away from Community Action was the first tiny step away from the relatively free-form organization that had characterized the OEO in its infancy and toward one of a more mechanical nature. David Burke's phone call to Bamberger would be the next.

Hired by Kennedy the previous year, University of Chicago trained economist David Burke had a perfect mix of intellectual talent and street smarts likely inherited from his father, a Boston police officer. He quickly helped Kennedy establish a capable staff that began pursuing potential legislative agendas (Canellos 2009, 112). Burke soon learned that if Kennedy was talking to him about something, it meant he had an expectation that he (Burke) was going to do something about it. So, when Kennedy began talking to Burke about health care, he began setting up meetings in Boston with all sorts of folks:

I got stuck on neighborhood health centers and he got stuck on neighborhood health centers because doctors in Boston were talking to him about it – it's a good idea. But there was some federal funding going into health centers. I found a woman... and her name was Lis Bamberger. I'd call her up, talking to her about neighborhood health centers, and she finally interrupted to say, 'You know, I have to tell you something, David Burke, and I don't even know you. But you're asking all the wrong questions'. I said, 'Oh, what should I ask you?' 'First you should ask me- 'Then she gave me questions. And that's where I got all my information" (Burke 2007, 19-20).

At OEO Lisbeth Bamberger was complaining to Julie Richmond about how she had simply too many demands on her time and how she'd had a call from David Burke in Senator Kennedy's office, asking if she might come up and see him, and how with everything that was going on she just could not do it (Schorr 2008). Julie Richmond became deadly serious. Softly yet earnestly he told her: "You cannot be doing anything more important than going and meeting with Ted

Kennedy's office.” (Pers. Com. 4/13/18). Bamberger quickly got in touch with Burke and made an appointment to see Kennedy along with Julie Richmond and Joseph English.

“What I knew was that Ted Kennedy, very young, full of vim and vigor, and his brother Bobby was already the Titan on the Hill, really looking for something to do. What he decided to do was to introduce legislation that would've put health programs into all of the OEO efforts, would mandate them to have it” (Pers. Com. 1/26/18). The idea recalls some of the early OEO health proposals where people responsible for running Job Corps, Youth Corps, and Head Start programs were facing an impossible task in terms of getting services to the recipients because so many of them had debilitating health problems and few had ever seen a doctor. Richmond, English, and Bamberger thought that creating health programs within each OEO program would be a fantastic waste of money because they would likely identify underlying pathology without providing them with doctors capable of actually treating the problem. “We're having this Friday afternoon visit, and I knew Ted well - Ted was struggling to stay awake. All he wanted to do was get on a plane for the weekend,” recalled English, “Then, either Julie or Lee, sure it wasn't me,<sup>45</sup> said ‘Look, enough words, there's one [health center] in Boston you ought to go see, and it's at Columbia Point, and by the way, I think that's McCormack's district, and Mr. McCormack is the Speaker of the House of Representatives. So, with all the rest of the stuff that would go on at Hyannis Port that weekend, Teddy goes to Columbia Point. You wouldn't think that would be so impressive?” (Ibid). David Burke similarly commented on the way Kennedy got involved in certain issues:

He gets involved in them in a strange way, and it's usually not grand – it's some things are very important. We spend a whole day touring this neighborhood health center in Columbia Point in Boston... And what came out of that visit – it was obvious, if you could have a neighborhood health center in the middle of poverty, it's got to be beneficial. But what was obvious to him was that they're going to work and they're wonderful, because for nursing

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<sup>45</sup> Clymer suggests that the visit came at the urging of English and Richmond (2009, 83).



mothers, they have rocking chairs. And we should remember to put that in any building, there always has to be rocking chairs and a provision for it in maternity sections of neighborhood health centers. That was so important. I loved it, I mean, that will make you stay up late working on a bill (Burke 2007, 20).

Geiger had called Gibson, who was vacationing in Maine at the time, to see if he would come down for Kennedy's visit, but he did not want to leave his family so Geiger conducted the tour alone. "We made arrangements to have dinner that night in Boston, in one of the hotels. We had dinner and discussed the outlines of a bill to create an office of health affairs within OEO. Just him and a staffer" (Pers. Com. 8/8/17). The staffer, almost certainly Burke, had already received a primer on community health centers from Bamberger and was prepped with all the information he could possibly need on the various parts of the Economic Opportunity Act amendments coming up for debate, the appropriations from the previous year, etc. Having been sold on the idea in person, Kennedy was ready to take legislative action on what he had seen at Columbia Point.

By the following Monday David Burke got Joseph English on the phone. "Joe, you got to be in an executive session of the Senate Tuesday morning, 11:00 o'clock because Ted is going to introduce legislation that makes the Neighborhood Health Center program a formal component of OEO and he's going to try to get you a hundred million dollars for it. Unbelievable." (Pers. Com. 1/26/18). English knew both Ted and Bobby Kennedy, who would be at the session having spent time at the White House assisting Sargent Shriver with JFK's funeral arrangements. But a request to testify startled English, who tried to explain to Burke that he did not yet formally work for the OEO, but Burke swept aside his concerns. "He wants you there and he will introduce the legislation and then he wants you to speak" (Ibid). English had reviewed some proposals by that point, but had never seen a neighborhood health center, and had not even been to Columbia Point. Unlike a public hearing, this meeting involved only senators and staffers and was held in the slightly cramped Senate committees' meeting room (Dun

Gifford 2005, 12). When a nervous English showed up that Tuesday, Don Baker, the general counsel for OEO, looked him up and down and bluntly asked him, “What the hell are you doing here?” English could scarcely stammer out that he had been instructed to be there by Burke when the hearing began, and English immediately began fielding questions from the chairman, Senator Joseph Clark, Jr., of Pennsylvania (Pers. Com. 1/26/18).

After working in a description of his medical training, and the fact that several medical professionals were employed at OEO, English emphasized the medical component of the health centers. He had grown up in Philadelphia and so he appealed to Clark’s recollection of an old set of public health clinics he had overseen during his time as mayor there, and he told Clark that what Ted Kennedy was proposing was to take what Clark had done for Philadelphia and upgrade it, and extend it to poor people all over the United States. “Thank God Don Baker and I were good friends,” English recalled. “Don Baker could have said ‘I don’t know who this is, he has no authority to speak for the U.S. poverty program’, but he didn’t, so needless to say we became great friends” (Ibid). Marcus (1981, 15) argues that the legislative history of the amendment “reveals no opposition to this significant expansion,” but the accounts of Joe English and Kennedy aide Klivert Dun Gifford demonstrate that significant opposition had to be overcome through closed subcommittee sessions. The lingering issue was the issue of Title II and the character of the community action projects. Dun Gifford suggests that the southerners and Republicans pressed the question of “what else” the centers were going to do beyond health care delivery:

The vote breakdown was close. It was fifty-fifty. The Republicans were scared of the poverty program because they knew it had a political side to it, not overtly, but that people were coming together and feeling their power. It didn’t have to be Democrat or Republican power; it was going to become political power if you enabled them to come together around programs and buildings. You’re either against that, or you’re for that. There’s not much middle ground” (2005, 12).

They pressed the question of what the ulterior motives of the program were. “What’s this ‘Power to the People’ business? What’s all this about?” they said. “Oh, that’s nothing to do with our neighborhood health centers,” Ted Kennedy responded. “Yeah?” The questions then turned to Bobby Kennedy: “What about this farm workers thing? Are they going to try to unionize the farms? Aren’t you marching with those people, Bobby?” (Ibid). The implication was that whatever the program was that they were proposing, it was sure to have a political side to it. But between the intensity of Bobby and the more laid-back approach of Teddy the authorization passed. “The legislation just came together, seamlessly. In terms of the interaction between the two of them (Teddy and Bobby Kennedy), they used the differences effectively. If Bobby was hard and pushy, Teddy was negotiating and teasing. It was very effective... but that’s not to say that Senator Joseph Clark and others on that committee weren’t there with them too. They were. I’m not saying it was only the two of them at all. But they were sure the stars of that long tense morning” (Ibid, 13).

The introduction of Ted Kennedy’s amendment to Title II of the Economic Opportunity Act stands out as a critical turning point for community health centers for a number of reasons. Most obviously the amendment sought to authorize \$100 million for the creation of approximately fifty health centers, and it had its sights set higher in terms of the total number of centers that would be formed throughout the country (May et al. 1980). Considering that allocations for health centers in 1965 came to approximately \$2 million, Kennedy’s proposed authorization radically altered the vision and perceived scope of OEO health programs (Levitan 1969, 192). Structurally the amendment carved health centers out of the general category of “community action” and created a narrower subsection of Title II in the EOA specifically to

authorize creation of “comprehensive health services programs.” Section 211-2 of the enacted legislation reads as follows:

#### COMPREHENSIVE HEALTH SERVICES PROGRAMS

SEC. 211-2. (a) The Director is authorized to make grants to, or to contract with, public or private nonprofit agencies in order to provide assistance necessary for the development and implementation of comprehensive health services programs focused upon the needs of persons residing in urban or rural areas having high concentrations of poverty and a marked inadequacy of health services. Such programs shall be designed—

(1) to make possible, with maximum feasible utilization of existing agencies and resources, the provision of comprehensive health services, including but not limited to preventive medical, diagnostic, treatment, rehabilitation, mental health, dental, and follow-up services, together with facilities and rehabilitation necessary in connection therewith; and

(2) to assure that such services are made readily accessible to the residents of such areas, are furnished in a manner most responsive to their needs and with their participation, and wherever possible are combined with, or included within arrangements for providing, employment, education, social, or other assistance needed by the families and individuals served.

The language emphasizes that the Director of the OEO shall consult with health agencies in order to ensure that the program is carried out under “competent professional supervision.” Such direction reflects Kennedy’s arguments to his fellow senators in which he emphasized that the health center program “should be considered separately from other War on Poverty programs, that it was ‘run by professionals’, that it was free of corruption” (Sardell 1989, 67). It also recalls Joe English’s discussion with Sargent Shriver and Julie Richmond in which he insisted on removing health programming from the aegis of community action. Whereas previously the structure of the health center programs had an informal sense to them, the Kennedy amendment made the program more rigid, and more explicitly defined in terms of its characteristics and scope. Despite gesturing at the term “comprehensive health services” the legislation makes it clear that the broader social program envisioned by the Gibson-Geiger model would only be provided “wherever possible.” Community participation is downplayed, and the services are henceforth to be made available to residents primarily “in a manner most responsive to their

needs” and secondarily “with their participation.” The language for the amendment was drafted by Kennedy staff in close collaboration with OEO officials, a process that would continue in subsequent updates to health center legislation (Sardell 1989, 66).

### **Kennedy Amendment Fallout I**

Kennedy’s amendment wrote health centers into the books of law on a national basis for the first time. Yet in so doing it also constricted the broad social vision that accompanied the earliest health centers. In a process Kenneth Burke (1984) terms “bureaucratization of the imaginative,” the pure aims of the “wild” set of notes that Geiger had scribbled on his yellow pads for Sandy Kravitz were now channeled into law.<sup>46</sup> There is a tendency to interpret the Kennedy amendment strictly from the perspective of “health care,” but in context it speaks to a broader shift in the political fortunes of the poverty program as a whole. Shriver was rightly concerned about the fate of the entire effort that summer. Just a week before the subcommittee meeting Senator Harry Byrd, a conservative southerner from West Virginia, ordered an entire newspaper column titled “Time to Recognize Antipoverty Program as a Flop” be inserted in the federal record. The column excoriated the program and described “the endless feuds and dissensions, clashes between politicians and the poor, lack of involvement of the poor at all levels, fiscal irresponsibility and chicanery, high salary grabbing, waste, mismanagement, abuse of funds, and other scandals” (U.S. Congress 1966, 19529). Kennedy’s visit to Columbia Point that very week sought to change the political fortunes of the program by, in essence, de-politicizing the nature of the health service component of the program by culling it out of the other CAP-sponsored activities. Health center funding at the federal level was secured, but it had been achieved through political negotiation and compromise that threatened the very concept of

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<sup>46</sup> Ironically Kravitz would leave OEO in 1966 (Lefkowitz 2007, 10).

community action on which the program had initially been founded. Whereas some have argued that the 1966 amendment to the Economic Opportunity Act “reveals the increasing pressure to dilute the impact of the War on Poverty in general, and health services in particular,” (Marcus 1981, 15) the amendment had quite the opposite effect. The earmarks for neighborhood health centers increased pressure concentrated on the positive impact and benefits of health services specifically as a means to strengthen the appeal of the War on Poverty generally.

Shriver immediately recognized the essential change that Kennedy’s amendment could have on the character of poverty programs. In an internal directive to Edgard Cahn, from August 24, 1966, Shriver instructed his assistant to “get up a thorough memo to be sent to all Regional Directors, top Washington staff, CAP Regional people, Legal Service liaison men in the regions, Head Start regional people, ‘Upward Bound’ personnel – Purpose of the memo: -- to explain that all these medical, ‘Head-start’, ‘Legal’ etc., ‘specialized’ programs gain their vitality and legitimacy because of and to the extent that they obtain ‘maximum feasible participation of the residents of the areas and of the groups to be served’ – e.g. the Houston Legal program, the Watts Health Center, etc. Such a memo is urgent: -- 1) In light of LBJ’s call to increase legal service programs there’s a danger they may devolve into paternalist, legal aid, charity-type enterprises. 2) In light of Senate subcommittee action yesterday adding \$100 million to Title II for health centers in the poverty neighborhoods same as above could happen to these centers” (Shriver “Personal Papers”, Box 40). A pressing fear was that Kennedy’s amendment threatened the original principles on which the War on Poverty was based. As “the business corporation of the social revolution,” Shriver had relied heavily on CAPs to roll out his poverty programs on a massive scale. Now, despite his exhortation to abide by CAP requirements, the genie was already out of the bottle, or perhaps better stated, the genie was being forced back into it. Given

the amount of political fallout and heat Shriver had been taking, this might have come as a relief. Following the final adoption of the EOA amendments by Congress in October, Shriver was able to tell Daniel Patrick Moynihan: “I think we shall endure because up until now we’ve been attacked by the Right and the Left, the Republicans and the Democrats, the bureaucrats and private citizens, and yet we’re still alive. Unless some unknown assailant suddenly appears, I think OEO will continue to fly” (Shriver “Personal Papers”, Box 42). Kennedy’s amendment had helped fend off these attacks in part by achieving bipartisan acceptance of the health center program. Kennedy had also launched his own career as a master of Senate congeniality and compromise, but such action was not without consequence.

Shriver had been enduring a delicate political balancing act for some time prior to Kennedy’s decision to support the health center program. The application that Jack Geiger and Count Gibson ultimately developed under the auspices of Tufts University introduced an ongoing aspect of the community health center program: political and congressional negotiation. The Tufts proposal identified two sites: one in Boston at Columbia Point and another at an unspecified “southern state” (Lefkowitz 2007, 9). Whereas the Columbia Point health center commenced operations with limited (if any) local objection, similar receptiveness would not be forthcoming at the southern site. The political wisdom at play in not disclosing the “southern state” meant that the application would not require extensive review by southern congressional delegations, given the potential opposition these might have toward programs designed specifically to help poor blacks (Ward 2017, 6). OEO’s Head Start program grant to the Child Development Group of Mississippi (CDGM) in particular had raised the ire of Mississippi Governor Paul Johnson, who labeled the program “an effort on the part of extremists and agitators to subvert the local authority in Mississippi and to create division and dissension

between the races” (Mills 1998, 66). In 1966, several months after the establishment of the first site at Columbia Point, Geiger finally decided on Mount Bayou MS, as the southern location for the Tufts program. Sargent Shriver, facing enormous pressure from the governor, local politicians, and press, ordered Geiger to suspend the program in March and refused to discuss the matter with him further (Ward 2017, 18). Shriver’s decision was not an isolated one. He had initially objected to the Denver War on Poverty, Inc. proposal “because of the OEO’s vulnerability in the Republican-dominated landscape of Colorado” (Langer 1966, 511).

In response to Shriver’s refusal to fund the Mississippi program, Geiger formulated an almost guerrilla-like response. He brought Tufts Vice President for Development Frank “Sandy” Tredinnick, Jr. with him to Sargent Shriver’s office on a day they knew he would be testifying on the Hill. They occupied his office until he returned, and Tredinnick ripped into Shriver saying:

‘How dare you do this? Tufts has made enormous investments of its own money as well as its overhead money in this project. It has hired faculty, it has recruited, it has launched an enormous recruitment effort with ads in all the major medical journals. It has an absolute legal obligation to fulfill all of the conditions of the grant, and there are two things we are prepared to do: We can sue you, and we will. That may wind its way through the courts, but we are going to go further, immediately, and call every academic medical center in the country and warn them against taking any health center grant from the OEO because there is no reliability that they won’t be suddenly turned off for purely political reasons that have nothing to do with the fulfillment of the grant. It will put them in the same situation of risk. We can be very convincing. You aren’t going to find any medical center, any academic medical, teaching hospital in the country that will take any OEO community health center grants.’ That was leverage (Pers. Com. 8/8/17).

Shriver, wanting his office back, turned the pair over to Julie Richmond to figure out a negotiated solution. In an unsent letter to Governor Johnson following the Geiger/Tredinnick protest, Shriver would emphasize the extent to which the program (a) heavily involved planning with local physicians and consultants, and (b) had been fully vetted with respect to its healthcare (i.e. non-political) purpose. “You may be assured that the Health Center will not engage in partisan political activity or civil rights activity. In other words, this is a health program”



(Shriver “Personal Papers”, Box 40). OEO assistant director and congressional relations specialist Gillis Long emphasized the fact that he had not sent Shriver’s letter and added his hope that “the compromise arrangement” would work out all right. A memo the previous day to Dr. Richmond and Dr. English (who had recently joined OEO from the Peace Corps) outlines the nature of the compromise: Shriver instructed the two to review a revised proposal that would include local hospitals (Tabourian and Sara Brown), local Meharry Medical School, and Tufts University as part of a “comprehensive ‘package’ program” fit for national presentation (Ibid).

Shriver’s suspension of the Tufts program, Geiger and Treddinick’s protest, and the subsequent “negotiated solution” demonstrates the very real political pressures the OEO faced in financing the health center program, and the suspicion many had regarding the “intentions” of health center advocates. Indeed, Geiger recounts having his activities reported on and monitored by a “spy” from the OEO as he evaluated potential locations for the health center in Mississippi to make sure he was not engaged in any politically volatile activities. But the episode also demonstrates the extent to which Shriver consciously sought to depoliticize (or perhaps better said “re-politicize”) the concept of “health” that the OEO grants were supporting. Here “depoliticize” does not indicate a denial of choice, agency, or participation, but rather a process that shifted focus from broad institutionalized congressional politics toward a more inclusive, personal, “small p,” form of politics. Building on Wright Mills (1959) and its feminist expression in the work of Betty Frieden (1963) and Carol Hanisch (1970), the activities of Shriver and the OEO appear to reflect an evolving awareness of the impacts structural politics was having on the personal lives of the people that the program sought to serve. This point is underscored by several War on Poverty architects who describe the naivete with which they initially approached the effort before becoming aware of the intractability and interlocking

causes producing the dire circumstances they encountered. To many defenders of “community action” that was exactly what the programs were designed to achieve, but what Shriver was in fact effecting was a process by which he would speak to the program’s merits at a national level, rallying support for the idea in its totality, but would consistently delegate the “politics” of the program to local groups and individuals. A growing conceptual awareness had revealed that the personal was political. The answer then was to make the political personal in the sense of removing the rock of structural politics from subsuming the highly personal lives it had been covering.

Shriver wrote a remarkably succinct summary of his approach in a letter to the wife of author and journalist William S. White, who had sent him a copy of her husband’s biography of FDR *Majesty and Mischief* in November of 1966. “If we can ever succeed in convincing the country that we really want local community action, and if at the same time we can get the congressmen to let community action take the place of traditional congressional action, we shall have then moved a long way from the ‘mischief’ of FDR to the ‘magic’ intelligent individual action for the social good of all” (Shriver “Personal Papers”, Box 38). The Geiger-Gibson proposal had emphasized participation of the community in the health center decision-making, program-planning, and self-education as consumers and employees. Shriver would build on this feature, planting the seeds of a core community health center belief in “personal,” “local,” “grassroots,” “community,” and “participation.” The attempt to balance these beliefs with a traditional medical model, founded on notions of scientific rationality, created organizations that emphasized or de-emphasized the level and breadth of community participation depending on political expedience.

## **Kennedy Amendment Fallout II: A Delicate Balance**

The passage of the Kennedy amendment was the first in a two-step process for funding new health centers. Authorization formally established the health centers, described its structure, assigned responsibility to OEO officials, and offered guidance as to how much money might be necessary, but the second step of appropriating the money would require additional individual effort. In what might be considered the first explicit act of health center advocacy (lobbying), Joseph English focused his attention on the chairman of the Senate appropriations committee, Senator Lister Hill. “I start doing some research and I find out that Lister Hill’s father was a doctor and that he went to my medical school in Philadelphia which sent hundreds of docs to the South,” said English “I called Sam Connelly, who was then the associate dean of Jefferson Medical School) for the alumni. I said, ‘Sam, do you realize that the father of the chair of the appropriations committee of the United States Senate is an alumnus?’” Connelly had no idea, so English suggested that Jefferson Medical School delegate him to go down to Alabama to do an article on the senator’s father.

Let me tell you. I walk in and of course, there he is. Remarkable man, but I mean, here’s the guy, I mean there are several committees he handled. The Southerners really won the Civil War, you could see it in the structure of the Congress of the 60’s. I start telling him about his father and asking questions and he sits there looking at me and says, ‘Why are you really here?’ I just don’t think I was able to come across with great credibility. I said ‘Sir, I need \$100 million. I work with Sarge Shriver, he’s got this incredible idea for health centers (Pers. Com. 1/26/18).

Lister Hill had suffered numerous political headaches resulting from ongoing political disputes between Alabama Governor George Wallace and the federal agency. OEO mandates to integrate funded programs served as grist for Wallace’s political mill. By early 1965, for example, Wallace had already waged a war against the Birmingham Area Committee for the Development of Economic Opportunity, a bi-racial community action committee led by a local lawyer, Erskine

Smith. He developed his own all-white committee for Jefferson County (including Birmingham), which the OEO, under Title VI of the Civil Rights Act, could not fund (Evans and Novak 1965). Of course, Wallace would use such funding rejections as a political club to take on the agency. With these ongoing conflicts in the background, Lister Hill's initial reception of English as an agent of the OEO was chilly at best.

“Did you testify before my friend in the House that you were finding rickets and kwashiorkor in the South?” he asked accusatorially. “Yes,” English replied. “But you also said that you found them in the North?” Hill continued. “Yes, we have a health center operating in the Bronx, Montefiore Martin Luther King. We have doctors who found those diseases up there too.” Hill a moment before saying. “Well that’s quite remarkable, but you know the only reason I’m still sitting here in the Senate is that I don’t chair any of these committees. How do you expect me to get you \$100,000,000?” To this English replied “Please. If you could see a child with rickets or kwashiorkor....” “All right” Hill interrupted, “I’ll make a deal with you. You get down to Alabama and you have a meeting with the medical society down there and you tell them what this concept is and what you want to do. If they endorse it and want me to help them get one of these health centers, you have your money.” English accepted, but not without a nagging doubt that he might make concessions in working through the Alabama program that would not conform to OEO regulations. But English managed to get members of both black and white medical societies to attend a planning meeting, after which they prepared a letter of endorsement to send to Lister Hill. “That was the first meeting with the black and white medical societies in Alabama’s history. And it was the concept of the health centers that made it work. We had a crew to get down there and sit with them and write the application. So it would beat all of our

requirements and we'd move it...you talk about bureaucracies... We in effect did the whole damn thing. So that's what we did with them." (Ibid).

A year later in July of 1967, Governor Lurleen Wallace approved a grant projected to serve 9,000 residents through an initial planning grant of \$53,035 and a subsequent annual operating budget of \$1.5 million. At the urging of officials and medical professionals in Lowndes County, Wallace waived her right to a thirty-day waiting period so the project could commence immediately (*Montgomery Advertiser* 1967). Sargent Shriver would highlight the success of the Lowndes County health center in a speech at the dedication of the South Central Multi-Purpose Health Services Center:

You know about Lowndes County. You know about Haynesville. Jonathan Daniels was murdered there. A Catholic priest was critically wounded. But today, things are changing in Lowndes County. A health center will soon open in Hayneville. Across the street from where Jonathan Daniels was murdered. Who's responsible for this? A white man, Dr. Howard Meadows. He's not an outsider from the North. He's from Lowndes County. So was his father. He goes back 5 generations in Alabama. Some of his relatives think he is crazy to open a health center. His life is in danger. He works with the local people – even if they're in the white citizens or the Black Panthers... Change is coming to Lowndes County. Not because of programs, but because of people" (Shriver 1967).

As OEO propaganda the Lowndes County health center was a boon. It struck all the right notes: personal effort resulting in locally developed projects utilizing the harmonious collective effort and participation of the entire population. And the impact of the Lowndes County health center was nothing short of miraculous: the infant mortality rate dropped from 46.9/1,000 live births in 1967 to 28.3/1,000 live births in 1971. The rates in neighboring counties were little changed (Reynolds 1976, 65). Using a fleet of fourteen vehicles to transfer patients to the Haynesville health center allowed the project to effectively cover the entire thirty-square mile county.

The story of the Lowndes County health center at Hayneville epitomizes the hopes OEO staff had for the program, but it also introduces a more problematic aspect of health center formation. Planning for the health center began in July 1967 following the first meeting of the

seventeen-member board of directors, which consisted of ten white members and seven black members (Wilcox 1967a). By October the program was conducting a health survey to determine the types of medical support the program would offer. Dr. Meadows, the program director, commented that above all else he wanted the people “to feel this is their program, and that they have a voice in what happens in the program” (Wilcox 1967b). Voices of dissent would emerge the following summer over the disproportionate hiring of white employees for the project. Several of the attacks singled out Meadows personally, suggesting that he intentionally delayed implementing the program so that he could hand-pick the employees (Fallows 1968). Another report suggested that Meadows never had much confidence in the black population and had told the Alabama Medicaid director that the black population that remained in Lowndes County (as opposed to emigrating with the collapse of cotton farming) were indolent, mentally defective, and inbred (Kopkind 1975, 53). The issue of grassroots control became increasingly messy. The first black man to hold elected office in Lowndes, Sheriff John Hulett, considered the program a paternalistic instance of “black people’s needs attracting lots of federal money for white officials to administer” (Cuoto 1992, 106). Over time the community advisory board sought to assert control over the grant.

Given the county’s long, distrustful, and often violent history of race relations, disputes such as those for control of the health center grant seemed inevitable. In 1965 two civil rights workers (Viola Liuzzo and Jonathan Daniels) had been killed in Lowndes County. In 1966 white land owners evicted black sharecroppers from their land plots for supporting the black political party (Lowndes County Freedom Organization, the first Black Panther Party), and in 1967 an arsonist set fire to the headquarters of the Lowndes County Christian Movement for Human Rights (the local OEO community action program) in Hayeville. Despite the promising

beginnings, the fight for control of the health center became more bitter, ultimately resulting in OEO defunding the program in 1972 (Kopkind 1975, 53). Sargent Shriver's idealistic portrait of the health center in his speech at Watts made his observation from that same speech that "No one should be fooled. Uniting ourselves is painful. Our country is groaning – not because we're dying, but because we're living" all the more prophetic as struggles over the health center intensified.

In one sense, the history of the Lowndes County health program typifies the battles over the limits of community participation and the historically problematic relationships between white and black communities, between existing public health boards and emerging grassroots organizations.<sup>47</sup> Some have argued that these struggles, specifically those tied to health center development, "situate questions of bodily harms and healing within the multiply scaled geographies of everyday life" (Lloyd 2014, 2). Such an analysis is fine insofar as it goes: the context of a violent struggle for civil rights, intense disenfranchisement, emerging black militant political organizing, and the rapidly escalating Vietnam War would set the stage for a politically manufactured backlash and the imposition of austerity measures in the early 1970s that would cut the radical aspects of health center projects off at the knees. But something else is beginning to happen at Lowndes, something that is tied more directly to the very reason Joseph English went there in the first place.

The health center amendment offered by Ted Kennedy placed a categorical, supply-side health program within the realm of federal-level politics as a distinct and separate policy objective. Working with highly motivated OEO bureaucrats, whose primary interest was health system reform (for the poor), the program would quickly begin narrowing its focus to medical issues. A health program immediately appealed, not surprisingly, to the urban setting of Ted

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<sup>47</sup> For an extensive treatment of the operational differences between community participant and community control of health centers see Hollister 1970.

Kennedy's Columbia Point as well as to the more rural areas represented by Lister Hill. Joseph English could readily appeal to Hill on a health basis whereas community action would have been a non-starter. Kennedy's arguments in favor of his amendment in committee mirror Sargent Shriver emphatic description of the Mount Bayou project as a *health* program. Of course, Shriver had been working on political support for the poverty program as a whole since its initial presentation to Congress in 1964, but the introduction of the Kennedy amendment opened community health centers up as a specialized branch of the program onto which advocacy efforts could be focused. This type of advocacy emphasizes very particular, well defined "improvements" in the form of disease eradication, service provision etc. It is less concerned with broad societal transformation. By January of 1967 the nature of this specialized advocacy began to draw wider circulation with the Office of Economic Opportunity. In a memo to Noel Klores, who had written for advice on funding health programs for Native Americans, Shriver would write that Joseph English had been very successful in obtaining funds for his health centers "principally, I think, because he managed to get a number of influential senators and congressmen to support the health centers *as such*." (Shriver "Personal Papers", Box 40). Shriver initially reacted to the categorical funding of the health center program as having the potential to turn the socially transformative institution into a paternalistic charity model. Here he bends to embrace a strictly service provision model, recognizing the waning political support for problematic citizen participation.

This approach to gaining political support for the OEO health center program laid the groundwork for decades of bipartisan support for community health centers. The President of the National Association of Community Health Centers (NACHC), Tom Van Coverden, described it to me in the following way when I interviewed him in March of 2018:



Again, I try not to get too partisan at all. We've got great bipartisan support which has been very key to our success, it's not always been easy to do but even when I use, for example, as we (National Association of Community Health Centers) use, two senior people Mike Leavitt and Tom Daschle, they thought health centers should be the oasis in the desert, the place where peoples of all kinds, colors, races, religions, political, can come and get a drink of water. I think that's, it maybe simplistic, but really how we've been able to really get the bipartisan support.

Mickey (2012) has documented the bipartisan history of community health centers and has suggested that this “bizarre trajectory” is best understood as the product of political learning in which conservatives and liberals adapted their stance on health centers based on how such a position would either aid or hinder the development of a national health care system (either through insurance, or direct service provision). But this bizarre trajectory had already been framed by the debate over the role of community action as opposed to more formal aspects of health care service delivery as emphasized by Sargent Shriver as a means to secure ongoing political support for the OEO. At the same time, there is a balance here, between community action and medical service delivery, between national health care and responsiveness to immediate and local needs. For better or worse, FQHC bureaucracy is the product of this balance.

### **The Path to a Bureaucratization Based on Need:**

I have opted to break off my stepwise history of OEO health centers at this point because, by and large, the fundamental features of the program had been established by early 1967. What followed was a more linear codification of War on Poverty programming into more bureaucratized systems of ongoing administration accompanied by ongoing political wrangling for continued support. I have summarized much of this history in the form of a legislative history log that I kept for my own reference while conducting my research (**Appendix B: Key Legislative Moments in FQHC History**). Additionally, Sardell (1988), Lefkowitz (2007) and Mickey (2012) all fill in the historical developments following the establishment of the first neighborhood health centers. But here I do want to briefly describe the characteristics that health

center program development acquired as the result of an ongoing *political* discussion, and then offer an example of how codification and entrenchment of the program occurred as the result of a bureaucratic process at the federal level.

In terms of maintaining political support, the House hearings over proposed 1967 amendments to the Economic Opportunity Act offer a representative sample of the grounds on which the debate would be held. In these hearings Sargent Shriver opened his presentation by introducing “some of the programs that are not well known” to the committee “for example the health program *under* community action” (Economic Opportunity Act Amendments of 1967, 848, my emphasis). He went on to introduce Dr. Joseph English in his role as Deputy Director of the OEO Health Program Division. English also backgrounded community action, adding a sense that these were immediately responsive to “needs.”

You have given us the opportunity to provide comprehensive health services to families in poor urban and rural areas of this country and I think the language of the legislation is interesting when it states that these services should be derived from the needs of the people to be served, not just what we as physicians think is right or what is convenient for us but that in these programs a primary emphasis be the needs of the people to be served and that it be with their participation....Those physicians, sir, will be organized with the needs of the entire family in mind (851).

This formulation is telling in that health care as a project, characterized as a collective political response to “need,” becomes the reference point for the hearings. Congresswoman Edith Green’s exchange with Dr. John Frankel, Health Director within the Community Action Program, demonstrates the cohesive currency that “need” was gathering.

**Dr. Frankel:** Well, in the first place we hope that we don't get 1,200 on the first day that the applications are opened up. However, what will happen is that the families will be screened and enrolled based upon their need.

**Mrs. Green:** What is the need? What is your criterion for need? There are more than 1,000 families that could stand comprehensive health care in Portland.

**Dr. Frankel:** This determination will be made locally and not by us here and I am not sure just exactly what criteria will be used but definitely family size as against income will be one of the

criteria. Actual health needs will be another, and desire for service will be still another, I am sure (867).

Needs and their criteria, not the fundamental proposition of whether or not the OEO's healthcare programming should exist, would continue to drive the health center model forward. And this was an active strategy commented on by some of the committee members. Charles Goodell from New York took issue with the \$2.4 million spent by the OEO on public information and relations ("ballyhoo budget") used to generate "great exaggerated claims for what has been done" (882). In response to this criticism Sargent Shriver hammered back using the rhetoric of need: "We are not exaggerating what we have done. We do try to dramatize the needs and will continue to, because the needs of the poor are always overlooked and their needs need to be dramatized" (Ibid). At its core then, the OEO health center program, backed by categorical authorization, would persist in demonstrating its utility in addressing "need" by utilizing reports, statistics, and public relations, documents, etc. Although the health center program and the Office of Economic Opportunity might have been born as a challenge to existing bureaucracies, the reliance on need as a rationale for continued political viability produced new administrative organizational schemes in which dramatizing need took center stage.

### **The Path to Consolidation through Bureaucratic Interest:**

Prior to the election of Richard Nixon in 1968, the health center program had received interest from other federal agencies - agencies that perceived the political viability of the idea, and the financial incentives to develop comparable models. Within five years of the first OEO-sponsored health center, similar projects emerging from the Model Cities program, the Department of Housing and Urban Development (HUD), the Regional Medical Program, and the department of Health, Education, and Welfare (HEW) burst onto the scene. In New York the passage of two pieces of legislation amending state public health law offered local health

departments new funding streams with which they could implement clinical services building on a health center model (Colgrove 2011, 7). The so-called “ghetto medicine” program would ultimately fund several neighborhood health center style-projects such as the Greenburgh Neighborhood Health Center. I mention the Greenburgh Neighborhood Health Center because it went on to become a division of the Mount Vernon Neighborhood Health Center system, which had been sponsored by the Model Cities program. If the genesis of health centers resembled, as I have suggested, a wayward bush with stubby branches, their persistence through time resembles a slow but steady process of topiary training and pruning.

David Blumenthal offers an exemplary case study of this in his 1970 Bachelor’s Degree Honors Thesis: “Out-OEOing OEO: Institutional Innovation in the Public Health Service.” In essence, the Public Health Service, a quintessentially regressive federal bureaucracy, saw the notable success of innovative programing coming out of the Office of Economic Opportunity (Neighborhood Health Centers specifically) and also recognized the financial support the health center program was receiving, and it began to pursue comparable efforts. These efforts, supported by OEO veterans including Joseph English, were codified into law as section 314(e) of the Public Health Service Act. In Blumenthal’s assessment, section 314(e) is notable because it constituted part of an effort “to remake an aging and dysfunctional organization” and a “determined effort at institutional innovation” (1970, 7). Blumenthal’s case study is instructive in that it reveals the extent to which different agencies both dabbled in neighborhood health centers and vied for bureaucratic control over the program and its finances.

This inter-bureau fight for control also incentivized departmental directors to carve out their own health center “turf,” ultimately generating support from unlikely sources. As an ambitious congressman from Illinois, Donald Rumsfeld became Nixon’s choice to head the

Office of Economic Opportunity. The consensus was that he would quickly move to dismantle the OEO, but Rumsfeld aggressively supported the continued efforts of experimental programming within OEO generally and neighborhood health centers specifically. “He was no longer a young congressman intent on burnishing his conservative credentials,” wrote Bradley Graham in his biography of Rumsfeld. “He had become a senior administrative official interested in preserving his new bureaucratic domain” (Graham 2009, 78). As Nixon prepared to develop a strategy for containing escalating healthcare expenditures, Rumsfeld saw an opening and revived an old Health Education and Welfare proposal to replicate the health center model with approximately 1,000 such sites across the nation. Members of competing bureaus such as HEW “viewed Rumsfeld’s proposal as a barely concealed power play – ‘He’d have OEO running the nation’s health program’, one of them later snorted – and were anxious to counter it” (Brown 1983, 215-6). If the health center program offered politicians a bipartisan oasis, it also held out the promise that federal bureaucracies could also drink from the same source. Carol Khosrovi, who worked closely with Rumsfeld as OEO’s Congressional Relations Director, suggested this to me when I spoke with her in February of 2018:

**Carol Khosrovi:** Don Rumsfeld also used to tell a funny story. Have you heard the story about the faucet?

**David:** No, I don’t think so.

**Carol Khosrovi:** Well, this has to do with bureaucracy. Rumsfeld once said that when he was a Congressman and various secretaries from various departments would come up to testify, in his own mind he envisioned that when they went back to their office where they had this desk which had all kinds of faucets on it and when they wanted to do one thing, they turned it on and when they didn’t they turned it off and they had all this power. He said, "Now I am head of an agency and I have a big desk and I have these faucets but what I've learned is that when I turn to the right, turn it on or turn it off, that the faucets aren't connected to anything. Nothing ever happens." I think that’s the best definition of what bureaucracy can be like that I can think of.

Although it is easy enough to interpret Rumsfeld’s support for health centers as nothing more than naked self-interest, it also suggests the slippery and cunning nature of the program’s

appeal. For ambitious federal bureaucrats (and young politicians such as Ted Kennedy for that matter) seeking to make their mark, health centers were a conduit to power and success. From this perspective, the health center program, as a movement, used individuals and self-interest to infiltrate multiple branches of the federal bureaucratic apparatus and to put the program on its trajectory of bipartisan support. Only as he prepared to leave his post as director did Rumsfeld relinquish control over the OEO health centers, signing a Memorandum of Understanding with Eliot Richardson, then Secretary of Health Education and Welfare, to transfer the program to HEW control (Marcus 1981, 149).

### **History: Conclusion**

I have had two primary concerns that I have sought to address throughout this chapter on community health center history and origins. The first has been to connect FQHC history to broader historical trends in the United States that have contributed to the evolution of healthcare systems more generally. These include questions about political support, appropriate models of service on which to build, the state of American healthcare infrastructure, and disproportionate access to health care along racial and economic lines. My second concern has been to capture a sense of the ethos held by the first generation of community health center advocates, particularly those associated with the Office of Economic Opportunity. These individuals and the programming models they developed laid out the framework in which FQHC administration would develop, and to a large extent they foreshadowed the style of bureaucracy I would encounter at Care Center. Where possible I have tried to link historical examples to instances in which I observed something comparable at my field site. But I have tread lightly on insisting that Care Center's bureaucracy was, in effect, patterned on the actions of historical actors. Community health centers celebrate their history and provenance, but individuals within them

are not always attuned to the level of detail that I have tried to provide here. Yet regardless of the level of familiarity, the tactical strategies deployed in support of early neighborhood health centers and the characteristics of those who supported them echo throughout my ethnographic observations. This is particularly true when it comes to describing Care Center's organizational structure. It is to that task that I turn in the next chapter.

## **Chapter 2: FQHC Organizational Structure and Bureaucracy at Care Center**

### **My Introduction to Care Center's Organizational Currents**

A few months after I first came to work at Care Center, prior to my initiation of formal fieldwork, I was blind copied (Bcc - >) on an email from the health center's CFO (Zeke Benjamin) to a group of Information Technology (IT) staff working on a project to implement a Voice over Internet Protocol (VoIP) phone system at all of Care Center's sites. The email said simply that David Erickson would be project-managing the effort; anyone with questions should feel free to reach out to me, and he included my email address and phone number. I had never discussed this project with Benjamin, and I had previously been working on managing a grant budget and preparing the associated vouchers. When I mentioned the email to a co-worker in the cubicle adjacent to me, he said: "Oh, that's par for the course, we just throw people at our problems." Over the next nine months I spent most of my workdays attempting to figure out how exactly VoIP worked, and what exactly it was we were trying to accomplish with the project. I learned a great deal about telephony, internet protocols, and IT infrastructure, and I had a chance to visit several of Care Center's sites as we (I along, with IT department staff) deployed handsets and tested the newly installed phone system. The experience sensitized me to a theme that would later emerge in my formal fieldwork: Care Center's highly personal/personalized system of organizational structure and the reliance on personal fluidity in moving between highly diverse work tasks.

At one point as I was working on the VoIP project, we went to a site in Care Center's Uplands service area. It was a small site compared to some of the other ones, and it had previously been part of a small independent practice. The staff at the site were furious with the change in the phone system, primarily because the phones at the site had previously all rung at



the same time a call came through, and the new system routed calls through a single number where it was held in a queue awaiting someone to retrieve it. Other staff at one of Care Center's administrative offices complained about that fact that the new system would assign employees extensions instead of direct inward dialing (DID) numbers. I reviewed some of these complaints with Zeke Benjamin and he animatedly explained that this was the result of an antiquated mindset: "They're used to having the phone ring and screaming at one another: 'Hey Agnes, I'm on the john, can you get that?'" While trying to manage the project, I recall thinking that this was just "resistance to change" and a problem to be addressed via *Harvard Business Review* techniques, or something comparable. But the more time I spent at Care Center, the more I began to think something slightly different was being expressed in the animosity that health center staff had to the new phone system. The individual, unique phone number for each person; the informal, personable manner by which people answered phones: these things all suggested that great value was placed on personal and personalized systems of organizing work within the health center. They also pointed to the fact that technological changes, like new phone systems, had something important to say about the "intimate relationship between the technology, the geographical environment, and the social environment" (McBride 2003, 275). This preliminary experience pushed me to develop a study of Federally Qualified Community Health Center (FQHC) bureaucracy as a distinct object in my proposed research, one that would attempt to treat bureaucracy as an "inhabited institution" (Hallet and Ventresca 2006) and bureaucrats as "participants in a complex social arena" rather than a cold, sterile analysis of organizational structure (Bernstein and Mertz 2011, 6).

In the first half of this chapter I shall introduce my field site(s) and attempt to evaluate the personalized patterns of bureaucratic activity that I observed and participated in at these sites

during my research. Using a working definition of FQHC bureaucracy, I will then introduce the way I used Max Weber's theory of bureaucracy as an analytic construct in investigating and evaluating some of Care Center's bureaucratic forms. The chapter will then make use of an approach informed by structural anthropology to offer a potential alternative interpretation of the underlying logic that Care Center's administrative organization followed.

The second half of this chapter describes some of the implications of Care Center's emphasis on a person-driven system of organizing, specifically the effect it had on the way the health center pursued the delivery of health care and/or other services. Additionally, this portion of the chapter contextualizes Care Center's person/personality-driven style of organization Center within broader structural features of the FQHC program, arguing that these features reinforce Care Center's reliance on individuals as opposed to more mechanical systems of organization.

### **The Field: A Quick Note**

Since George Marcus' introduction of the term "multi-site ethnography" in 1995, anthropological studies have consistently rejected the idea of strictly bound and delineated field sites in favor of fluid movement between local sites and the broader "world system" in which they participate (Marcus 1998b; Appadurai 1996; Gupta and Ferguson 1997). This convention has produced a sense that anthropological studies must necessarily be freed from the restrictions of a single field site. But the emphasis on expanding the field(s) of ethnographic study produces a conceptual problem in terms of how best to *restrict* the material (sites, locations, time, space, etc.) entering a final written account. Additionally, receiving Institutional Review Boards' approval for a seemingly limitless field or "study location" is a longstanding complication for researchers using a multi-sited approach. In answer to these challenges, Matei Candea has argued for the use of "arbitrary locations," a methodological strategy of pruning the "limitless

narrative possibilities,” the tantalizing promise of a “multi-sited” approach. The descriptions of my “field sites” that follows is a conscious effort to accept the limitations I placed on my research in terms of geographic sites and the contours of my narrative description. I principally focused on two key sites because they offered me access to seats of organizational power (CEO, CFO, COO, CMO, etc.), they housed the departments that I initially associated with bureaucracy (finance, human resources, credentialing, etc.), and I worked at one or the other of these two sites as part of my employment at Care Center. That said, bureaucratic life at Care Center did not restrict itself to the arbitrary locations I lay out below, and throughout the narrative that follows I will occasionally depart from these sites when this assists in clarifying or furthering specific points of investigative inquiry. I tend to emphasize this type of departure simply to make a point about the perception of bureaucracy (and bureaucrats) as things typically contained within a single physical location (e.g. the Pentagon). At the same time, by consciously limiting or bounding the extent of what follows I hope to hedge against the fantasy of knowing or representing *everything* that makes up FQHC bureaucracy in all its messy complexity.

### **Nickerson**

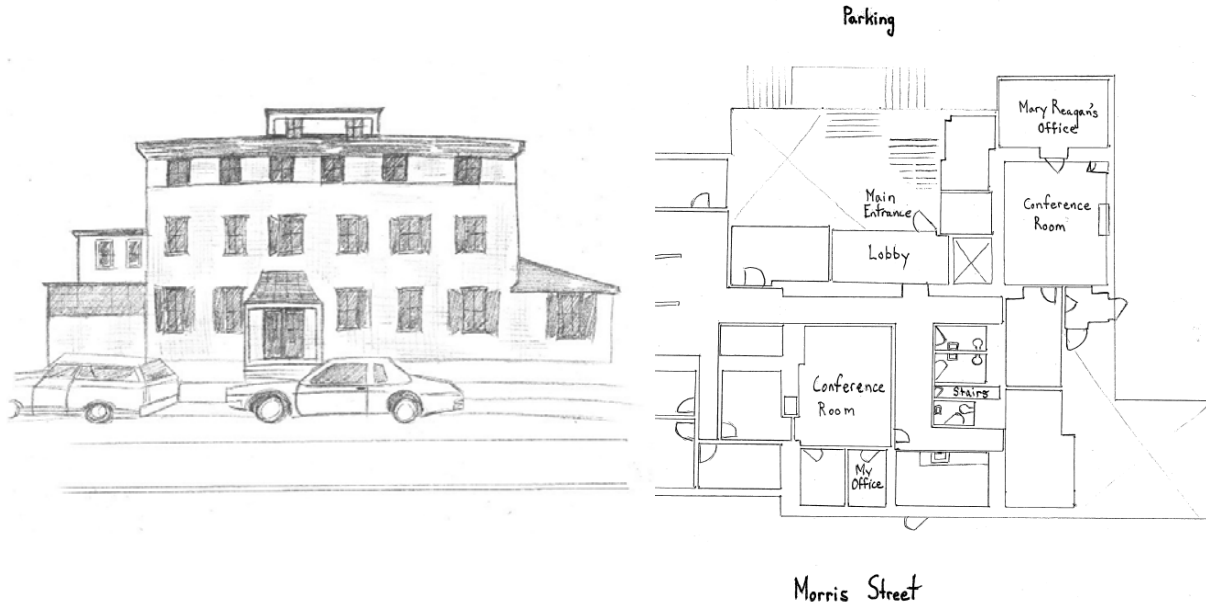
I divided my two plus years of fieldwork at Care Center between two administrative office locations located in Nickerson, NY and Wilthook, NY, approximately twenty miles away from one another. These were not Care Center’s only administrative locations (Care Center’s billing, facilities, IT, and capital projects departments were scattered throughout the region), but collectively the two offices (Nickerson and Wilthook), housed the CEO (Mary Reagan), COO (Abigail Worthington), the CMO (Alexandra Bacall) and the CFO (Zeke Benjamin) and their associated staff. These four individuals oversaw practically all aspects of Care Center’s bureaucratic work and afforded me ample access to a wide cross-section of staff members and

their daily office activities. The office locations at which I did not physically conduct research were included in my research obliquely in that I interviewed staff members from those sites either telephonically or in person when they were required to travel to Nickerson or Wilthook for meetings.

I first worked in Nickerson (9/2016-12/2017). I lived approximately five minutes on foot from the office there. I oversaw a diverse set of projects during my time at Nickerson as a “project manager,” beginning with a New York State health technology implementation project, evolving into regulatory work associated with Care Center’s ongoing expansion. This scope involved preparing Certificate of Need (CON) applications in order to receive New York State Department of Health Operating Certificates for new Care Center sites. The “office,” (**Figure 2.0**) originally built in the late 19<sup>th</sup> century, faced Morris Street, a major thoroughfare that runs through the length of the town before continuing on toward Wilthook. The three-story building embodied a mix of Neo-Colonial and Neo-Georgian styles and had undergone several modifications, the last being its conversion into office space in the late 1960s. If you approached the building from Morris Street, you had to grasp a heavy set of brass door handles and with some effort you could push into an entry corridor (the original hallway to the building), with matching offices (formerly parlors) to the left and right). If you approached the building from the rear, as I did when walking from my apartment, you would stroll through the town and onto a quiet residential street. Eventually you would pass a large concrete retaining wall and turn left up a graded driveway into a parking lot. The building loomed over the lot and had a sort of haphazard appearance because the original whitewashed brick portions of the building peeked out from behind a post-war brick box stapled to the back. A set of clumsily attached concrete

stairs, stained and weathered from water and salt in winter and cracked through in spots, would lead you inside.

In the rear entryway, there was a faux-mid-century modern sofa over which a wall sign



**Figure 2.0. Nickerson. Illustration by Lana Klemeyer (2019). Reprinted with permission.**

with plastic lettering identified the various tenants. To the left of the sofa, a Care Center sign was affixed to a dingy beige door. A four-digit code punched into a manual keypad on the door allowed me daily entry. The office was disorienting because none of the rooms were labeled, and it was not clear how extensive the interior office space was when initially entering. On the right, a dim corridor led to a glass door beyond which various cubicles appeared in the distance. Exposed brick bordered that corridor to the right, and recesses in the wall contained prints of posters from various FQHC conferences. To the left, tinted Plexiglas sliding panels opened into a large room with a broad, long table running the full length (about twenty feet), surrounded by rolling chairs, and ending with two matching offices (9.5 x 6.5) with similarly tinted windows and doors. To the left of the entry doorway another glass door (matching the one to the right that lead to the cubicles) looked through toward another corridor at the end of which stood a door

open to the side of the building through which a small amount of daylight entered. That corridor opened on to Mary Reagan's conference area and office, the windows of which looked back over the parking lot at the back of the building. The conference area contained a large glass table, several sleekly paneled closets (holding things like cleaning supplies, several carefully prepared file folders, Christmas decorations, etc.). Architectural renderings of several Care Center capital projects lined the walls, and a large secretary desk still wrapped in plastic stood prominently to the right of the entry. At the far end of the conference area, a windowed door looked into Reagan's office adjoined by a kitchenette. The office was decorated in with a mix of plushy furniture, modern hanging light fixtures, a massive still life painting of a vase full of flowers, and a photo-mosaic portrait of Reagan, the tesserae being photos of health center employees past and present. It had been a gift to Reagan from Care Center executive staff on the anniversary of the health center's foundation.

The appearance of the building's landlord at the Nickerson office was a common occurrence. The building experienced a steady stream of maintenance issues. On two separate occasions during my fieldwork it flooded dramatically, and there were several less severe leaks and overflows

Care Center's occupation of the building steadily increased throughout the time I spent there, growing from approximately ten employees (including Mary Reagan) on one floor to thirty-five spread out over three. The Nickerson office was often called the executive office, although the COO, CMO, and CFO all had offices in Wilthook. The CEO would frequently convene various executive bodies, meetings, and workgroups in the building. Staff from across the organization would attend these meetings. This often resulted in a confused jumble of cars overflowing into the fire lanes of the rear parking lot.

Care Center first opened an office in Nickerson around 2008. This move came after several years of locating its only administrative offices on Canaan Street in Wilthook, the city where the first Care Center site was opened. Opening the office reduced Mary Reagan's travel time to work from about thirty minutes to three minutes, and the organization had steadily increased its presence in Nickerson since then. The growth of Care Center's administrative staff prompted planning discussions about the creation of new corporate headquarters that would take into account the geographic/demographic distribution of the health center's employees and sites. Although that analysis did not favor expansion in Nickerson, Reagan had countered that every Fortune 500 company's headquarters were in the city where the CEO lived.

### **Wilthook**

The second half of my fieldwork took place in Wilthook, NY (1/2018-3/2020). I transferred from the Nickerson office to Wilthook in December of 2017 when I accepted a position as Associate Vice President working primarily on Care Center grants and grants administration. In this position, I reported to Gail Sutherland, a Vice President in Administration who worked under the Chief Operating Officer (Abigail Worthington). The move offered me access to a very different administrative setting, in large part because the Wilthook office (**Figure 2.1**) was located a few blocks away from Care Center's first health center and had historically been the de facto corporate headquarters for the organization since 2003. The building on Canaan Street in Wilthook was a nondescript 1980s office block covered in stucco foam insulation, quite different from the building in Nickerson. Law offices and accountants made up the balance of the building's occupation; however, by the time I concluded my research, Care Center offices had swollen to encompass 95% of the leasable square footage. The building's entryway, overhung with a pastel awning labeled "professional building," opened onto

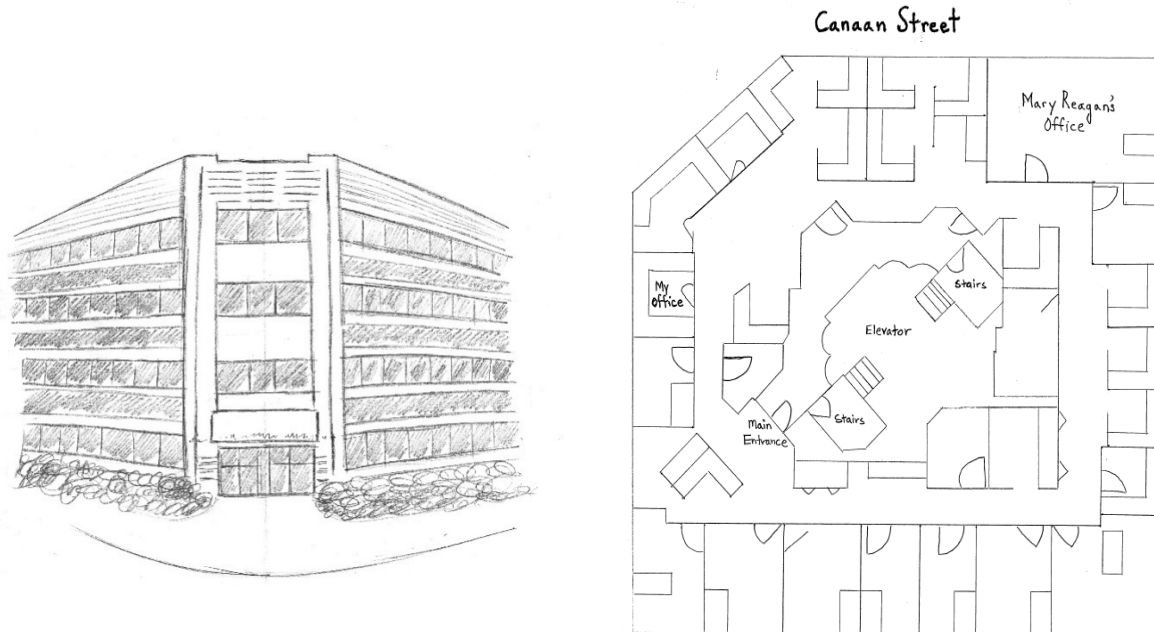
a single elevator shaft running through the core of the building and framed by sparking wall-to-ceiling mirrors with twin stairwell entries on both sides. Various motivational “succesories” posters adorned the walls in the lobby and on each landing bearing the image of some nondescript, dramatic landscape followed by a series of textual musings such as the following: *ATTITUDE What happens to a man is less significant than what happens within him.* Care Center’s training, human resources, informatics, finance, and general administration (grants, credentialing, quality, and executive assistants) were all housed in the Canaan Street offices along with the offices of the CFO, COO, and CMO.

One area of similarity between the Nickerson office and Wilthook office was the consistent lack of parking spaces immediately adjacent to the building. On an almost weekly basis the Canaan Street email distribution list would receive admonishments about parking in visitor spots. Several of the executive assistants, relying on the absenteeism of their supervisors, would rotate through the parking spaces indicating the name and title of its proper occupant. I found this out by asking one of them how she knew what days she could find a free spot in the lot, and she told me that she checked her boss’s schedule via a Microsoft Outlook calendar to make sure, although that was not an absolute guarantee, that her boss would not show up unscheduled. The limited number of parking spaces likely resulted from the fact that the businesses located in the building prior to Care Center’s increased occupation of the space were not high in employee counts. This also produced an office layout in which each floor maintained a distinct kitchenette area and multiple bathrooms. I once texted a Care Center VP working on facilities and capital projects, Winston Wright, to suggest that the layout was the result of slowly taking over many self-contained suites within the building. His immediate response: “No, it



really just is sloth. If we changed nothing else and put everything (stacked bathrooms, pantry, etc.) on one floor we would save about 20% of spaces/rent.”

The offices on each of the floors were located in a circular manner around the central



**Figure 2.1. Wilthook. Illustration by Lana Klemeyer (2019). Reprinted with permission.**

elevator core. This layout occasionally resulted in comical games of tag if someone was looking for another employee who happened to be “walking the circle” at the same time. Exiting the elevator on the landing of the fourth floor, one could choose to try a door to the left or to the right to enter the area where my office was located. About fifteen people might be present on the fourth floor at any given moment, although at maximum capacity the space was fitted out for thirty. I would occasionally see the landlord of the Canaan Street offices as well, but he mostly conducted maintenance activities on weekends.

### **FQHC Bureaucracy: A Working Definition**

I will now offer a working definition of what I mean by FQHC bureaucracy because the definition, to some degree, outlines the contours of my research and the locations in which I pursued that work. By FQHC bureaucracy I mean *a system of administration and administrative*

*work undertaken in office settings (i.e. non-clinical settings).* This broad definition encompasses executive officers, finance staff, project managers, communications staff, operations directors, administrative assistants, billing staff, data and informatics analysts, training staff, human resources specialists, and IT staff. Although most introductions to bureaucracy, Max Weber's first among them, distinguish between "administrative staff" and the "governing body" that appoints it, I made no attempt to artificially cleave these two apart. To do so would impose a structure and a distinction on Care Center's organizational form that might, in practice, simply not exist. Juan Carlos Olivares, the CEO of a large FQHC program in Oregon appeared to validate this approach. I happened to run into him after a meeting he attended at Care Center's Nickerson office, and I asked him explicitly if he considered himself a bureaucrat despite being the CEO. He immediately answered, "absolutely, there's a certain inevitability to that in FQHCs." Although not the focus of my research, a similar argument might be made for the putative distinction between the lower boundary of administration and "frontline" workers. But as I indicated in my introduction, my intention is to step back from micro, frontline, "street-level" healthcare bureaucracy and to enter the meso-level zone of administrative activity. My selected field sites are therefore directly linked to the definition of bureaucracy I have outlined above.

### **Points of Analytic Departure for Studying Bureaucracy at Care Center**

Max Weber's theory of bureaucracy offers a point of departure for much of the research I conducted at Care Center. Before reviewing some of the core characteristics that Weber identified in describing an "ideal type" of bureaucracy, I want to make my use of a Weberian perspective clear. I intend to use Weber's ideal type as a comparative mental construct, and in Weber's words, something that "cannot be found empirically anywhere in reality" (Weber 1949:

90).<sup>48</sup> It is my intent to describe Weber's ideal type as an effective means for organizing and framing the research that I undertook at Care Center.

I will offer a brief outline of Weber's treatment of bureaucracy before using that model as a comparative tool in my description and assessment of Care Center's administrative organization. Weberian ideal-typical bureaucracy is an administrative organization characterized by the following six principles or features: (1) a clear-cut division of labor and job specialization; (2) a hierarchical distribution of responsibility, supervision, and authority; (3) management through files and offices that are distinct and separate from private holdings or possessions; (4) specialized and technical qualification or prerequisites for employment; (5) official activity requiring the full working capacity of the official responsible for that activity, with obligations to the rules and domain specified by the office; (6) a distinction between public and private spheres of ownership and activity (Weber 1946, 196-198). Using these characteristics, I operationalized them as a guide for the types questions I asked and as a way to organize observations within the field setting: (1) How are job functions divvied up among Care Center administrative staff? (2) How are responsibilities and supervisory relationships constructed at Care Center? (3) What is the relationship of Care Center staff to offices, files, and other material means of managing work? (4) On what basis are Care Center administrators selected and installed in their positions? (5) How are job obligations defined or circumscribed at Care Center? (6) Are there distinctions between public and private spheres of activity among Care Center administrative staff? I did not formally incorporate these questions into the initial iteration of my interview schedules, but rather they shaped the types of topical areas I paid attention to as the research evolved. I

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<sup>48</sup> Many of the critiques leveled against Weberian bureaucracy, particularly those of a neoliberal orientation, tend to discard the methodological utility of the ideal type in favor of poorly articulated denunciations of it, as if it were an empirical fact (Osborne and Gaebler 1992; Osborne and Plastrik 1997; Lounsbury and Carberry 2005).

emphasize again, my purpose is not to argue (however accurately) that the ideal type as described by Weber does not conform to the social reality at Care Center but rather to use the ideal type as a comparative counterpoint off of which I develop a social portrait of Care Center bureaucrats as they conduct the everyday business of administering FQHC services.

In response to some of these initial questions, I quickly learned that divisions of labor and job specialization among Care Center administrators were not particularly pronounced. I mentioned that I was put in charge of implementing VoIP throughout Care Center's network. Up to that point, I would have described my level of IT knowledge as rudimentary at best. At one point, Zeke Benjamin, a CPA by training, joined a conference call with the external telecommunications engineers with whom we were working to set up an automated menu of call options. He commented to one of them, "Pretty elegant solution David's come up with for the structure of the call flow, right?" One of the engineers responded haltingly, saying "It's... well... it's... interesting..." I had a good working relationship with him, and he later asked me if I had any training in IT or telecommunications, to which I sheepishly answered that I was trained in anthropology. He laughed and replied: "I would have thought poetry from the way you've set up your auto attendant menu."<sup>49</sup> I was clearly not selected for the work on the basis of a firmly prescribed course of training. The result was a jarring contrast between my idiosyncratic, "poetic" approach to telecommunications and the mechanical structure typically associated with phone system design. The reasons for placing me in charge of the project were never explicitly made clear, but in a later chapter I will argue that the way people are selected for the work they perform at Care Center is part of a broad "organizational style," highly intertwined with its institutional history and "grassroots" mentality. I present the subject here because the contrast

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<sup>49</sup> A telecommunication *menu*-driven options through which callers can obtain information, perform tasks, or connect to a requested extension.

between “mechanical”<sup>50</sup> systems of organization and “person-driven” systems of organization emerged as a frequent theme in my interviews and observations.

In May of 2015, while I was still working in the Nickerson office, I traveled to Wilthook to ask Mike Foss, a younger member of the finance department in the Wilthook office, whether he thought the organization was driven by individual people or by mechanical systems. Sitting in his third-floor Canaan Street office, which was sparsely adorned with his framed degree and a faux-antique map of the world, he turned away from a pair of computer monitors and an oversized PC to chat with me.

**David:** I think it's common for a lot of people to enter this particular health center by virtue of some very personal connection that they have with someone. I've known Mary Reagan my entire life ... A question I ask almost everyone is, do you think the organization is driven by individual people or by certain mechanical systems?

**MF:** I think it's largely driven by individual people. Of course, to elaborate on that, I think it's driven by-- I think I would prefer if it was driven more by mechanical systems, I think there's a lot of-- most of the decisions that we make are very personal and that's why I think it's driven by individuals. Our mission is very personal so it's a very person-based business that we live in, but it is also a very person-driven business because of the fact that this started with such a personal mission and such a great movement that it's hard to sometimes see the mechanical end of it. I think that only those of us who are in the administrative offices really understand the machine as it were, that moves through here. But I would definitely say that people move the organization, not machines.

The surprising thing about Foss's response was not so much that he looked at the organization as being driven by individuals, but that he seemingly wished that it were more mechanical in its orientation. He continued:

I think that, if the organization did not break on such a relationship basis I should say, then maybe I wouldn't be here.<sup>51</sup> And there are arguments that you can find great people and connect them, and make them feel more of a connection to an organization with that type of leadership methodology. I think there's potential for that to be a positive. And I think that that was definitively a *positive* impact and a *positive* way of leading at the start of this organization.

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<sup>50</sup> I tend to associate the term “mechanical” with Weberian notions of efficiency in bureaucratic organizations as described by Morgan (1986) as opposed to Durkheimian contrasts between mechanical and organic solidarity.

<sup>51</sup> As mentioned in my **Introduction**, I also knew Mary Reagan personally prior to working at Care Center. This “relationship basis” is reflected in the health center's senior leadership. At an Executive Council retreat held in June of 2013, approximately 68% (n=15) of the attendees described their connection to Care Center in terms of a personal connection to Mary Reagan.

When it was born, it was born as *one* health center, and it was a single mission and a passionate one, and that's how they found people, they found people who were also passionate and found the mission to be personal. That's how we got so many good people at the beginning of this organization to grow into a system that helped as many people as possible. What I think we need to do at this point, though, is recognize that the CEO can no longer hire every person in the organization, and she did many years ago.

I know for a fact that she used to hire every single person who she used to interview personally, every single person who came to this organization. We've got hundreds of employees now, she can't do that. It is just one example of ways in which when you grow to the size that we are you have to let go of some of that personal connection to every person in the organization, and understand that the mission has become bigger than individuals. It's more important that we look at all of our employees with a very objective and performance-based viewpoint because they're responsible for the care of hundreds of thousands of patients. Those hundreds of thousands of patients are more important than us maintaining personal relationships. I think that we oftentimes will put them in the opposite order.

Within the system Foss described, Mary Reagan's individual and personal connection to each employee informed how work was organized. He also indirectly pointed out that Care Center still was organized along personal/personalized lines as opposed to a more "objective" basis. The other intriguing aspect of Foss's take on Care Center's formal structure is an apparent yearning for more bureaucratized systems. He appears to call on bureaucratic processes as a trope (Florian 2018) that could provide structure and efficiency while reducing dependency on personal relationships. By casting these processes in a positive light, Foss raised questions about the role bureaucracy has in an evolving organization.

Mary Reagan's approach to business decisions often hinged on personal relationships, or on things that could, in some way, be personalized. At one point Care Center had considered moving into a new service area. Health Center staff, myself included, had met with the owners of a large building co-located with a college of osteopathic medicine and had done some spatial programmatic modeling to evaluate the viability of the location. The health center also conducted a market analysis that, among other things, addressed the question of how many comparable providers were actively practicing in the proposed service area. In looking at provider-to-patient ratios per/100,000 persons, the location scored well above all optimal ratios.

The analysis also indicated that another FQHC had aggressively moved into the area and that the project would demand substantial marketing investment in order to “woo patients already served by other providers.” These findings were validated by the Health Resources and Services Administration’s Uniform Data System (UDS) Mapper resource, a mapping program that aggregates FQHC data along with other federally-linked providers of health services. The UDS Mapper indicated FQHC penetration of the low-income population rested at 71%. These facts did not bring the discussion about the new site to a close however, and it remained a standing item on a recurring evening-hour capital projects conference call that included Mary Reagan, Zeke Benjamin, Abigail Worthington, and Winston Wright. The matter was still on the agenda, with Reagan refusing to remove it, until one evening about two months after the analysis had been completed, Winston Wright informed the group that he definitively had to give word to the building owner about Care Center’s plans. Reagan initially balked at the idea, saying she was not yet ready to give up on the idea, at which point Zeke Benjamin intervened saying “Mary – imagine if Donna (the CEO of the dominant FQHC in the proposed service area) came to Wilthook, built a massive facility in conjunction with a medical school, and set up shop around the corner from Canaan Street.” Reagan paused before replying, “Well, I wouldn’t like that at all, why would she do something like that, we have a good relationship? I guess that makes sense. We can let it go.” I recount this vignette here to emphasize the extent to which the decision-making process broke on the personal relationship Mary Reagan had to a fellow FQHC CEO, not the empirical data and associated analysis suggesting that the project would be, in the best case, a challenge. When the word got out that Care Center had chosen not to move forward with the project, a Vice President spoke with me about the decision, saying, “Well at least we

made a decision based on the data for once.” His shoulders sagged with disappointment when I recounted the interaction between Reagan and Zeke Benjamin.

The contrast between personalized decision-making and structure, as opposed to more impersonal forms of organization, was particularly striking for newer employees at Care Center. In January of 2017, some five months before I visited Foss in Wilthook, I asked my new neighbor in the Nickerson office about his experience working at Care Center and with Mary Reagan. He had been hired at Care Center after working for a large European banking firm. “She is very present in our culture. She is a people person, and she likes having her people around.” Julie Saxton, a Care Center VP working on the organization’s advocacy and government relations who had previously worked at a large hospital system, occasionally expressed frustration at what she perceived as Care Center’s “unstructured” environment. Reagan had at one point assigned her a task, but she was taken aback when other people in the office appeared to be working on the same thing. A consultant from a large national health care technical assistance firm diagnosed her frustration as a contrast between what she was accustomed to in the hospital setting and the “organic way” in which Mary Reagan let Care Center’s organization evolve. For Rex Thompson, the Director of the Community Relations and Affairs department, his initial arrival at Care Center involved a process of creating a structure around things that were not explicitly documented. Having worked in several not-for-profits prior to working at Care Center, Thompson frequently compared Care Center’s culture (his words) to what he had observed and experienced at other organizations. On an unseasonably warm February day in 2017, I walked with Thompson a few blocks away from the Nickerson office to a trendy coffee shop packed with students studying in groups and several middle-aged women clad in form-fitting workout clothing. As we sipped cups of coffee, he explained to me:



**RT:** I came in and I asked for, I think I've told you this before I asked for two things, an org chart and budget before I started, a month before I started, and sometimes people would laugh or they would say, "Okay" or they would say nothing and I still don't have those things. I sit down with her (Mary Reagan) my first day and I made her go through the organization from Mary down to the site staff not with names necessarily, but just like wrote down what each person was and...

**David:** How did you find the organizational chart?

**RT:** Well I had to make it myself [laughs] but I think there are really well-defined workflows. There are well-defined workflows with Zeke (Benjamin), especially Zeke but with Mary too. But they aren't written down anywhere, and she has various structures in her.

Meyer and Rowan have explored the way in which the development of organizational language – the labels on an organizational chart for example – are called upon to demonstrate that an organization is acting on “collectively valued purposes in a proper and adequate way” (1977, 349). At Care Center I infer that developing fluency this type of language (e.g. Rex Thompson’s individual self-authorship of a written organizational chart) offers helpful insight into style of organization that Care Center valued.

Zeke Benjamin’s experience of coming to work at Care Center in 2012 echoed Thompson’s. He immediately contrasted his attempts at incorporating data-driven decision making into the way Care Center executives approached their work:

So my perception of coming to the health center was that it was incredibly tight-knit and I was introducing a way of thinking and doing things that was hard for the health center to deal with but that - I want to think I don't know, this would need to be confirmed - that I was bringing into the health center a skill set that was sorely needed.

He offered an example of developing a nurse practitioner (NP) model of care delivery as opposed to a MD model and the skepticism of Felicia Finley<sup>52</sup> (A Care Center ex-CMO who still maintained an active role in clinician management) regarding the ability of NPs to handle a certain panel size. “I said, ok, well, let’s test that. Sounds like it could be true, but I don’t know

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<sup>52</sup> Finley’s transition from the CMO role took place during the initial year in which I actively conducted fieldwork at Care Center.

that. So, we're running this by a consulting group. This is a challenge for Mary [Reagan] because she will draw on years of experience, which is completely valid, but not sufficient. When I speculated about whether Care Center was organized mechanically as opposed to being more personality-driven Benjamin cut me off: "It's all persons and personalities. We just had this conversation around the executive council table yesterday. We are not an organization - and there are many like-kind organizations - driven by the enjoyment of execution. They are driven by the enjoyment of thinking and processing and being intellectually rigorous. So, it's a different set of skills."

Given the consistency of this theme of personality-driven organization, I sought out Roger Ross, Care Center's VP of Human Resources, on the same day that I interviewed Mike Foss to see if he might offer an opinion from the perspective of talent acquisition and employee management for the entire company. I found him in the newly renovated second floor of the Canaan Street offices. Barrel chested with neatly cut silver hair, Ross explained that he had been working in human resources, mostly with hospitals, for thirty years.

**David:** So, coming from a hospital setting to the Hudson River Health Care setting, what were some of the-- was it sort of shocking or different or did you notice some--?

**RR:** I'm still recovering.

**David:** [laughs].

**RR:** It's almost two years in and I'm still recovering.

**David:** Is there a specific moment where you thought, "Wow, this is very different?"

**RR:** There was-- I don't know if it's a moment as much as a cumulative awareness like, we've got--however many they were, originally, 25 centers that are kinda, sorta, doing the same thing - but not necessarily. They're out there and they have a fair amount of flexibility and freedom, whether they're consciously aware of that or not. And then, each center has their own little culture that they've grown up with... We are under one umbrella but we're still becoming one organization, we're still on that. The balance there is wanting to become centralized and, I'll say, bureaucratic in some ways, both for compliance purposes as well as efficiency but not losing the uniqueness of the community, the staff and the patients, who have a unique personality and not wanting to destroy that. I think we're still struggling with that balance organizationally, with that tension.

Despite being thirty years apart in age, Ross's account sounded remarkably similar to what Foss had explained to me a few hours earlier. Although this might seem self-evident, the tension between organization along the lines of a Weberian ideal type, and a more person-driven approach directly impacts how Care Center executed its decision-making.

**David:** Something I do ask people sometimes is, if you think the organization has typically had a focus on individuals or on systems. If you were to compare those two, or if there is a different type of focus that the organization has had?

**RR:** That's actually great, a great question, and a really good insight. We can still be fairly individual driven in terms of our thinking and, again, partly for those factors that we just talked about, the longevity. I know the people, and Cheryl knows lots of people, Abigail knows lots of people. We tend to think a lot about that and the people impact or "Hey, this person could do that. Hey, David, I know, could do that because I know his skills, abilities, etc." as opposed to the director of--.

**David:** Sometimes-

**RR:** -- patient population. That's the appropriate box under which that responsibility fits, we tend to-- David can do that, Shirley can do that. Mike can do that [laughs].

My own experience in working on implementing various project objectives resonated with Roger Ross' assessment. Once, while working on developing an interface that would connect the radiological images taken at a Care Center site to a radiological group that would interpret the images, I sent John Bewley, Care Center's VP of Technology Services, a text message asking how he might categorize the development of templates for ordering and sending these images through Care Center's Electronic Health Record: IT?, Operations? Admin? Finance? He wrote back staggered set of messages first saying it would fall under operations, then, as if questioning himself, "Maybe admin." He finally concluded the exchange saying simply, "It's Jane." He I sent this while walking out of a local Nickerson gym where I had gone to during lunch. Bewley's response indicates that manner in which Care Center consistently organized its work was not with strictly delineated hierarchies and mechanical processes. Rather, work was initiated by individuals (in this case Jane Medcalf, Care Center's VP of

Clinical Informatics) and in many instances completed by them as opposed to funneling the effort through departmental structures.

From an operational perspective Abigail Worthington explicitly referenced this individual and personal approach to organization.

This is a very personally oriented organization. We have recently struggled with this question of how to organize to be the most effective. An organization that's been very person-driven, relational too -- You look at command-and-control organizational charts that are very clear. As you get bigger your need for clarity around an organizational chart increases. I think that we've had iterations of conversations about the value of moving to a more command-and-control. There are individuals in our organization that come from that mindset much more. I think that that may be a process, something that happens for us over time because of our size. I think it has implications as well and I think that there's inner personal tension about that too.

I asked explicitly about whether she had experiences where an individual person is held responsible for a specific task, instead of a department, and she was quick to reply: “We do that all the time. It's because our job descriptions are blurry at the edges, because what we do doesn't fall neatly within boxes. We push people to work beyond an original scope all the time. You may start with what is a structurally defined job description, but if you've been here more than two months you've definitely done work that's outside of that.” When I asked Worthington if she could imagine what an ideal system of organization might look like she let out a sigh that almost sounded like frustration.

In terms of how we're organized, I think there's always room for improvement to figure where the lines are. It's enormously challenging in this organization to separate that from the people who sit in those roles. I think that I have done this exercise too, if you could ignore all of the humans who are here, how would you organize it? It definitely would be different, but the fact that this organization tries to tap into the particular talents and strengths of those who are here means that we have -- means our reality is a little different.

Worthington's challenge (or my perceived sense of her frustration with the current state of Care Center's organization) involved sharpening blurry lines and ignoring humanness in order to separate persons from specific roles, and articulated an ongoing tension within Care Center

between a perceived sense of organization and control and a historically patterned reliance on individually driven effort.

Care Center's budgeting process also reflected the tension between the impersonal features of a Weberian-style bureaucracy and a highly organic and person-driven approach to organization. In broad terms, the idea behind budgeting for positions is to control positions through the implementation of a system that simply identifies a numerical representation of the staff with standardized roles and a standard "model" throughout the organization. As Mike Foss explained it:

In an effort to try to control that process, we've tried to look at, not people, but positions in saying, "Your site requires this many people to run your operations." It's not about individual performers, it's not about names, it's not about personalities, it's about, "For this many doctors that are seeing this many patients, we need this many support staff," and that's cut and dry. That was the effort.... When we looked at position control and actually tried to implement this, what ended up happening is that we completely abandoned the idea of-- And I should be specific, so when we brought all of our positions to our executives that are making decisions on whether those positions are accurate and whether we need any more positions, less positions, all that-- Inevitably ended up looking at the individuals and going line by line, person by person, name by name.

Shifting to a system of budgeting based on positions revealed the extent to which Care Center's entire approach to bureaucratic organization placed individuals and people before structures. It also revealed the extent to which Care Center was undergoing a rapid evolution toward a so-called "modern form of organization" in which "the role, not the person, constitutes the fundamental structural and behavioral element" (Kallinikos 2004, 21). Perhaps the most reflective assessment of the process came from Zeke Benjamin, the individual primarily responsible for implementing the position-oriented approach.

I think what makes it difficult is that the way in which some people understand what's going on in their identity markers is based on a person which is based on a humanistic kind of approach to their work, whereas for me in terms of budgeting, it's just a widget. It's a widget and a cost. For me the objectification of that - there's no internal conflict... For Mary, it's all about the people.

I was struck by Benjamin's invocation of the term "humanistic" in his description of how Care Center's administrative staff approached their work because it was a specific example of how bureaucratization (budgeting for positions) was connected to an objectification of the individual persons included in that process. It echoed Worthington's comments about how organization might occur were one to "ignore all the humans." One might interpret this from a Marxist humanist perspective, in which individual laborers within Care Center become alienated from the specific character of their labor and, instead of persons themselves, become "widgets" - an instrument of ongoing organizational production. Benjamin's description also reflects the Weberian process of rationalization wherein traditional, personal associations are discarded in favor of Benjamin's rule-based impersonal position control. But in his discussion of budgeting, Benjamin also distilled fundamental features of how Care Center was institutionally organized around persons as opposed to systems. It bears noting that Benjamin actively contrasted his status as a Care Center "newcomer" to "legacy" staff like Mary Reagan. I mention this because within the sociological literature on institutional change, Gouldner's *Patterns of Industrial Bureaucracy* specifically, enactments of new forms of bureaucratic rationality are often imposed locally through a succession in leadership. Although not an exact parallel, the arrival of Benjamin at Care Center closely resembles Gouldner's description (1954) of the departure of "Old Doug" from the "General Gypsum Company" and the subsequent arrival of Vincent Peele accompanied by "a rigorous application of the plant's formal rules" (Ibid, 61) and a pronounced "growth of bureaucratic organization" (Ibid, 70).

### **Wet and Dry Bureaucracy: A Structural Detour**

The use of Weber's conception of bureaucracy to inform my initial inquiry into Care Center's organization gave me a clear sense of how the health center was *not* organized, but it

did not necessarily help illustrate how the health center *was* organized. And while one might go through the exercise of evaluating whether or not this person-forward system aligned with other forms of Weberian authority (charismatic or traditional as opposed to legal/bureaucratic) this felt somewhat artificial. The Nickerson office building actually prompted a different line of inquiry one winter day in 2018 when the combination of a cold spell and the antiquated system of insulation caused a pipe to break, flooding the CEO's office along with several other work spaces. The building had experienced multiple leaks, floods, exterior cement erosion, and issues with water draining from the sinks throughout the time I had worked there, but this time the damage was so severe that it displaced the CEO from her office for a month. I had moved to the Canaan Street office in Wilthook by this point in my research, and I usually spent the mornings complaining to our compliance officer next door to me about the blast of heat that greeted us on a daily basis throughout the winter months. But I still lived in Nickerson, and I stopped by the office there on my way home to observe the effects of the flood.<sup>53</sup> Something about the contrast between the waterlogged Nickerson office and the oppressive heat of the Wilthook office prompted me to consider whether there was another way of schematizing Care Center's system of organization.<sup>54</sup> Drawing on the structural approach of Claude Lévi-Strauss and Roland Barthes I began to *dissect* some of my observations and interviews and then *articulate* them into oppositional pairs, the most fundamental being the opposition between "wet" and "dry."

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<sup>53</sup> The Nickerson office experienced another similarly catastrophic flood in 2019 on the evening when a Board meeting was supposed to take place. Despite the availability of space less expensive to lease and maintain located nearby, Reagan preferred to remain in the Nickerson space, replacing and repainting the areas affected by the flooding.

<sup>54</sup> Structural analysis can only take shape in the mind because its model already exists in the body. From the very start, the process of visual perception makes use of binary oppositions, and neurologists would probably agree that this is also true of the brain processes. By following a path that is sometimes accused of being over-intellectual, structuralism recovers and brings up to awareness deeper truths that are already latent in the body itself (Lévi-Strauss 1973).

I have summarized some of these structural oppositions in **Figure 2.2** and included a more comprehensive list as **Appendix C: Catalogue of “Wet” and “Dry” Terminology**. Several of these instances should sound familiar (Tom Van Coverden – “health centers should be an oasis,” Julie Saxton - “organic” organizational evolution, Mike Foss – “cut and dry,” Roger Ross – “under one umbrella” and “float to the top,” Abigail Worthington – “tap into particular strengths”). **Figure 2.2** is not an exhaustive inventory, but it should be sufficient to illustrate how Care Center thinking, both institutionally and individually, can frequently be mapped and rendered intelligible by using binaries of this sort. And also do not want to use this analysis to “prove” something like a structuralist theory of “culture” or to over-psychologize the individuals I interviewed, but rather to suggest that these oppositions are patterned, and that they were consistently deployed by Care Center’s bureaucrats.

<b><i>Wet</i></b>	<b><i>Dry</i></b>
“grass roots”	“under one umbrella”
“organic”	<i>mechanical</i>
“stuck in the weeds”	“mile high view”
“scrub data”	
“Need a coherent solution and get off the PPS tit”	
“decisions float to the top”	“cut and dry”
“freshen up”	“stale”
“fluid roles”	“cookie cutter”
“tap into particular strengths”	
“drink the Kool-Aid”	
“health centers should be the oasis in the desert, the place where peoples of all kinds, colors, races, religions, political, can come and get a drink of water”	
<i>Nickerson (flooded) ?</i>	<i>Wilthook (not flooded) ?</i>
<i>Personal/ Humanistic</i>	<i>Impersonal/Mechanical/Anti-humanistic</i>
<i>Subjective</i>	<i>Objective</i>

**Figure 2.2. Analysis of “Wet” and “Dry”**



Identifying these binaries and documenting them within the ethnographic context allows us to use them as “conceptual tools” to develop various propositions about what was occurring at Care Center (Lévi-Strauss 1969, 1). I provisionally take from this the recognition that when Care Center employees used “wet” and “dry” terms to impose form on what they experienced, they were, to a certain degree, entrenching (or potentially attempting to dislodge) specific claims about how the health center should be organized. This analysis also generates a comparison between Care Center models of organization, and Weber’s ideal type wherein the category of “dry” aligns more closely with the Weberian ideal and the category of “wet” departs from it. The co-existence of the two introduces a very real tension at Care Center between the different conceptual models informing how work there should be conducted, something Karen Ashcraft has termed “organized dissonance” or “the strategic union of forms presumed to be hostile” (2001, 1304). This circumstance reflects the ongoing concern FQHCs have for inclusionary “small p” politics, a lasting legacy of the obligatory participatory requirements written into FQHC legislation.<sup>55</sup> At the same time the tension inherent in an environment of “organized dissonance” points to the emerging demands placed on not-for-profit organizations, like Care Center, to develop more business-like (bureaucratic) practices (Eikenberry and Kluver 2004; Sanders and McClellan 2014).

As a classificatory scheme the categories of wet and dry also probe what Mary Douglas termed “the relation between minds and institutions” (1986, 7). This relationship is most apparent in the person of Care Center’s CEO, Mary Reagan. She would frequently cite her own longevity *as a Care Center employee* at formal and informal health center functions. Her emphasis was on the incorporation of her personal self with Care Center as a whole. I previously

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<sup>55</sup> See Chapter 1: History and the FQHC World in Context: Kennedy Amendment Fallout I

described Rex Thompson's reaction to Care Center's organizational system in order to illustrate the emphasis on a person-oriented approach. But Thompson also specified that Mary Reagan had "various structures in her." The sense he had of the health center's organization quite literally fused structure with Reagan's physical body, again recalling Lévi-Strauss:

Structural analysis can only take shape in the mind because its model already exists in the body. From the very start, the process of visual perception makes use of binary oppositions, and neurologists would probably agree that this is also true of the brain processes. By following a path that is sometimes accused of being over-intellectual, structuralism recovers and brings up to awareness deeper truths that are already latent in the body itself (1973, 22-23).

The use of organic metaphors to narrate and interpret organizational structure has been extensively catalogued by Morgan (1980; 1986), and others have extended his approach to analyze the way a corporate body fuses with the person of the CEO (Walenta 2015; Krause-Jensen 2010). These analyses are helpful in putting these mind/body metaphors into dialogue with a structural analysis of Care Center's organizational schema. In so doing I am inductively diagramming organizational structure, but I also am attempting to show how these structures are "reproduced in small on the human body" (Douglas 1966, 42). By extension, the structural categories of "wet" and "dry" and tension between the two echo feminist analyses of the body metaphor that emphasize "the ways in which the body is a permeable, leaky, flowing space" producing a "socio-spatial nexus for political action" (Rasmussen and Brown 2005, 478).

My own experiences working on certain Care Center projects with Mary Reagan offers a typical instance of how these structural categories played out in terms of bureaucratic work. In February of 2018 I was startled to receive a phone call on my cell phone from Reagan, who animatedly began telling me about a Crain's healthcare award for innovation.<sup>56</sup> I say startled

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<sup>56</sup> In writing my description of this interaction I have relied on the timestamps from my cellphone records, Microsoft Outlook meetings on my calendar, emails, tracked changes/comments (also timestamped) on the application document itself, as well as fieldnotes.

because in the time I had worked at Care Center I could not recall a single unprompted, work-related call from Reagan, although I would occasionally receive text messages enquiring as to whether or not my wife and I were around in Nickerson and able to attend this or that event. She urgently conveyed the importance of preparing a nomination for one of Care Center's executives and instructed me to deliver frequent updates on my progress. I asked Gail Sutherland, my direct supervisor following my move to Wilthook, if preparing non-monetary award nominations was a typical task assigned to our department, and she immediately complained bitterly about the fact that she had to waste so much time on this type of work, primarily because they usually did not know very much about the nominees and had to back into a "flowery description" of them based on CVs or resumes.<sup>57</sup>

Two days before the nomination was due, I began to receive multiple group texts written to Cassandra Suerte, Gail Sutherland, and me. "David I must see the direction you are headed in today Please send ASAP" read one, another making sure the application would be kept secret from the nominee instructed me to "use Julie and Rex and (Jerry as you suggest)." She also commented that Julies' perspective having written for the *Tribune*, a widely circulated newspaper, was perfect for business writing and this specific nomination. I got in touch with Saxton and attempted to explain the background of the nomination, at around 9:15 PM two days before the application was due. She let out a befuddled chuckle at the thought that her experience writing for the *Tribune* would in any way contribute to the effort, but she agreed to review what I had written and would later offer feedback to Mary Reagan and me. At 7:12 AM the day before the application was due, my phone began to buzz with texts from Reagan to Saxton and me, including one stating that the application needed "harsh editing." I opted to take

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<sup>57</sup> In my first year working on grant-related activities (2018) our department generated six award nominations as compared to approximately thirty grant applications (16%).

a shower instead of immediately replying, but I heard my phone ringing just as I finished. Julie Saxton had called me to ask, with a certain amount of urgency in her voice, if I had time for a conference call with Reagan to discuss edits. I paused a moment to adjust the bath towel I had just wrapped around myself after getting out of the shower, put the phone on speaker, and reached for the coffee cup that I had left on my kitchen counter before my shower. I was just asking if we could discuss at 8:30 – after I had a chance to get to Wilthook – when a loud scream from one of her children broke over the phone. After letting out a sigh, Saxton agreed and hung up. I finished my coffee, got dressed, and set out for Wilthook. While I was walking from the bus station toward the Canaan Street office around 8:30, Mary Reagan’s number appeared on my phone and she breathlessly began peppering me and Saxton, whom she had conferenced in, with questions about the nomination. “Will you get quotes from the board finance chair? Who will offer content about the Jackson County expansion? What about the financial health piece?” etc. Saxton and I took turns attempting to respond, before Reagan interrupted to say, “This first part, I don’t really like the way it flows.” The first part asked to “briefly describe the mission statement of the organization where the nominee works.” “We need to freshen it up, make it a little more exciting so it goes better with [the nominee’s] accomplishments. It’s really stale.” I pointed out that I had repeated Care Center’s mission statement in order to be responsive to the application’s structure and the prompt for that specific section. “I suppose that’s true,” Reagan countered, “but it needs something.” She dismissed Saxton and me saying, “This is my top priority, I’ll be driving this afternoon, so call and give me updates.” When I finished walking to Canaan Street and sat down at my computer, I had received a conference call meeting invitation in my Outlook inbox sent to me by Bethany Murphy, another one of Reagan’s assistants. The call was with Care Center’s Board of Director’s finance committee chair to discuss the

nomination and, if possible, to furnish me with appropriate quotations about the nominee to include in the final product.

Mary Reagan's suggestion that Care Center's mission statement had become stale (i.e. Old French *estaler*, 'to halt'; synonymous with 'dried out') and that freshening it up (i.e. Old English *fersc*, 'not salt, fit for drinking') would better help it characterize the nominee's efforts reflects an ongoing effort, at least on her part, to find a way to bridge the structural opposition between "wet" and "dry" that I have outlined above. Emphasizing the individual person (the award nominee) here contrasts directly to the more formal, institutionalized mission statement and pushes forward the effort to keep Care Center fresh, drinkable, and "wet." In fact, Reagan enlisted the organizational apparatus (Julie Saxton, multiple administrative assistants, a member of the Board, and me) as individual persons (not institutional departments) to assist in renewing the character of Care Center's mission by focusing on the individual accomplishments of a top executive. Following Schwartzman (1989) I have interpreted the various "meetings" convened to discuss the nomination as a constitutive social form that both reflects and replicates Care Center's underlying systems of organization.

This brief structural detour has allowed me to set Care Center's organizational forms in contrast to the bureaucratic characteristics associated with Weber's ideal type. Care Center bureaucrats typically defaulted to "wet" terminology in describing the health center's institutional organization. This system was best exemplified in the person of Care Center's CEO, whose suggestion to "freshen up" the "stale" mission of the health center for an individual award nomination amplified the health center's commitment to a person-driven approach. Her effort to bridge "wet" and "dry" categories is perhaps best expressed by Abigail Worthington's

pithy summary of what working with Reagan was like: “She makes me feel like I’m on firm footing and quicksand all at the same time.”

In the final section of this chapter I shall trace out some of the ways that this person-driven approach expressed itself in Care Center’s administrative operations.

### **Organizational Implications of Wet and Dry**

**Betsy Connell:** I don't know about zombies, doctor. Just what is a zombie?

**Dr. Maxwell:** A ghost. A living dead. It’s also a drink.

**Betsy Connell:** Yes. I tried one once. But there wasn’t anything dead about it.

*I Walked with a Zombie (1943)*

If Mary Reagan exemplified the structural tension between “wet” and “dry” categories, she also demonstrated the association that a “wet” approach maintained with renewal and growth. About a year after I had prepared the award nomination, I poked my head into Jerry Russo’s office on the third floor of the Canaan Street office in Wilthook. An amiable fellow of about 48 with whom I had bonded over the poor performance of local sports teams, Russo oversaw various aspects of financial reporting for Care Center. Mike Foss worked closely with him, and we would occasionally share a collective laugh over this or that peculiar Care Center business decision over drinks in Wilthook or at impromptu get-togethers following after-hours health center functions. Mike Foss was sitting at one of two chairs located in front of Russo’s desk. “Your ears must’ve been ringing,” Russo called out to me. “Apparently Sarah’s father got into a discussion with Mary about grassroots the other night.” I had frequently discussed the organizational sense of grassroots with Russo and had included several questions about that in my more formal interview with Foss. Foss now went on to describe how, over a few glasses of wine, an acquaintance had suggested that community-based organizations could not maintain their grassroots character as they grew. “I’m sure that went over well with Mary,” I jokingly replied. “No,” replied Foss haltingly, “No, it did not.” I suggested that nothing seemed more

terrifying to Reagan than being constrained by systematic structure, and Russo chimed in, “You know, it’s funny, usually as you get older you tend to see people get less radical, not more. In Mary’s case, it seems like the opposite has happened.” Becoming more radical (from the Latin *radix*, ‘root’) emphasized the ongoing growth stemming from roots, not only of the CEO, but also of Care Center as a whole.

Some senior Care Center staff with whom I shared Russo’s observation suggested that the emphasis on growth and renewal really had more to do with the CEO’s own fear of mortality (or possibly a concern for her legacy), and that as long as Care Center continued to grow and change these ultimate questions could be avoided. Care Center’s bureaucracy *did* exhibit certain tendencies that seemed connected to a fear of death, or conversely, a constant renewal of growth. For example, senior staff at Care Center often would “retire” but continue to hold ongoing roles within the organization. As a result, Care Center had two ex-CMOs and one ex-COO actively working on various health center projects during the time I conducted my research. Other executive-level staff who, for a variety of reasons, had been marginalized from the Care Center’s executive-level leadership bodies did not leave the health center. Instead, they continued working at the health center in varying states of liminality.

These figures, all holding titles atypical from a corporate standpoint (*Chief of Practice Evolution, Chief of Clinical Planning and Development, Chief of Training and Patient Activation*, etc.), would periodically emerge and interact with Care Center administrative staff, pursuing various projects seemingly unrelated to the basic suite of health center services. On one such instance, following my move to Wilthook, Sarah Bond, who provided administrative support for several grant-supported programs, came to my office to let me know I should be expecting to work on a grant with Alan Johnson, one of Care Center’s ex-CMOs whom I had not

seen since interviewing him a year earlier in Nickerson. I soon received a forwarded email from Abigail Worthington in which an attorney working with a legal aid association expressed interest in partnering with Care Center on a project to provide legal services limited to “breast cancer victims and their families.” Worthington had forwarded this email to me, Sarah Bond, and Alan Johnson, indicating that we could help understand and assess the opportunity. Bond scheduled a conference call with the legal aid society to discuss a potential project. Johnson joined the call by cellphone while on a break from a Care Center provider meeting and described how a neighbor’s undocumented friend had had trouble accessing cancer treatment services and how this prompted the discussion. When the attorney explained that the project was primarily focused on breast cancer only, and that working with undocumented individuals in the current political climate was almost impossible, Johnson expressed his desire to still have Care Center “work with” the legal aid society and emphasized how important the matter was to him personally. He then indicated that he would leave the follow-up “in the competent hands” of Bond and myself. Over the next week Bond and I enlisted the support of Care Center’s informatics team to parse out the number of potential individuals with a breast cancer diagnosis who might be able to take advantage of the proposed services. In response to a follow up email from the attorney, Abigail Worthington instructed me to “keep Alan in the loop.”

My purpose in presenting the legal aid project is not to determine whether it was worthwhile to pursue (although given the limited number of potential beneficiaries identified and the specific regional area in which it would operate, it was not clear how substantial the impact would be). I am more interested in the fact that an *ex*-CMO at Care Center had the authority to drive a highly specific project on the basis of a *personal* interaction he had with a neighbor. Felicia Finley, another one of Care Center’s *ex*-CMOs, followed a similar pattern. She would



forward emails to my direct supervisor, Gail Sutherland, and to me regarding additional grant opportunities that would support the *Genetix* Research Program<sup>58</sup> and she would encourage us to apply. But Finley could never summarize or articulate what exactly it was that she, or the program, was trying to accomplish by pursuing the funding. Finley had, with the CEOs support, enlisted Care Center in the *Genetix* program which focused on enrolling not only Care Center patients in the study, but also the community at large. For Care Center administrative staff focused on basic operational issues (visit volume, physician retentions, etc.) the investment of clinical staff time on a project only distantly associated with direct patient care produced a certain level of resentment and ridicule. This is not to say that people were antagonistic to the overall purpose of the *Genetix* program, but seemingly perplexed by the prioritization of this work over other aspects of the health center's operation.

In the summer of 2018, John Bewley and I were on a conference call about a supplemental funding opportunity for the program during which Finley asked Bewley to come up with "some technology" ideas to support the program. Bewley coolly replied that there were lots of technology projects out there, but that he would first need at least a rudimentary sense of what Finley was hoping to accomplish. I had previously interviewed Bewley and had heard him emphasize a desire to avoid this exact situation:

**JB:** IT is a service. As much as we can be cutting edge in a lot of things, I can't drive where providing patient care is going to go. I can make it happen, but I need a clinician saying, "Can we do this?" Then, the analogy that I'm always giving is, "I don't want to be the tail wagging the dog."

**David:** Do you ever feel like you are?

**JB:** No, because I won't let that happen. Because when that happens, then I put myself and my department in a much more liable position, that we should not be in. There are certain

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<sup>58</sup> The *Genetix* Research Program was an ongoing NIH-sponsored initiative to gather health-related data over many years from people living in the United States, with the ultimate goal of accelerating medication, and treatment development.

things that I will give direction on, but I can't be directing where patient care is going because I am not a clinician.

I texted Bewley while we were both on the call to write, “Wtf? You’re in charge of programmatic content now?” which prompted a simple “lol” in response.” At the moment, as an employee of Care Center, this type of interaction was particularly frustrating because I was required to translate something from this conference call into responsive content following the explicit format of the grant application. But compared to Bewley’s work, my responsibility seemed relatively simple to accomplish. The frustration here comes from a tension, not necessarily resolved, between administrative staff focused on clear roles, responsibilities, and technical requirements, and a more fluid, unbounded approach to program design and development. That said, Finley was certainly proud of the research program, as were several of the staff who worked on the programmatic portions of the work, going so far as to label it her most successful project of the year at an executive team meeting held in December of 2018.

Cheryl Jacobs, a Care Center ex-COO, also introduced similar types of projects. In one instance Mary Reagan, who had made the acquaintance of an academic bioethicist focusing on legal aspects of surrogate families, asked Jacobs to “work with him” to see if he could “do something with Care Center.” The project expanded into multiple planning sessions and the introduction of a non-mandatory bioethics-training module in Care Center’s online training platform that was sent to all employees.

These vague solicitations of support, these agitated yet seemingly reactive pursuits that drifted through the work lives of Care Center administrative staff, without any sense of connection to basic health center service provision or any sense of formalized structure, bore an uncanny resemblance to the movements of zombies. I introduce the zombie trope here fully aware of the potentially negative connotations it might have, but I find the characterization

useful in describing the way “organized dissonance” actually plays out within the Care Center context. I have also focused this discussion on senior leaders not to disparage their abilities, or the projects they pursued. There is something profoundly kind, comforting, and humane in the value Mary Reagan placed on these individuals and their passion for continuing to contribute to Care Center’s work. But I have concentrated on them because these individuals are particularly illustrative examples of how fluid role assignment transcends formal organizational structures.<sup>59</sup> I use the term zombie in contrast to business and organizational studies that use it to characterize un-enlivened workers (Hacker 2016), comatose organizational pursuit of objectives (Gray 2018), or even as a humorous critique of bureaucracy (Conway 2010).<sup>60</sup> I also am not attempting to interpret the appearance of zombies as a symptom ongoing confusion about the workings of neoliberal capital (Comaroff and Comaroff 2002). Rather, in the Care Center context, I am more focused on the tendency for zombies to elude an all-encompassing definition, to defy categorization, and, following Kevin Boon, the characteristic fact that most zombies have experienced “the absence of some metaphysical quality of their essential selves” (2011, 7). From the perspective of formalized structure, this type of individual transcended fixed categories and boundaries and the metaphysical quality they lost was associated with integration into those categories and boundaries. They were immortal, shorn of any clearly specified role within the organization. Members of Care Center’s “zombie leadership” continued to exist, adding chaotic projects to the health center’s portfolio. In terms of a “dry” perspective associated with a clearly defined organizational structure, the presence of these individuals was highly disruptive, echoing

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<sup>59</sup> The inability for individuals within Care Center’s administration to shed responsibilities if they changed titles was not confined to senior leadership. I experienced this when I transitioned from the role of “Project Manager” to “Associate Vice President” and, despite being instructed to “leave my portfolio behind,” I found myself drawn back into the old work even as I took on new responsibilities.

<sup>60</sup> “Bureaucracy is an organizational structure which is created in order to level every aspect of human existence, to make everyone equal in the eyes of the bureaucratic authority, an apolitical absorbent mass, much like Romero's zombie hordes” (Conway 2010, 82).

the analysis of zombie phenomenology put forward by Steven Shaviro in which he argues that zombies “continue to participate in human, social rituals and processes – but only just enough to drain them of their power and meaning” (2017, 8). By disrupting strictly defined roles or hierarchies, these “extra-ordinary” zombies, in the analysis of Chera Kee, moved to resist bureaucratic dehumanization through a studied rebellion against strictly regimented organizational forms. In fact, Care Center’s extra-ordinary zombies were remarkably adept at blurring the boundaries between the categories of “wet” and “dry,” a duality inherent in their character that could “seldom be contained in a simple binary dialectic” (Cohen 1996, 17).

The emergence of zombies within Care Center’s administrative apparatus inevitably leads to the persistence of “zombie projects,” projects that, although sometimes suppressed, could break out at a moment’s notice. A consultant from a national firm first used the term “zombie project” in her evaluation of Care Center’s strategic planning process, and she developed a method for culling these projects by using a set of objective criteria and by ranking each one according to its alignment with organizational priorities. Her approach aligns with the discourse of business analytics purveyors such as *Gale Business Insights* that recommends using appropriate techniques to kill off as many zombie projects as possible through a targeted undermining of factors that distort “our reasoning processes” (Reinertsen 1998). When Care Center executives attempted to use the consultant’s system at an executive retreat by “ranking” several potential zombie projects by placing stickers on projects they considered worth pursuing, the process was quickly abandoned. It became clear that a project sponsored by one of the executives, a *Chief of Community Collaboration Development and Strategy* (CCCDS), was categorically being eliminated by the exercise. Reagan intervened, halting the exercise, according to one attendee, “because she felt people were ganging up” on the CCCDS. There

may very well have been a bullying mentality at play in this interaction, but there is also an explicit rejection of an adherence to regimented, formal, “rational,” processes. “At Care Center there’s no corporate-assisted suicide.” commented Winston Wright when I described this event to him. The paralysis around letting projects die was reflected in a ceaseless reconfiguring of Care Center’s various executive decision-making bodies. E-Cabinet, Executive Team, Business Council, Strateg-E, Executive Council, and other variations were all convened during my time at Care Center, but each one was disbanded or reformatted as soon as they began to implement formalized decision-making processes and/or regimented structure. “It’s more of a conversation,” said a staff member who completed minutes for the E-Cabinet, “Nothing is ever really voted on or decided. It’s really hard to know if there are any follow-up items to include in the minutes.” This system allowed many projects simply to persist, without discernible end.

### **Bureaucracy of Persons and Personalities**

One of the more intriguing comments Rex Thompson made about coming to work at Care Center had to do with the fact that health center decision-making often hinged on quirkiness:

You can't underestimate quirkiness. I mean a lot of decisions get made just for no particular reason, because somebody saw something, or said something...some idea. Various people in positions of great power here have said to me about themselves candidly, they've said things like, "I've got a screw loose or wires loose," essentially, "I don't see the world the way everybody sees it." They've kind of admitted to an esoteric nature and that gets writ large because there isn't a lot of structure. The esoteric nature of the organization isn't intentional, I... I... I'm convinced. I think a lot of it is just because it *is* and my hope, this may be pie in the sky, but my hope is that there is the chance to bring some structure to it while still retaining things that make it good, but I've only been here 7 months. Talk to me in a year.

It seems, and I did not ask Thompson to clarify this during our interview, that he conflated “quirky” (as in “idiosyncratic”) with “esoteric.”<sup>61</sup> In terms of Care Center’s decision-making process the characterization of the health center as “esoteric” as opposed to “idiosyncratic” made little difference. Decision-making was frequently secretive and confined to a small group of

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<sup>61</sup> I briefly spoke with Thompson again nearly two years later and read this quotation to him, asking if looking back on it he meant “idiosyncratic” as opposed to “esoteric.” He said, “looking back on it, I think it’s actually both.”

people (esoteric). An example of this is the lack of clearly set departmental budgets as described by Thompson in the passage I referenced earlier in this chapter. At the same time decision-making did have a quirky or “idiosyncratic” quality to it in that individual interests or opinions frequently set the corporate agenda in an almost whimsical manner that did not necessarily align with a broader strategic plan or overarching mission. “If we were trying to operationalize towards profit,” Thompson told me, “I think it would empower mission more. I think it would get rid of a lot of vanity projects and decisions that are made not on data or strategy. Just on gut feeling.” The result, as Thompson explained, was that this quirky/esoteric decision-making process came to be inscribed across the totality of the organization (*writ large*) as if it were completely natural (*it just is*).

In this section, I will explore the impacts this “quirkiness” and fluid, unstructured, personality-oriented approach had on Care Center healthcare projects. I will then argue that Care Center’s emphasis on individual persons and personalities (quirky/esoteric in Thompson’s words) was far from “natural.” In fact, this emphasis on fluid roles and individual persons was aided by structural features of the FQHC program in synergy with Care Center’s organizational form and reinforced through the organization’s leadership.

The fact that so much of this “quirkiness” came directly from “positions of great power” warrants comment here. To be sure, Care Center’s executive leadership had a range of eccentric interests that they pursued directly or empowered individuals within top leadership at Care Center to pursue. The impact this had on how Care Center bureaucrats (I include the executive class among them here) structured their work persisted throughout the time I conducted research. It was conspicuously observable in the fact that technical expertise and empirical data were frequently de-emphasized when working through decision-making about what types of projects

to pursue or *not* to pursue. Within administrative science literature, the impacts of the unique characteristics of executive-level staff on organizational strategy and performance has been well documented (Iaquinto and Fredrickson, 1997; Jensen and Zajac 2004; Berson, Oreg, and Dvir 2008). I have offered one example of how this played out at the health center by reviewing how Care Center evaluated an opportunity for expansion into a new service area, but this style of decision-making was ubiquitous at Care Center. At one point, I evaluated a funding opportunity put out by the Health Resources Services Administration (HRSA) to support an Advanced Nursing Education Nurse Practitioner Residency Program. The purpose of the grant was to subsidize payments to new nurse practitioners (NPs) in primary care through clinical and academic residency programs. NPs did not typically go through a formal residency program following their academic training in the same way that the MDs did and, because NPs were expected to carry full patient loads upon accepting employment at places like FQHCs, they frequently experienced overwhelming challenges resulting in burnout, workforce limitations, and a reduction in the quality of care delivered. In evaluating the opportunity, I identified several challenges that Care Center would have to address including (a) simply preparing an application by the deadline, and (b) implementing the grant based on the obligatory partnership with an established educational institution to support the didactic portion of the program. I reviewed this analysis with Abigail Worthington who commented that she would love to simply let it go, but that Mary Reagan would not stop asking about it. I suggested that if the purpose was to address a workforce issue (either in terms of recruitment, or ongoing performance of NPs) we could recoup the benefits of such a program by partnering with an academic institution that would place residents at Care Center sites. “You’re being completely reasonable,” Worthington told me, “I just have to find the right way to say that to Mary.” The implication here is that “reason”

had very little to do with how the decision would ultimately be made. Rather the manner in which Worthington spoke to Reagan would produce the final outcome. One Care Center VP to whom I described this process of decision-making offered a unique term to describe it: “Mary whispering.”

“Whispering” offers a practical way to connect broader theoretical notions of Weberian rationality (specifically the contrast between formal and substantive rationality) with Care Center’s bureaucratic practice. In the example described above, whispering was necessary in order to translate my use of Weberian “formal rationality” to assess the NP Residency program into the “substantively rational” language more readily accepted by the CEO. This distinction, sprinkled throughout Weber’s writing but explicitly discussed in *Economy and Society*, contrasts “quantitative calculation” and its application with “social action under some criterion (past, present, or potential) of ultimate values, regardless of the nature of these ends” (1978, 85). Although Weber focused on economic action, I extend this distinction to broader organizational and executive decision-making at Care Center. The existence of a particular skill-set associated with translating or going between these two forms of rationality introduces the fact that multiple forms of rationality existed within Care Center’s administration. “Nothing is ever ‘rational’ in itself but only from a particular ‘rational’ point of view,” says Weber in response to criticisms of *The Protestant Work Ethic and the “Spirit of Capitalism.”* “If it helps to achieve anything at all, I should like this essay to help to reveal the multifaceted nature of the seemingly unambiguous concept of the ‘rational’ ” (2002). The significant effect of this “radical perspectivism” is that rationalization as a process ultimately “depends on an individual’s implied or stated, unconscious or conscious, preference for certain ultimate values” (Kalberg 1980, 1185-6). In the case of Care



Center, the CEO's latent preferences became the de facto criteria for decision-making as opposed to more mechanically driven calculations.

The distinction between formal and substantive rationality emphasizes the extent to which Care Center's "ultimate values" were tied to the conscious or unconscious preference of its CEO, and the lengths to which people would go to "whisper" as a way to toggle between these two forms of rationality. When I asked the VP who first mentioned "Mary whispering" to give me an example, he offered an instance in which he had been working on a planning session and one of his staff members was prepared to reply to Mary Reagan with a formal summary of the work done to date and with follow up questions. The VP advised against this course of action, saying that Reagan probably was not really interested in the formal aspect of what had been accomplished, but was apparently distracted by the fact that one of her long-time advisors had not participated in the project to date. He advised the staff member to write back, including Reagan's advisor, asking that they find a time to discuss. Reagan wrote back immediately praising the suggestion and copying an assistant to facilitate scheduling. The VP let out a frustrated, sigh saying the he felt really great for a moment at having mastered the art of "whispering" but then questioned whether or not he was "getting stupider" working at Care Center because "Mary-whispering" was not really a broadly recognized or transferrable work skill and was particular to the individual to whom the whispering was directed. Abigail Worthington, a skillful "Mary-whisperer" by multiple accounts, crystalized the specificity of this skill. Once, while negotiating through Care Center's budget, she emerged from her Canaan Street office, red faced and looking somewhat stunned. "David, how the hell are you?" She asked walking toward the fourth-floor kitchenette. I responded and asked her how she was doing. She let out a "Whoosh" sound and shook her head. The VP of nursing had, by this point,

popped out of her office adjoining the kitchenette to tell Worthington that they were fortunate to straighten out the funding for one of her positions. Worthington replied, “I guess, but then I had an hour and a half with the Reagan-meister,” again shaking her head slowly and walking back toward her office. I was struck here by the slang use of “meister” to describe interacting with the CEO. While I want to avoid taking an overly scholastic approach to a simple turn of phrase, Worthington’s use of it in this context emphasized the personal familiarity she maintained with the CEO. It also designated Mary Reagan as a “meister” or *maestro*, but mastery in this context is an individual, personal mastery. That is a mastery simply of being Mary Reagan. The skill set of this maestro was not technical proficiency, but rather the skills associated with her individual being and her personal ultimate values. As Robert Jackall eloquently observes: “the basic framework of managerial work is formed by structures of personalized authority in formally impersonal contexts, fealty with bosses and patrons, and alliances shaped through networks, coteries, cliques, and work groups...” (192).

I should also briefly point out that this phenomenon is typical in business, and one of the most frequently cited articles from the *Harvard Business Review* is Gabarro and Kotter’s now classic “Managing Your Boss” (1980). But these reviews, and literature on boss-subordinate relationships generally,<sup>62</sup> emphasize the one-to-one relationship between leaders and followers without interpreting the dynamics of that relationship as a product of broader socio-organizational structure. There is also a tendency for this literature to focus on for-profit corporations, but the fact of the matter is that the stakes for managing the boss in not-for-profit organizations are typically higher than that of for-profit firms. Not-for-profit companies, because they are self-perpetuating, seldom subject to liquidation, and highly restricted in terms

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<sup>62</sup> For an extensive review of leadership/followership see Uhi-Bien et al. (2014).

of board “ownership” over organizational assets/profits, tend to produce CEOs who generally have “an almost unmatched degree of autonomy” (Glaeser 2003, 1-2). As such these organizations tend to eschew profit motives and are “much more likely to follow whatever quirky ideas dominate the opinions of their CEO” (Ibid, 5). From an organizational studies perspective, this circumstance leaves not-for-profit organizations vulnerable to maladies such as “founder’s syndrome” that occurs “when, rather than working toward its overall mission, the organization operates primarily according to the personality of a prominent person in the organization, for example, the founder, board chair/president, chief executive, etc.” (McNamara 1995). At least one VP I interviewed diagnosed the Care Center with founder’s syndrome, saying “I come at this from the nonprofit space, not the healthcare space or the health center space or anything like it. We have lots of symptoms of a certain phase of *founderitis*. So, every nonprofit goes through a massive transition after the founders move on and they have a new CEO or a new executive director. We saw the first one, so before I started [at Care Center], I saw endless symptoms of *founderitis*, that's what we have.” Again, this phenomenon is not unique to FQHCs, but the impact of it on health care delivery might be.

This idiosyncratic, person-driven basis for rationality and organizational structure had several functional side effects on daily work, one of which I will briefly mention here. Because Care Center decisions relied on being responsive to the individual preferences or “quirks” of its CEO, the basis for workplace evaluation consistently emphasized the manner of presentation and the manners of the person presenting that information over more impersonal forms of assessment. Rather than a formal ethic, etiquette and comportment took precedence, and it was not uncommon to have this aspect of one’s performance called out. At one point, while contemplating the initiation of a care management program that bore with it substantial capital

investments and quantifiable downside financial risk, Mary Reagan complained about including members of Care Center's finance team in the planning process because she wanted to have "people with enthusiasm" involved in the project, rather than the finance department who would just present an austere financial analysis. This mindset extended to Care Center's work with external partners. On one occasion, after explaining the technical impossibilities of a loan-repayment structure resulting from the specific conditions of a grant award to a group of Care Center partners on a large capital project, I received a note from the CFO. He instructed me to work with a consultant on pursuing the loan repayment structure regardless of its technical viability because "we need to pause regarding our comportment." Although etiquette has consistently been "trapped within the shallow realm of mere appearance," the Care Center experience suggests the extent to which etiquette structured the bureaucratic operations of the health center as opposed the rules of a formal ethic (Scapp and Seitz 2007, 2). The emphasis on etiquette then can be interpreted as a means by which a Foucauldian governmentality or "care of the self" was insinuated into the daily performance of administrative work within Care Center (Hamann 2000, 82). If rationalization in the Weberian sense focused on the development of methodical self-control (Brubaker 1984), the sense of self-discipline emerging at Care Center focused on etiquette, comportment, and development of effective appearances. In short, management becomes a "moral technology" (Ball 1990).

I have focused on the very specific features of Care Center's personalized process of decision-making, but this system often resulted in an equally idiosyncratic style of delivering health care services. For FQHCs, often among the first responders to emerging public health crises, this mode of project implementation bore with it immediate implications, one of which I shall summarize here. During my fieldwork at Care Center, New York State and the United

States continued to experience substantial increases in opioid use and opioid-related deaths. In New York this was evidenced by the opioid overdose rate/100,000 population, which increased from 13.5 in 2015 to 16.8 in 2016, to 19.1 in 2017 (New York State Department of Health 2018). During this time FQHCs nationally played an important role as a source for opioid use disorder (OUD) treatment, with approximately 48% providing medication assisted treatment (MAT)<sup>63</sup> according to a 2018 survey (Zur et al. 2018). It should also be noted that several barriers existed to accessing MAT, including having potential MAT prescribers undergo a federal “waiver” process (regulatory/workforce), limits on the number of patients for whom MAT could be prescribed (regulatory), and limitations on reimbursement for the delivery of MAT (financial). Caitlin Simbel, a Care Center MD with multiple additional professional degrees, and a specialist in infectious diseases, had been actively treating OUD since 2004 utilizing MAT, and she aggressively sought to expand the delivery of MAT at Care Center sites during my period of research. I introduce Simbel here because in addition to advocating for the expansion of MAT at Care Center, she also aggressively sought to segregate MAT provision as a sort of specialty model apart from basic internal medicine. The efforts of Care Center’s ex-CMO, Felicia Finley, who, according to one of Simbel’s colleagues would “do whatever Caitlin wanted” and was particularly effective at managing the boss by sustaining her interest in the program, installed the prescriber-led model as the default model for delivering MAT services. In describing this model, Simbel would frequently indicate that providers interested in prescribing MAT wanted to focus exclusively on OUD patients, and in recruiting MAT prescribers she frequently criticized those whom she considered “less sensitive” to the stigma experience by persons who used opioids.

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<sup>63</sup> MAT involves the use of prescribed opioid agonists or antagonists to suppress withdrawal symptoms and relieve addiction cravings and has consistently demonstrated efficacy in reducing the frequency and quantity of opioid use: Mattick, Breen, Kimber, et al. (2009); Mattick, Breen, Kimber, et al. (2014).

Simbel had definite exposure to this model, even mentioning a professional relationship that she maintained with a national prominent lead on the nurse-led model in Massachusetts, but she derided the program, particularly with respect to retention in treatment at twelve months. “Care Center’s retention in care is much better than this [i.e. the Massachusetts model],” she accurately wrote to me: Care Center’s retention percentage was at 58%, the nurse-led model at 51%. Several Care Center staff scoffed at Simbel’s objections, arguing that she simply wanted to fashion “her own little kingdom” using this model. I should pause to note that this type of critique was rather consistently leveled against Simbel’s method, and from a fairly diverse set of employees in terms of race, gender, ethnicity, rank, etc.

The tension that arose from Simbel’s approach to MAT programming resulted from the fact that it requires substantial personnel investment (Licensed Clinical Social Worker/Licensed Masters Social Worker biopsychosocial assessments for concomitant mental health disorders, monthly visits with the MAT provider, care management visits, extensive monthly laboratory testing, case conferencing, etc.). As a result of these factors, visit times for patients in Care Center’s MAT programming were approximately twice as long as those for non-MAT patients. Alternative models for providing MAT existed, one of which sought to address lengthy visit times through the use of nurse care managers/coordinators who served as a “ ‘glue’ person...critical for offloading the burden of care from physicians and allowing them to manage more patients” (Chou et al. 2016, 10). Due to the fact that Care Center’s model relied primarily on an MD-level prescriber conducting these visits, it was financially impossible to sustain, or expand, in the absence of grant funding. Through this model, Care Center saw approximately 450 MAT patients in 2018. To put this into a comparative context, a sister FQHC providing MAT services in New York City utilizing the nurse-lead model saw approximately 400 MAT

patients, despite having seen approximately 80% fewer patients than Care Center overall. The point here being that the nurse-led model produced substantially more access, at least in terms of visit volume, to MAT.

I do not want to suggest that one model of providing MAT in FQHCs is necessarily “better” than another, but they are substantially different, at least in terms of a very crude measure of access represented by the number of patients reached. I also do not want to minimize the impact that structural barriers (including those I outlined previously) have on limiting access to MAT, nor to indicate that Care Center’s MAT programming was ineffective. To the contrary, it was extremely well received both by patients, clinicians, and by the broader communities in which it operated. However, in providing this very cursory review of Care Center’s MAT programming and Caitlin Simbel’s role in promoting an MD-dependent model I want to suggest that at the level of access to treatment, individual decision-making within organizations has a profound impact. While I was preparing my notes for this section of the chapter at Wilhook one Saturday, I happened to see Care Center’s Director of Care Management, who worked closely with Dr. Simbel. I stood outside her office waiting for a cup of coffee to finish brewing from a Keurig machine and asked her why we (at Care Center) developed so many idiosyncratic program models (like the MAT model) that depended so heavily on individual persons as opposed to organizational structures. “I think it’s the other way around. I think Caitlin feels like she has to individually dominate the program, because there’s nothing else that would provide any structure at all.” Another program administrator who worked with Simbel went further, suggesting that Simbel would never accept a circumstance in which she had to accept a structured authority and that “the only reason she stays at the health center is because she can do whatever the fuck she wants.” To me these comments seem to mutually reinforce one another.

If individuals have structures inside them, then structures must necessarily exist as individual persons, as Rex Thompson pointed out with respect to Mary Reagan, producing what Jo Freeman termed “the tyranny of structurelessness” (1972). In the absence of a formalized decision-making structure, individual preference (or quirkiness) on the part of Simbel drove the manner in which Care Center implemented MAT service delivery, potentially limiting access to treatment in terms of raw numbers. And while the bureaucratic regulations governing the provision of MAT *are* complicated and potentially restrictive, this should not obscure the extent to which individual preferences (“quirkiness”) within organizational settings also structure access to specific services. I reiterate that this phenomenon is not exclusive to FQHCs, and the causal links between elite staff, “organizational culture,” and organizational outcomes has been well documented elsewhere (Berson, Oreg, and Dvir 2008). But in the FQHC setting, “sales growth,” “efficiency” and “satisfaction” have different stakes than in the corporate business settings that typically are the subject of this type of analysis

The approach to MAT at Care Center, dominated to a large degree by the forceful personality of Caitlin Simbel, illustrates how the structure by which services were delivered depended heavily on a lack of rigid organizational structure coupled with the preferences of individuals. And while several Care Center staff might have raised an eyebrow at Simbel’s approach, her commitment to patients and her concern for treating OUD was never seriously questioned.

### **How Broader Aspects of the FQHC Program and Personalities Reinforce One Another**

So far in this chapter I have attempted to show how Care Center was fundamentally an organization driven by people and personalities without a rigidly defined structure in place. I have attempted to show this by suggesting instances in which the quirks of one or another individual ultimately can produce unique arrangements in the delivery of healthcare services.



Although its executive leadership cultivated much of this emphasis on individuals and the fluid roles they have within Care Center, the extent to which the broader structural environment in which FQHCs operate facilitate that system cannot be understated. When Rex Thompson suggested that operationalizing toward profit might support mission more, he introduced the notion that certain structural features bounding Care Center's world rendered a formal profit-motive orientation relatively insignificant to the sustainability of the organization.

**RT:** I think cynically speaking organizations are driven by need primarily. In our case we don't have a need to make money, so market-based decisions are irrelevant. We bleed patients so to speak. Every year we lose employees, but we still get the same amount of money. We have to account for certain things, but if we were a fully for-profit organization that bled money for a number of years in a row, that would be fucked. We would be out of business.

**David:** How do you think that the health center-- Have you seen the health center mitigating like a negative result since it doesn't have to worry about this? Have you seen what types of impacts that might have?

**RT:** I don't think the same kind of responses that we have made. We before-- We historically, the Royal we, I don't think those would be either tolerated or effective in a for-profit or even many nonprofits. That depends on whether there's a relationship between performance and income. There isn't a relationship between performance and income here as far as I can see. Not a direct relationship. Do you disagree?

The implication here is that because of federal support, certain market logics simply did not apply to Care Center's work. Another Care Center VP stated the matter more bluntly: "Excess resources allow individual priorities to compete with the grassroots priorities. We just run the (FQHC) program and pat ourselves on our back." In this final section I outline some of these structural supports, and argue that a certain level of amnesia regarding how substantial these supports are in preserving Care Center's financial success have persisted at Care Center. This amnesia in turn offered apparent vindication for the emphasis on the quirky, personality-based administration.

A peculiar feature of the health center's administrative and corporate structure contributing to Care Center's success was the existence of multiple *subrecipient* agreements. Subrecipients (sometimes "sub-recipients") are entities that receive subawards from a pass-

through entity to carry out part of a Federal program and that meet the various requirements of the FQHC program as described under section 330 of the Public Health Service Act. To a certain extent the health center program was founded on the basis of such agreements: The original Office of Economic Opportunity health centers required that the first applicants be sponsored by a separate institution. Even my field site had gone through various “subrecipient” arrangements, from its foundation as a contractor for the New York Metropolitan Regional Medical Program, to its reception of funds passed through a sister health center whose capacity for demonstrating medical underservice outstripped its own. But subrecipient arrangements began to spread following Reagan-era attempts to block grant funding for FQHCs. States had been given the option of taking over health center administration, but if the state were to do so, it would be obligated to fund the health center at the same grant level and meet various governance requirements of the program (i.e. having a community board) (Mikey 2012, 43). Some existing neighborhood health centers viewed their corporate structure as a particularly powerful tool for self-preservation and formed networks capable of meeting these requirements. The Rochester Primary Care Network (formerly the Rochester Health Network and the Neighborhood Health Centers of Monroe County) in upstate New York was one such example. To effectively meet the administrative demands of the federal program the organization retained a staff capable of monitoring the programmatic and financial requirements while serving as the umbrella organization for several individual community health centers operating beneath it.

While such arrangements did have antecedents, they exploded as part of George W. Bush’s managed growth initiative as a mechanism to convert existing ambulatory sites to the health center model. By the early 2000s numerous hospital-sponsored ambulatory care clinics, primary care practices, rural health clinics, public health departments, and community-based

providers were experiencing significant financial losses due to the large number uninsured and underinsured patients these organizations were seeing. Several features of the FQHC model made it appealing for these groups, specifically the financial resources available to FQHCs: enhanced cost-related Medicaid and Medicare reimbursement (Prospective Payment System/PPS rate),<sup>64</sup> Federal Tort Claims Act coverage for malpractice, and 340B discounted drug pricing. Each of these benefits, seemingly so arcane and abstruse, suddenly placed health centers into a position of relative strength compared to their non-federal counterparts. Even organizations highly similar in basic morphological structure (comprehensive primary and preventive care, to all persons regardless of insurance status or ability to pay, etc.) suddenly looked like strange stepchildren in the eyes of FQHCs. A 2004 instructional document prepared jointly by the National Association of Community Health Centers (NACHC) and an attorney from the firm of Feldsman Tucker Leifer Fidell LLP<sup>65</sup> for FQHCs considering entry into this type of arrangement delivers this remarkable exposition:

The range of specific goals and objectives of affiliations can be as broad as the mission and creativity of the health center and its partner(s) permit and, in turn, the collaborative activities explored by the health center and its affiliation partner may be extremely varied (National Association of Community Health Centers 2004, 3).

The guide continues to outline several “typical” goals of the program such as: enhancing the amount and type of services provided, expanding access locations, improving appropriateness of care delivery, maintaining and enlarging patient bases, improvement of community needs

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<sup>64</sup>As described by the National Association of Community Health Centers (NACHC): “In recognition of the critical role FQHCs play and the value they deliver for Medicaid patients and state programs, Congress, on a bipartisan basis, created a specific payment methodology for health centers, the FQHC Prospective Payment System (PPS). This payment system is central to the successful relationship between FQHCs and Medicaid, and to health centers’ continued viability” (National Association of Community Health Centers n.d.).

<sup>65</sup> Jacqueline “Jackie” Leifer, a partner in the firm, had sought multiple injunctions to prevent the implementation of primary care block grants for the FQHC program in Georgia and West Virginia, the only two states to apply for the funding (Reynolds 1999, 24). Feldsman Tucker Leifer Fidell is one of a handful of law firms specializing in federal grants law, and it often litigates on behalf of section 330 grantees.

assessments, broadening acceptance of patients regardless of insurance status/ability to pay, and enhancing and improving clinical, administrative and managerial capacities, resources, expertise, procedures and systems, including costly “backroom functions,” by sharing, purchasing, selling, or integrating such functions (Ibid). This last goal is particularly intriguing in that it essentially converts FQHC bureaucratic expertise into a coveted product worth trading in through subrecipient arrangement. The goal also ties the breadth of a health center’s mission to its “creativity.” For some health centers, this license to creativity resulted in mere essays in the imaginative process, but Care Center set its sights higher.

By 2007 Care Center was seeing approximately 48,000 patients at sixteen sites. Processing and billing claims for some 200,000 visits to the Care Center network forced the health center to ramp up its billing department. Other FQHCs found themselves swamped in administrative tasks they had not been quite prepared for prior to George W. Bush’s growth initiative, and they began seeking support. Care Center saw these demands as an opportunity and founded a fully owned subsidiary for-profit company (Management Service Organization; MSO) to support and meet an increasing demand for maximizing claims reimbursement. Employees from Care Center would be leased to Keys-2-Care in order to staff the business, and time and effort would be divided between the organizations and tracked. Care Center’s MSO, “Keys-2-Care,” developed a remarkably simple yet immediately effective business model which involved “scrubbing” self-pay (i.e. uninsured) claims by checking social security numbers against Medicaid eligibility in order to re-bill claims that were either unpaid or paid at less than the insured rate. Keys-2-Care would then charge clients a percentage of the recovered claim. This is not a particularly complex business model, and most hospitals and health systems attempt

to utilize patient data to screen patients for unknown coverage and/or scrub claims to find that coverage after the fact (Figueredo 2016).

Other FQHCs began developing similar marketable administrative service products at about the same time. Hudson Headwaters Health Network in New York's Adirondack Mountain region, for example, began offering 340B third-party administrative services in order to track and manage this program for other covered entities. I spoke to John Ruge, the founder and Executive Chairman of Hudson Headwaters after meeting him at a Regulatory Modernization Initiative Integrated Primary Care and Behavioral Health workgroup meeting in Albany, NY in August of 2017. He described the development of his "contract business" as the result of "management, good luck, and serendipity." The 340B program allows health centers, Ryan White HIV/AIDS programs, specialty clinics, and critical access or "disproportionate share" hospitals to purchase pharmaceuticals at substantial discounts. The intent was to subsidize the cost of coverage for uninsured or "self-pay" patients – presumably those least able to afford pricey pharmaceuticals by allowing covered entities to claim any profits gained - by dispersing medications to insured patients. Dr. Ruge received a grant to create the infrastructure necessary to manage the program and realized that not every health center could afford the sunk costs of such an investment. This spawned his side career of providing 340B management services to fellow FQHCs. The growth of the program, particularly in hospital settings, where the financial gains associated with the program have not demonstrably contributed to better care for low-income patients, has recently come under considerable scrutiny (Desai and Williams 2018).

In the case of Keys-2-Care, the thinking was that as a fully owned subsidiary of Care Center, the additional revenue stream brought in by Keys-2-Care could help contribute to the bottom line of the parent organization, thereby contributing to the overarching mission of

delivering health care. As Care Center continued to grow, so did the level of its “back office” expertise, thereby introducing new clients and product lines into the Keys-2-Care portfolio. It would be incorrect to insist too much on the emergence of subrecipient models as the inspiration for the founding of Keys-2-Care – these two things simply coincided - but the foundation of Keys-2-Care broadened the horizons of its parent organization, and soon Care Center sought new external outlets for its creative machinery. In 2011 Care Center found such an outlet by formally adopting LA Health, a network of FQHC “Look-Alikes” as a subrecipient. In describing the process, the health center would say “Care Center’s experience in meeting community need, addressing patient barriers to care, maximizing patient revenue and local resources, and meeting federal requirements will provide the technical assistance to LA Health to ensure success under the subrecipient model.” The advantages to LA Health were clear. The advantages to Care Center were less clear. That said, LA Health would acquire its technical assistance not directly from Care Center, but through an MSO contract with Keys-2-Care.

None of what I have described was conveyed to me in the form of an organizational chart, or even necessarily in as succinct a summary as I have tried to give here. The nature, and even the existence, of these institutional relationships was not always transparent to staff members working at Care Center. One vice president described his confusion at initially being approached with a request to dedicate several hours of his time to helping the LA Health prepare their application for Patient Centered Medical Home (PCMH) certification.<sup>66</sup> “My boss told me I couldn’t do it, that we had enough work just getting Care Center up to date on the standards. Then I have to hear about how we don’t bring in any revenue. I didn’t even know who these people were.” His experience was not so different from my own initial exposure to Keys-2-Care.

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<sup>66</sup> For an overview of PCMH see Arend et al. (2012).

I received an unheralded email from the Director<sup>67</sup> of Keys-2-Care with a copy to Care Center's CEO, CFO, COO, and two other VP-level members of Care Center.

The email stated that LA Health was seeking to understand the potential possibility of entering a new market in Guildsville, New York. LA Health wanted to learn as much as possible about the area with an eye toward expansion and planning including information about health statistics, demographics, transportation, history, income levels and family size, etc. The Director also indicated that the request was rather comprehensive and that we could discuss it with the CEO of LA Health further if we desired. He closed his email with a note to code the time spent working on the project to Keys-to-Care and to label it "strategic management." Assistance in retraining us on how to do that would be available if necessary.

When I received this email, I had only a vague familiarity with LA Health as a subrecipient (or even what that meant), let alone what it meant to code my time to Keys-2-Health. I requested clarification on this point and learned that within the Automatic Data Processing (ADP) payroll software used to track employee timecards (*etime*) multiple pay codes exist that an employee can select from (Sick, Vacation, Holiday, Care Center Salary, Care Center Hourly, Keys-2-Care Salary, Keys-2-Care Hourly, etc.). I would later learn that Keys-2-Health had sold LA Health more hours of "technical assistance" than they could possibly fill using the relatively small number of Care Center employees who were working on the contract, so the CEO had begun to fill these hours with additional time and effort from new Care Center employees. Guildsville was about sixty miles away from Care Center's primary administrative office location and several large urban centers stood between them.

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<sup>67</sup> He also held an executive role at Care Center.

This innocuous email is one of dozens I might have received on a given day. But its apparent simplicity obscures the transformation it outlines. With a simple click of a drop-down menu a person's entire organizational affiliation, time and effort, can switch from a community health center to a for-profit company. I have chosen to emphasize this particular feature of Care Center's structure because it reinforced the health center's emphasis on fluidity of roles, and it demonstrated the fact that a for-profit "competitive advantage" could be found in simply performing basic FQHC bureaucratic functions while on the books of another company. It also reflects a creative use of this fluidity for the purposes of generating revenue. The confusion on the part of some Care Center staff at being approached to conduct work for Keys-2-Care recalls my earlier discussion of zombie-like disruptions, in that Care Center employees could easily transcend fixed organizational categories and hierarchies through their dual role.

If the process of working for Keys-2-Care emphasized fluidity of roles, it also supported a belief held by some Care Center executives that the success of the business was predominantly associated with the personal talents of the organization as opposed to structural advantages. One executive articulated this following a three-year site visit from the Health Resources and Services Administration to assess Care Center's compliance with health center program statutes associated with Section 330 of the Public Health Service Act. "I'm so sick of it. It's like every three years they make you feel like you're a government employee," he commented following the site visit. I made a note to ask him about this, and I did so when I had a chance to discuss my new role with grants administration following my transition to the Canaan Street Office. I explained that I considered our Section 330 grant to be part of my core function, and the only thing we absolutely could not do without. The executive scoffed at this, saying that the grant did not really offer that much ongoing support and that he would just as soon operate sites out of the



federal scope of service and without FTCA coverage. “We only continue to think that way because we have a legacy CEO and a legacy COO who’ve been doing things the same way for 25 years.” To a certain extent he was correct. Of Care Center’s budget, only about 10% of revenue was directly provided by its Section 330 funding. When I asked Jerry Russo the executive’s comment made any sense, he laughed aloud. “Of course not, you know that’s not true. PPS, FTCA, it’s impossible to exist without those.”<sup>68</sup> At a later point Russo described this type of thinking as relying too heavily on “PPS muscles” wherein FQHC staff convinces themselves that their competitive advantage in receiving enhanced payments for Medicaid visits somehow translates into a broader physique for competing within the healthcare marketplace. At Care Center the structural circumstances that enabled “individual priorities” to take precedence created a certain “amnesia” (Hacker and Pierson 2016) regarding the presence of external forces governing the program’s ongoing financial success and heightened the sense of confidence that the administration of Care Center placed on individual efforts and individual personalities.

## **Conclusion**

In this chapter I have introduced the concept of FQHC bureaucracy and described the structure of this bureaucracy at Care Center. I have used Max Weber’s theoretical treatment of bureaucracy to frame my analysis of administrative life at Care Center, but I have also argued that work was primarily organized around individual persons and personalities rather than strictly defined hierarchical patterns. By using a technique inspired by structural anthropology, I offer an alternate logic or mechanism on which bureaucratic activity at care center was based (categories of “wet” and “dry”). This type of organization clearly had substantial impacts on how Care Center delivered services. I have concluded by suggesting that the broader structural

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<sup>68</sup> Prospective Payment System (PPS) and Federal Tort Claims Act (FTCA) constitute two substantial benefits available to FQHCs.

context in which FQHCs operate reinforces Care Center's organizational form, particularly as it relates to individually-driven projects and activities. In the next chapter, I shall explore Care Center's structure against a backdrop of tremendous organizational growth, industry consolidation, and Care Center's grassroots foundation.

### Chapter 3: When Grassroots Grow

In this chapter, I shall build on the descriptions of Care Center's organizational structure that I provided in Chapter 2 by describing the "grassroots" foundation of Care Center and the impact of "grassroots" on Care Center's bureaucracy, including an analysis of how organizational growth interacts with the ongoing maintenance of this grassroots character. To do this, I will first describe an interview with one of Care Center's founders, who references several aspects of what I have come to understand as "grassroots." I will then offer a working definition of the term, supplementing that definition with additional data from various interviews I conducted. The specific circumstances necessitating and prompting Care Center's foundation created informal patterns of bureaucracy/administration which often emphasized the role of individual persons and relationships over more mechanical systems of organization and evaluation. Following this initial description and definition of "grassroots," I will describe the way in which grassroots patterns persist even in the face of ongoing growth. Several concurrent changes (technological and spatial, for example) tended to push Care Center's bureaucrats away from the initial connections they held with the patients and community targeted by the health center's founding efforts. Yet even as this growth and separation continues, bolstered by Care Center's operationalization of ever-broader notions of need, active efforts are made to simulate intimate connections between the health center's bureaucracy and its grassroots origin. I will conclude the chapter by attempting to demonstrate that Care Center's grassroots *style* of organization continues even as its bureaucracy becomes more estranged from its foundational origins. This circumstance has significant effects and often produces peculiar mechanisms for deciding what types of health care services will be delivered, the way they will be delivered, and the form in which evaluation of that delivery will take place.

## Searching for Grassroots

To understand how Care Center's grassroots style informs the organization's bureaucratic practice one must first describe what exactly is meant by "grassroots" and what that means to individuals working with the health center. It is worth noting that FQHCs generally have referenced their "grassroots" character as a historical fact mandated by the provisions of the Economic Opportunity Act, which called for active participation of the community in the establishment and development of the first community health centers. Indeed, the National Association of Community Health Centers (NACHC) distributes policy updates and health center news through a "Health Center Advocacy Network" from the email address [grassroots@nachc.org](mailto:grassroots@nachc.org). Unsurprisingly then, several of the health center employees I interviewed referenced "grassroots" as a prominent feature of Care Center's ethos. A Care Center Executive Vice President and one of the health center's founders, Roberta Thompson, offered me one of the most explicit descriptions of grassroots and what exactly it means. I interviewed Ms. Thompson on a warm, sunny day in October 2017. To find my way to her office I walked through a simply landscaped plaza straddling the corner of a city block that fronted a two-story glass and steel atrium grafted onto a former department store originally built around 1928. The plaza, formerly the island of a gas station, connected a structure resembling a tiny brick house to the looming, modern entryway of the atrium. A solitary woman with a baby stroller leaned casually against a railing at the entryway, smoking a cigarette. The building housed the very first Care Center health center and had recently undergone a nearly twelve-million-dollar renovation, primarily using grant money received as part of the Affordable Care Act (ACA) Capacity Development program. I walked under an awning, through the glass doors and into the atrium. Upon entering, the only person I saw in the sizable open space was a receptionist, sitting off to the right. Off to

the left stood a massive banner emblazoned with a larger than life-sized photograph of a woman with a quotation framed in a green text box saying “City officials should say to us... ‘These women fight hard!’ Because that’s what we do. We fight hard.” Turning back to the entrance behind me, I saw an even larger photograph of four women identified as the founders of Care Center. I walked past the reception desk, through a large opening into waiting area for the health center’s medical services. Four adjoining desks with low privacy barriers faced rows of lime-green chairs – nearly empty save for a few patients, including a dark-haired woman chatting softly on her phone in Spanish. The staff seated in the desks talked quietly or stared vacantly into their cell phones. I continued down a hallway to a glass-enclosed office space on my left. I entered and indicated to another receptionist that I was there to meet with Ms. Thompson. I was promptly ushered in. Roberta smiled and beckoned me in with an upbeat “Oh yes!” I asked Roberta about the start of the health center, and she happily obliged.

It was right there at the adult home we were running for veterans, that I received that first knock on the door from John Goodman who was working with the community action program. They presented me with a survey drawn up by the community action program for the community that dealt with health care, housing, jobs, education, to see what the community felt as needs. I filled it out and passed it on to John. I was familiar with that because some of the residents at the adult home that we were taking care of had to go to the County Health Department (clinic), for care.... I was aware, I was also aware because of my own family when we were working. We had insurance, but we were underinsured. Our family was young and growing and we bought the insurance that we could afford so it didn’t profit us much for that. We had to avail to the services that were rendered through the County Health Department, for the indigent and uninsured. That was really the beginning, so the input from the residents that we were caring for and our family needs presented that picture to me to say, ‘What can I do to help in this?’ because this was close to home.

I had heard parts of this story periodically throughout the time I had worked at the health center in one form or another: in the 1970s, Wilthook, NY, a small city in the suburbs of New York City, had a severely limited number of health services available. For the citizens of Wilthook, just as for those of similar towns and cities, access to outpatient services could only be secured by traveling to County Health Department “clinics.” This frequently involved substantial

amounts of travel via unreliable bus transportation and often left Wilthook patients stranded without an option to get back home following appointments. Frustrated citizens (the founders among them) worked with the local Community Action Program to distribute surveys and hold multiple meetings. Having identified outpatient health services as a critical need, they set about identifying and applying for funding to create a community health center.

Ms. Thompson's story offered some insights on the historical foundation of Care Center, but several informal documentaries, histories, and collateral materials do exist, and they are far more detailed in terms of parsing out the specifics of who did what and when. More intriguing is her emphasis on personal, hands-on connections to the immediate problem to be solved and the actions taken to address it. In describing the early days of getting the health center going, Ms. Thompson fondly recalled, "We got money, a donation from the Rotary that was some local organization, just some local fundraising... you couldn't get no more grass roots than we were, okay? We were able to raise money, they sold dinner, and they sold pies, and cakes and whatever to help get money to put to the organization." I asked her about still having an office on Main Street today, even though Care Center had larger administrative offices just a few blocks away. "As you come through those middle doors, this was the office space across from the elevator where Mary (Reagan), Dr. Williams and I first were housed. It really has special meaning to me that in forty years to go full circle, to go to different spots all over this building and across the street and then come back to here. It's because it's our beginning," she recounted. "It's right across the street from where the first meeting was held. It's six blocks from where the second meeting was held. This is really the genesis of our program. Being able to stay close to that - it really not only has a foundation, but it makes me centered and grounded."

It was not until after I had thanked her for her time and concluded our interview that I realized I had not really asked her very much about what her *current* position in the health center entailed. I knew that she frequently described the history of the health center during employee orientation and occasionally would travel to new service areas, chauffeured by a member of Care Center's facilities staff, to deliver a similar description of the health center's foundation. Care Center's position description for Ms. Thompson describes "working with the President to develop good community relations" and "represents Care Center in governmental agencies as directed by the President/CEO" and includes multiple specifics on her oversight role for a subsidiary 501(c)(3) organization focused on housing programming.

Ms. Thompson's reflections on the foundation of the health center exemplify the primary features of a grassroots style or mentality commonly referenced by Care Center staff. And although her account frames this in historical context, these same qualities were described, exhibited, and observed throughout my time in the field. Here I loosely define "grassroots" as a philosophy that emphasizes front-line, hands-on efforts that directly and personally inform the actions taken by health center staff and connects those actions to specific community-level circumstances and input.

While "grassroots" was widely referenced, the long-tenured staff (twenty+ years) whom I interviewed at Care Center (working on areas including grants, finance, capital projects, special programs, clinical quality etc.) were often the most expressive and direct in their description of the concept.

Gail Sutherland echoed Roberta Thompson's description of having an office on Main Street in Wilthook when she first came to work at Care Center: "From the moment I walked in, it was just a wonderful group of people. I thought, these are a great group of people. I really loved

it, and we were over in the health center (on Main Street). I got to walk through our services every day as I came to the office and I liked that, I felt part of something good.” Sutherland emphasized how the proximity of administrative offices to clinical services helped directly connect her work to the patients at the first Care Center site.

Diana Goodman, a senior member of the finance department who came to Care Center in the mid-1980s, summarized it this way: “I have to say, the story, grassroots, it was something pretty rewarding. Like I said, I’m being thrown into this (setting up a system to accept insurance and create super bills via diagnosis code),<sup>69</sup> but there’s just some rewarding qualities about it, just figuring it out. I felt like whatever hat you had on, you rolled up your sleeves. Everybody who worked in the organization then was pretty much that way.... It was like a Mom and Pop grocery store... You put out fires, so yes, there are some pains, even not just in finance because we were HR at that time because there was really no HR Department. It was a small family as you picture a family business would be.” Her description positively emphasizes the cozy and appealing sense of family, as well as the hands-on nature of the work. She also references the fact that “grassroots” often involved relatively fluid delineation of responsibilities. Goodman also described the current Care Center as “thirty grassroots organizations that are under one umbrella, because I’d probably choose not to think of it as being a large corporation even though... I think we still have that. I think we still have that but I’m not sure.... You came in for an earache but you’re diabetic, got to take off your shoes. Then they’re going to find out your other issues. They get involved in more than just the earache you in for or whatever.”

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<sup>69</sup> A superbill is a form used by medical practitioners and clinicians so they can quickly complete and submit the procedure(s) and diagnosis(s) for a patient visit for reimbursement. It is generally customized for a provider office and contains patient information, the most common CPT (procedure) and ICD (diagnostic) codes used by that office, and a section for items such as follow-up appointments, copays, and the provider’s signature (AAPC).



Again, the emphasis here is on direct, personal connections to the actual lifeblood of individual patients seen at health center sites.

I had the chance to chat with Alan Johnson, the former Chief Medical Officer (CMO) of Care Center, and I asked him about coming to work at the health center in the early 1990s. Sitting in my well-lit office a few paces away from Mary Reagan's executive office (about fifteen miles away from Wilthook), Johnson told me:

Well, certainly we were small and intimate, and my office was across the hall from Mary's, in the second floor on Main Street. There was me and Kim and Roger who did finance around the corner, and we had Mr. Smith with us for a while, who was a nurse who was sort of the Operations Director, and we were a small group. There weren't that many of us to make decisions. We were the decision-making group, and Roberta (Thompson), obviously, and that was our, whatever we call it exactly, I don't even know what we called it then, executive something or other. There was a team, a counselor group, a board, I don't know what it was called.... You had a hands-on involvement in everything. At one point, I was making up the schedules for the departments. For a while I actually supervised the Nursing Supervisor. I got rid of that as soon as I could. But my interaction with the physicians was personal, and I knew them pretty well, as people.

Johnson offered examples of what this "hands-on" involvement amounted to: face-to-face discussions with physicians if there were concerns about quality, jointly interviewing and negotiating provider contracts with the CEO, and a sense that "if anybody would be willing to work in the health center, we should employ them." Johnson's last comment struck me as particularly noteworthy in that it suggested that specific qualifications were never the absolute basis for employment and might be overshadowed by one's general connection to the health center.

I have previously referenced Care Center's hiring practices as they relate to the way the health center's bureaucracy is organized along personal lines as opposed to Weberian ideal type governed by rules, clear hierarchies and impersonal interactions. I did so not to critique Care Center for not conforming to the ideal type, but as a way to introduce the organization, and to offer a general sense of how its administration functions. I raise the question of hiring practices again here to suggest that they are inseparable from what I have called a grassroots style. Such

“grassroots” hiring practices were reflective of the “hands on” approach that Johnson described, but also inseparable from the philosophy of Mary Reagan, the CEO. Said one member of the Executive Cabinet: “My sense of how Care Center hires, specifically how Mary (Reagan) hires, is that she finds people she thinks are good people that she wants, decides she wants them, and figures out how to use them later.” A senior member of Care Center’s finance department offered a similar assessment: “I think that the organic aspect of Care Center is, our leadership likes to hire smart creative people and that's part of our history. That we collect different specialties, whether it be IT reporting or revenue cycle in me or marketing from someone else. I think that collection, in a large organization but specifically this one, has organically forced us to evolve and not kept us idle in re-evaluating or keeping up with current trends and current needs in the environment. I think that that helps us and keeps the environment dynamic and not mundane and as bureaucratic as other places where they don't have that.”

These hiring practices reflect an additional feature or component of the definition of grassroots I have tentatively offered. Grassroots hiring often does not focus on objective, technical aspects of qualification, and tends to draw more on subjective, personal appraisals. Indeed, the founders of Care Center were primarily characterized as “fighters” or “activists” as distinct from healthcare professionals.<sup>70</sup> Care Center’s CEO, celebrates this feature of the organization, often citing her arrival at the health center as an “in-kind” donation from the County Health Department as a volunteer. Other senior members of the health center’s administration, including Abigail Worthington, the Chief Operating Officer, came to work at Care Center under similar circumstances. In June of 2018, Care Center convened a panel of health center volunteer “alumni” to discuss their experiences and subsequent career

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<sup>70</sup> See Methodology: **Limits/Delimitations** for an interpretation of the links between War on Poverty program founders and their pugilistic characterization.

development. As Mary Reagan listened in on a conference line, Worthington told a group of about ten current volunteers: “I was fascinated by the idea that you didn’t have to be a doctor or a dentist to work in health care, that there were so many ways you could work in the health center.” Earlier that year, when I had a chance to sit with her in her Wilthook office, she described her experience in more detail:

**David:** Another part of it is, and this is where I usually begin, is just asking people how they came to the health center and what their reactions were at being put into this circumstance. I think I know a little bit about your history.

**AW:** [I came to the] health center through the AmeriCorps program. It's a different way to join because you enter the health center world without a predefined role, whereas if you are hired as a medical assistant or you're hired as a nurse, there's a clear job that you're going to function in. I think that even particularly earlier on when we joined through the program there was enormous flexibility in the way AmeriCorps members were used within the organization... at the time I did all sorts of things because there just wasn't anyone else to do them. I was delivering fluoride varnish to schools and writing curriculum and writing grants and doing blood pressure screening in a farmhouse, and I taught tobacco cessation classes... I think it's a wonderful way to join an organization because you feel infinitely useful. Because if you could think of it, if you could identify it as a gap then there was at that time enormous flexibility to be able to try to work on it.

I take Worthington’s description to reflect a grassroots style of employment, but it is also marked by what might be called “informalism.”<sup>71</sup> It stresses the immediacy of the issues that must be addressed, and emphasizes the need for a direct, personal response to them.

Initially it seemed to me that grassroots were closely associated with the first Care Center location, but the grassroots style and approach extended to other programs and sites as well. When the health center staff I informally spoke with would mention “grassroots,” I would ask them if they could give an example of someone who displayed those characteristics. “Cheryl Jacobs, for sure,” said one. “Salt of the earth! That’s Cheryl, grassroots all the way,” said another, and when administrators and executives spoke about her they referenced her efforts at

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<sup>71</sup> I initially described this as “amateurism” but I realized that this term only emerged when speaking to health center employees with comparatively fewer years tenure at Care Center who often had experience in larger hospital settings and/or experience with for-profit industries (construction, IT, etc.).

connecting executives to individual sites through visits, and how her fundraising efforts for farmworkers consistently caught their attention. I recalled Ms. Jacobs and her fundraiser at the Staff and Volunteer Recognition Luncheon. Ms. Jacobs was quite possibly the most energetic person I knew at Care Center, always scurrying about, vociferously greeting people. In conversation, she would frenetically dart from topic to topic. One senior executive described her as “remarkably adept at violating the ‘*Yes, and...*’ rule of improvisational comedy in that she would often veer onto a completely unrelated topic in response to what someone had said. She had been the Care Center’s Chief Operating Officer, a fact that, when communicated to people who had just met her, produced confused (or possibly concerned) looks of amazement.

I interviewed Jacobs in February of 2017 in her office in Wilthook. She had been working with an agency that provided health services to agricultural workers about 28 years prior and had met with Dan Corr, who let her know that Care Center would come to take over the health services program. The two locations are approximately thirty miles apart, one urban, the other farm country producing various root crops, celery, onions, potatoes, and a few fruit orchards. “I met Dan, became a consultant at that point. It was very small, it was the Wilthook Community Health Center. I would report to Dan every month what I had done, but I worked right with the clinical team, and I worked in outreach, and did all those things. There was definitely a sense of mom-and-pop like – we were the cowboys and cowgirls – if you look to it that way, but we were part of this really mission-driven organization. Mary Reagan came before the grand opening. She was putting prints in the waiting room. We got beautiful chairs instead of these picnic chairs that we had.<sup>72</sup> All of a sudden there was like this the CEO who cared and was really making a point of providing this kind of connection.” Jacobs emphasized the informal

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<sup>72</sup> This recalls Ted Kennedy’s fascination with the rocking chairs provided for pregnant women he observed during his 1965 visit to the Columbia Point health center.

“wild west” like character of the health center’s early effort. It also highlighted the immediacy of the needs that each health center employee (including the CEO) sought to address: clinical work, outreach, transportation, decorations. One person might do all of these things. Other senior staff reiterated this flexibility of role. Gail Sutherland, for one, referenced a line included in almost every Care Center job description: “I think that as assigned duties and *other duties as assigned*, has become a hallmark of who we are and what we do. There seem to be no boundaries. No boundaries in terms of, what can be asked of you, what can be expected of you and necessarily, a clear understanding.”<sup>73</sup>

Jacobs went on to describe how this type of flexibility and lack of formal “rules” or boundaries informed how people went about their business. “In the earlier days we also had a lot of flexibility. When ideas came up we could say, ‘Hey, can we try this?’ Now, these weren’t dangerous ideas, but they were ideas that maybe changed a system and how we did things.” I take Jacob’s meaning here to indicate that local level, impulsive or ad hoc solutions would address local level circumstances without the interference of a top-down “rule” governing people’s actions, and that organizational change would result from the introduction of ideas that organically emerged. It also echoed the martial tone of the founder’s portraits I saw at the Wilthook Health Center. Grassroots must include a general sense of “fighting against.”

Care Center administrators with less tenure at the organization often relayed an indirect understanding of the grassroots character of the health center. Dr. Gregory Mills had been at the health center for about seven years when I scheduled time to ask him about his impressions of the health center’s organizational structure and how that organizational structure translates into the type of clinical care patients might receive. “I’m no organizational theorist...but my sense is

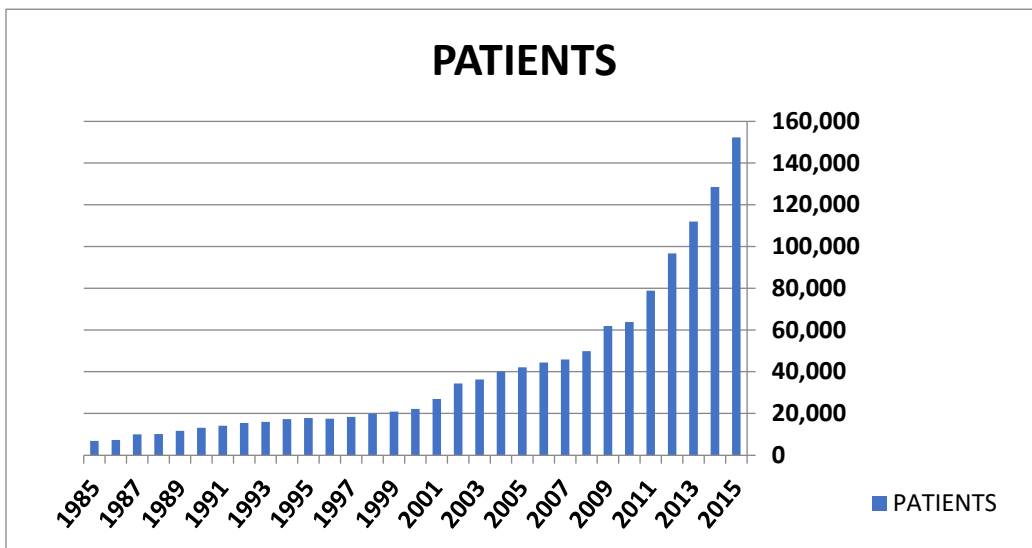
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<sup>73</sup> For example, my job description included the following language: “Care Center may change the specific job duties with or without prior notice based on the needs of the organization.”

that we have been in and are still in this period of transitioning from that mom-and-pop, very personal, to a much larger organization with a 175-million-dollar budget and in ten counties and big geography.”

### Growth

It is impossible to imagine telling the story of Care Center without taking into account the massive growth that it experienced prior to and during my fieldwork. Gail Sutherland shared a spreadsheet showing the increase in patients from the mid-1980s through 2015. **Figure 3.0** illustrates this increase.



**Figure 3.0. Care Center’s Growth**

From approximately 7,000 patients in 1985, Care Center had swollen to 153,000 patients in 2015. Not surprisingly several health center administrators often reflected on this growth when discussing the idea of “grassroots” and considered how they perceived it to have impacted their relationship with Care Center’s grassroots origin. When it comes to describing the growth of Care Center, several critical changes in FQHC policy and in the larger environment of medical care converge. First and perhaps most immediately impactful from a national perspective was

the enactment of George W. Bush's "Health Center Initiative." Rolled out during his 2000 presidential campaign, the initiative was specifically designed to create 1,200 new health centers and increase patients by 6.1 million within five years (Mickey 2012, 49). The expansionary effort is clearly reflected in Care Center's growth pattern from 2000 to 2008, wherein the health center doubled the number of patients seen. A similar pattern is reflected by the growth in Care Center locations, which went from six in 1999 to sixteen in 2008.

This growth was accompanied by substantial changes in the organization's administrative spatial arrangements, a clear indication of an evolving organizational form. Several authors have proposed that the broad changes in industry environment mutually interact with the development of changing of organizational forms (Djelic and Ainamo 1999; Murmann 2013; Pacheco, York, and Hargrave 2014). The changes to Care Center's spatial arrangements, then, should be evaluated in tandem with the massive growth of FQHCs in the broader environment. In 2003 the primary administrative office, which had been located on Main Street in Wilthook, moved several blocks away to the four-story, multiple tenant, office building on Canaan Street. This shift, perhaps more than any other, pushed the bureaucratic functions of the health center away from its service delivery functions, and Care Center veterans recall it as a "seminal" moment, one going so far as to say that this was the exact moment at which the health center lost its grassroots identity. Gail Sutherland looked back at the spreadsheet and pointed to the date the offices moved and said simply, "It was traumatic."

Another change, equally impactful, occurred in 2006 with the implementation of Care Center's electronic health record (EHR), *PracticeWorks*. Cheryl Jacobs described the implementation of the EHR, funded by New York State's "Health Efficiency and Affordability Law for New Yorkers" (HEAL NY) Capital Grant Program, as a move from "limping along"

with a mix of practice management software and a clinical documentation system to a full-on sprint following the switch to *PracticeWorks*. Several accounts have documented the way EHRs interact with the relationship between medical providers and patients (Jensen 2004; Mechanic 2008; Fisher et al. 2009; Wibe et al. 2011). And although I focus my account here on EHR implementation as one of several events that converged on Care Center during a specific period of growth in which dramatic shifts began to take place in the health center's administrative structure, it is worth noting that Care Center's clinical experience with *PracticeWorks* did significantly change the relationship between providers and patients. Alan Johnson, in particular, was fond of repeating his "turkey" story:

**AJ:** Somehow, I got it {the story} from the GE EMR Director in 2000. Lady comes in your office the Monday after Thanksgiving, and the problem is, is that she dropped the frozen turkey on her foot on the weekend while she was cooking it. It's painful. It's swollen, they examine it, get an x-ray says, it's just a fractured toe. In your EMR, falling object -- right toe, fractures, and there's treatment, that's enough perfectly accurate. Nothing wrong with it. Coded correctly, billing will go out right. That's all the note says. When she comes in your office the next year for a check-up in November, you're not going to be able to remember to tell her to be careful when she opens the freezer door.

You're going to lose some of the rich content about that person that builds the relationship between you and the patient. Because patients all think their doctors remember them, but if you got 1,000 patients -- I certainly remember their face, but you rely on the notes to give a couple of clues. Little Joey's -- the soccer injury, last year reminds me to say, how is the soccer? And he thinks I know everything about him.... That gets lost a little bit in the EMR. I think that that is going to be one issue, and I think it happens when you're so metric driven. That's what you start worrying about more than anything else. That's not so bad, if it's making sure this is the path we're in. But it changes the qualitative stuff about being a healer, gets subsumed and takes a secondary place to the system needs.

A subsequent Chief Medical Officer of Care Center, Alexandra Bacall commented on Johnson's story saying that it was "great to read, as a reflection back on those wonderful engagements... and our system now just is almost like a treadmill. Clinicians have a desire and they may even engage in the same way with that very rich dialogue with their patients but because of the need to be efficient you won't see it. In fact, when I write my notes I can almost write my note before I see the patients and I fill in just a few details to capture the essence of that



visit.” And indeed, several members of Care Center’s administration referred to the health center’s practice of scheduling fifteen-minute visits in comparable terms. In looking at my transcripts I coded both of these stories as “*distance from business to patient*” and would try to look at the electronic health center in terms of its capacity to do specific things. First, as Johnson and Bacall both suggest, the EHR pushed clinicians away from their patients and prioritized mechanical metrics, interactions, etc. Second, the capacity to capture increased levels of metrical performance linked patients more directly to “system needs” or the bureaucratic apparatus within the health center. The distance from business to patient was simultaneously increased at the clinical level, but reduced at the administrative level in that administrative staff could more directly engage with patient data. But in no way did that process put the health center’s bureaucrats into a closer direct, physical and personal, engagement with health center patients.

As I have stated, I do not think the experience of EHR implementation at Care Center is unique to the FQHC environment, but the context in which the implementation converged on the health center produced a unique effect on the organization, given the widespread existence of a grassroots mentality. The historical trajectory of the health center, as one located within communities, operated by communities, and charged with directly addressing the needs of specific communities (all pieces of a “grassroots” sensibility) places an almost disproportionate emphasis on direct, personal connections to patients in terms of legitimacy, credibility, and so forth. As such, I would contend that any actions that push this type of connection apart have an exaggerated impact on patients and staff (for better or worse) within the FQHC setting relative to other types of healthcare organizations.

The implementation of *PracticeWorks* and the development of enhanced analytics in the form of report writing and authoring tools opened up a floodgate of new business interests

culminating in the establishment of Care Center’s fully owned, for-profit subsidiary, Keys-2-Care in 2007. I have discussed Keys-2-Care in terms of its potential to incentivize and drive efforts in ways that diverge from clearly articulated, and stated, FQHC objectives, and the way these efforts are enabled by virtue of a fluid organizational structure that allows employees to seamlessly toggle between the two entities. I reintroduce Keys-2-Care here because of its contribution to the distancing between Care Center patients and business. The capacity for the informatics<sup>74</sup> department to structure data allowed clinical measures and summaries (1) to become more homogenous, (2) to distance the process for defining and controlling clinical measures from clinic space to administrative space (i.e., informatics department space), and (3) allowed the universe of patients to extend outward through the introduction of Keys-2-Care clients. I spoke with Bob Wilkinson, the director of Care Center’s informatics department (also the director of Keys-2-Care’s informatics arm), about this process. Bob, a hard-nosed lunch-pail sort of guy with an engineering degree and a capacity for sentimentality as evidenced by his fondness for Disney World, told me: “I find a lot of time is spent helping people make the question more structured and uniform. A lot of people in the industry or in this organization need help interpreting the deliverable.” Wilkinson’s description simultaneously conflated the Care Center deliverables with Keys-2-Care client deliverables and identified the way his department tinkers with the distance patients might experience between themselves and the health center they visit. “Maybe there’s three different ways to store that information on one client, or maybe another EMR has a totally different way of doing it. We take all those different ways and we’ve forced them into a standardized normalized table so that we have control of it at the database level. There is a lot that happens to the data before it actually gets to the end users.” There is

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<sup>74</sup> Informatics as a department was dedicated to information processing, engineering reports, and managing data.

something almost violent about this description of a “forced” normalization. But the reach of these actions continued to extend to new “clients” with whom direct contact was limited. “I’ve only met maybe two of our clients in person,” he told me, “and not their patients of course. And not at their health center.”

Some clinical staff members at Care Center who did not lend any of their time to Keys-2-Care directly commented on this distancing effect:

*In May of 2018 Sarah Bond, a health program administrator walked quietly into my Canaan Street office, a glass-windowed room about ten feet long, shades drawn against the sun which beats in throughout the morning and, in combination with an unbalanced HVAC system made it exceedingly hot. I usually sat looking at two computer screens, and my back to the door so I could ignore the staccato sounds of the copy machine tray adjusting to some print job, or the pencil sharpener, or a back and forth debate over the proper report selection to display a given number of measures via graphs in a data visualization program called Spotfire. She let out a sigh, and I was suddenly aware that she was standing there, an almost willowy figure, who occasionally shifts between speaking, and a near whisper. She was remarkably conscious in matters of wellness, proper preventative health activities, and, what I took, to be a general sense of holistic health. I remember a “best practices” webinar she gave for clinical staff on various risks and preventative steps to mitigate them associated with medication interactions. I do not recall meeting many people at Care Center who were quite as sensitive to other people’s discomfort as Sarah. She asked me if I want to get coffee because she’d “just about had it with the office for the moment.” I immediately agreed, and we slipped out from the back door, although given the office’s layout, a circle within a square surrounding a central core where the elevator and stairs crisscross their way up four floors, it’s not always clear which route is the*

*primary entrance. I pressed the button for the elevator and she clapped her hand to her forehead in exaggerated shock at my decision to not take the stairs.*

*We emerged into almost blinding sunlight on the street, walked the two blocks toward a coffee house and she began telling me of her ongoing frustrations with a presentation she was obligated to give that morning, attended by Care Center's clinical quality council. "I don't even know why they have me present on this stuff. It's a research project, but it's more about maintaining authorship or recognition." Apparently irritated about the preoccupation with the health center's role and prominence in the project she continued: "I don't care about that, I've already been on enough papers, and it's really not that big a deal." We gathered our coffee and sat at a table towards the back of the cafe, away from the baristas shouting out the names of those waiting for their more complicated drinks to be prepared. "I'm going out to a food prescription grant bidders conference this week, pretty sure it's a total waste of time," she said. I asked her why, and she let out a sigh. "We tried it in a few counties, but I kept getting phone calls from the program asking my why the doctors weren't filling out the prescriptions for the food." The program, "Healthy Opportunities Through Solidarity (HOTS)" had been established in 2003 after staff members noticed improved health outcomes for people in the organization's medical and supportive case management programs who were receiving weekly home deliveries of pantry items. A referral from a medical provider prompted by a two-question screening process to assess the patient's access to food, which would include background clinical information and a consent form, coupled with an in-person visit to the HOTS location, would set a person up for food delivery. "It didn't work because we increasingly track a million medical measures and have a set number of patients that doctors are supposed to see in a day. So "social determinants of health" get pushed aside. There's no empathy, like, do our patients need*

*us to run Keys-2-Care? What we've become is fundamentally talented at measurement, but not as compassionate." She had a phone call to get on, so we left the coffee shop and walked slowly back toward the office, grumbling slightly over how beautiful the weather was outside.*

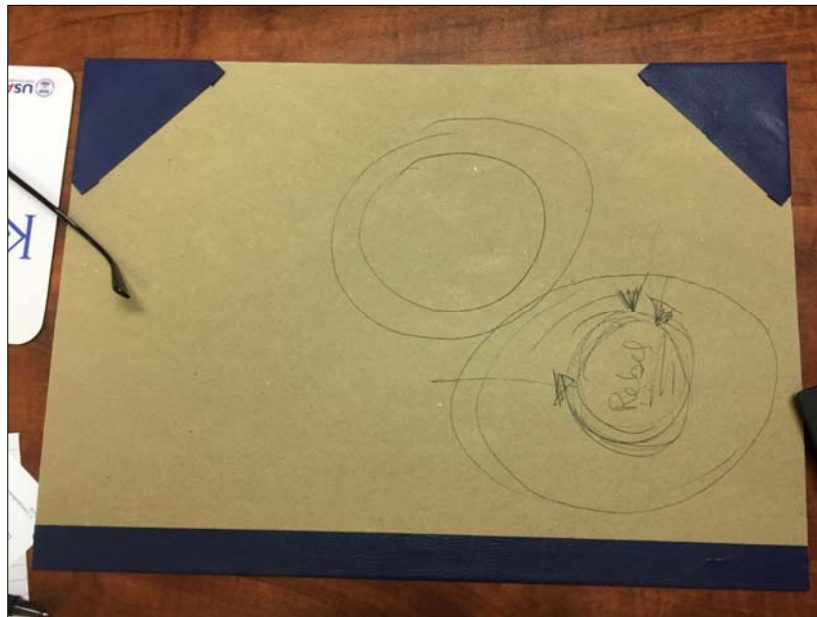
Despite not being among the longer tenured staff at Care Center, Bond articulated the direct impact of the ongoing distancing from business to patient could and often did have on the nature of service delivery at the health center. It also points to a tension that runs to the core of how FQHCs developed historically (recall here the efforts of Jack Geiger and the Medical Committee on Human Rights [MCHR] to provide a “medical presence,” a “co-suffering” or compassion) and where the changes in growth, technology, and a distancing from patients might take them. There is a tension here, one that runs through most of the discussions I heard regarding health center growth, between an organic, personable, and person-oriented organizational structure and a more mechanical, impersonal, organizational structure. Katherine Chen’s ethnography of organizational practices at the Burning Man event emphasizes the critical importance of “blending practices” to avoid extremes of under- and overorganizing [sic] (2009). The takeaway here is that finding a “sweet spot” that balance the two ultimately contributes to the development of an “enabling organization” that takes advantage of bureaucratic formalization without stifling organizational creativity (Ibid, 21). Care Center exemplified the ongoing challenge of developing and implementing a perfect blend of organizational practices.

Cheryl Jacobs described this as a shift between Care Center’s “rebel core” and encroaching structural “pigeon-holing”:

We've gotten more structured and a little more mechanical. However, we still have a core of rebel-ness about us. I'm going to have to draw a picture. When you think about how we were when I first started, the rebel core was about that big, and maybe the structure was that big. I would say our rebel core has gotten smaller. How much smaller? I don't know. And more structure have as we've gotten bigger, which really is a function in necessity. We could not have done the same things we have now. Really it wouldn't have been a functional model. You have to have structure as you grow. I think having some piece of a cowboy or rebel--

maybe those are the wrong words. But I feel that if you can keep that core and not lose sight of that core, you're going to be more likely to be a strong organization. Because if you, and I do feel like we still have that, sometimes I think it gets chiseled away, but I feel that if we can maintain this core without losing it, this keeps us grounded in our mission and adds to the strength of Care Center.

She scratched at her desk blotter as she spoke of the need to maintain the rebel core, pointing multiple arrows to it, and circling it several times.<sup>75</sup> As she drew me a picture of the chiseling away of the rebel core (**Figure 3.1**), I asked her if it made her wonder about how connected people at Care Center were to the daily realities of patients. “David,” she said. “I see so many



**Figure 3.1. Care Center’s Shrinking “Rebel Core.” Photo by David J.B. Erickson**

decisions made by people who don't have any real clue about the patients or the staff. That is a major problem with our administrative services, and that's why I say I make it my personal goal always to get to at least six sites a week, to actually go to the site.”

I initially interpreted the concerns of Jacobs and Bond as a reflection of a slowly dissipating “grassroots” orientation in the face of intense organizational growth. But the

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<sup>75</sup> I have included a photograph of Jacobs’ diagram here because it offers a visual representation of the tensions involved in organizational practices that Care Center faced in the context of substantial growth. It also reflects the phenomenon of “organized dissonance” I described in **Chapter 2: Organizational Structure**.

question of growth, and the associated shifts in technology that produced a vast informatics apparatus only describes certain changes in the relationship Care Center had vis-à-vis its patient population. This formalized many features of the patient clinical encounter, but it did not stamp out the “rebel core,” nor did it eliminate the existence of a pervasive grassroots mentality within a bureaucracy that valued the direct immediacy of interaction between the organization and its patients. Quite to the contrary, the changes I outline above were accompanied by dedicated attempts either to maintain the initial connection between Care Center and its patients or by attempts to simulate such a connection.

### **Keeping Roots in the Ground**

On a blustery October day in 2017 I had the opportunity to walk through one of the Care Center’s sites with the COO (Abigail Worthington), the VP of Capital Projects (Winston Wright), and a former Care Center executive who had gone on to run a network of FQHCs in another state and some of her staff. The purpose of the visit was to introduce the visitors to Care Center’s clinical workflow and planning model, and the approach to construction at the site, specifically the interior system of custom pre-fabricated partitions. Following the visit, we sat in a ground-story conference room and snacked on various grain bowls and vegan wraps discussing the various potential benefits prefabricated wall systems had in terms of ordering replacement parts, or modifying interior space inexpensively and speedily, and how it offered flexibility in terms of categorizing the work as “construction” or “equipment” from an accounting perspective. The visitors and Wright departed, and I had a chance to sit with Worthington for a few minutes before she had to join a conference call. I asked her if she thought Care Center was a grassroots organization, and she let out an almost involuntary laugh. “No, no it’s not.,” she said. I asked her if there was a moment when it lost that status, and she shook her head, but did not offer a response.

For as frequently as I heard “grassroots” either mentioned or referenced, few Care Center executives or administrators actually called the organization “a grassroots organization.” When I asked if Care Center was a grassroots organization, some administrators, like Wright, would tell me: “It started as one, so technically I suppose so, but one could hardly consider its current operation grassroots.” A senior VP in the finance department, skeptically questioned whether “grassroots is something to return to under existing leadership,” because it involved “focusing your resources on grassroots priorities.” Others, like Bob Wilkinson in informatics were blunter: “I think we’re more of a corporation, a larger entity that leads enterprise-wide solutions, and our staff or managers or executives now have a mindset to direct an enterprise, as opposed to a health center. And I think we’ve transformed, over the past five years, from running a health center to running an enterprise.”

Health center staff who considered the question in the context of changes that had taken place (growth, technology, etc.) considered it a struggle. Diana Goodman exemplified this type of struggle as she tried to articulate the impact of changes on the organization. “I think we’re more professional, if that’s the right word. I don’t know if that’s the right word. I think we’ve just grown. Yes, what’s the word I’m looking for? When you start with grassroots, not that everyone wasn’t professional, but it’s... it’s more of a machine. I think it’s changed, but it still attracts the same heart – that people come here.” And although she had gestured at grassroots (“thirty grassroots organizations that are under one umbrella”) she also recognized the increasing pressures on a grassroots approach: “My point is, I don't want to discourage these mom-and-pop little grassroots things because that \$500 check that they get can do amazing things with that on the grassroots level. But I got rules, and sometimes it cost us so much more to try to manage the amount of time on this \$250, \$100 and \$500. I hate that because I don't want to discourage it,



but we have to have rules.” Goodman’s reference to rules here is not without a sense of irony given the grassroots tendency to “rebel” against such structures.

Alison Cartwright, a regional operations manager I interviewed at a Care Center site located in a multi-tenant social service cooperative introduced a similar thought:

It's hard to say, and again, because I've only been here three and a half years, not even quite three and a half years, from what I hear from other people is that because they started as such as a small tight group, the little steps of growth little, little, little and the passion and compassion that's been constructed along the way that way, that part of it's being lost. Is it good, is it bad? I don't think it's all bad, but those long-term employees struggle with that, and some of those are at upper management levels. That's part of what I see as a challenge organizationally.

Perhaps nobody felt the challenge of this struggle more than the Care Center CEO Mary Reagan. I chatted with Robin Esther, an assistant who had worked with Reagan for more than 20 years, about the organizational changes that happened as Care Center grew.

**David:** Do you think that the health center organization requires a change in how people focus their energies from extremely general to areas that require more specificity?

**RE:** It's out of necessity. We were much smaller. A lot of times I really wanted to pull my hair out but certainly, it was one health center, two health centers. Then it grew exponentially, and then I did get staff from time to time. I think it has to happen that way. You have to splinter up the job.

**DE:** Has it worked? I wonder about this because Mary (Reagan) seems very attached to that original structure. Does that sound like her?

**RE:** Yes, yes. Very much.

**David:** Sometimes I find myself asking why Mary cares about the wording of a letter of support –

**RE:** I know {laughs}

**David:** - for an application or something. I have no idea why you are concerned with it.

**RE:** Absolutely, absolutely.

**David:** Why do you think that is?

**RE:** I don't know. I think it's a focus on the wrong thing. I think sometimes. It's hard for her to let go. With her history, she's still the one at the top, but it's hard for her to let go from 25, from 30 years ago.

I have introduced the idea that persons and personalities were the dominant drivers structuring activity at Care Center, but the force with which the CEO's personality pervaded all aspects of bureaucratic life made the struggle to balance organizational changes with grassroots history particularly intense. Organizationally, the growing sense of distance from the grassroots foundation of the health center produced several attempts to hold closer to a perceived sense of connection.

Perhaps the most striking example of how the organization actively promoted the sense of ongoing "grassroots" was the annual Staff and Volunteer Recognition Luncheon I described as my introduction to my fieldwork at Care Center. The fact that the event continued to occur on an annual basis, given the size of the organization, provoked confusion among health center staff. Robin Esther was baffled: "Half the people there probably don't even know who she is. They see her once a year at the Christmas thing, a holiday party, which is way too big. Oh my gosh. Honestly, it's too big. Why keep having it? I don't get it."

In spite of the fact that many administrative staff questioned the continuation of the luncheon, the purpose of having it, the message it sought to deliver was immediately recognized. Gail Sutherland for example commented on the general din of people talking while Mary Reagan addressed the staff:

I am deeply disturbed that not everyone is respectful when Mary is speaking. I think it may that we are missing that piece of -- somehow they haven't drunk the Kool-Aid yet, and I'm sorry, because they don't get it. We're better when we're all on the same page that we are passionate about what we do, and who we are, and honor that.

For Sutherland, "drinking the Kool-Aid" or buying into the mission of the organization is something worth honoring, revalidating, and re-enacting on a yearly basis. It also reveals the deep respect that Care Center staff had for the accomplishments of their CEO and the organization's passion for its work. For those who have drunk the Kool-Aid, the value of the event was readily apparent. Erik Santos, the regional VP of Operations for the service area and

sites Care Center took over from Jackson County, lauded the staff luncheon. “I think it was really great. I think that is really great right now that is every site knows Ms. Thompson, every site knows Cheryl. Now coming to the site and going through the site, that is making a big difference, because sometimes they feel the disconnection. But they want also to see Mary (Reagan) coming.” As the manager of sites far removed from Wilthook, Santos immediately recognized the purpose of having an event where each Care Center site connected with a founder and the long time CEO, in essence, connecting with Care Center roots. Alan Johnson explicitly defined the purpose of the event: “You want to keep people remembering the roots of this.”

The large cutouts representing Care Center’s CEO (Mary Reagan), founder (Roberta Thompson), and CFO (Zeke Benjamin) that I described in my introduction to Care Center were a particularly striking example in which the connection with health center roots were conveyed to the staff. There had been a similar cutout of Mary Reagan dressed in a red blazer and large pearl necklace floating around her executive office. She was making a muscle in a Rosie the Riveter pose above a caption saying: “We did it!” It had apparently been a prop used to promote a flu shot campaign the year before. But this one had been ordered by Care Center’s event planner specifically for the staff event, and it pattered around in the executive offices for the next few years. I asked several staff members what they thought of the cutout, and opinions ranged from disgusted (“I thought it was appalling. If there were going to be cut-outs of anybody I would’ve wanted it to be three patients, or an outreach worker, patient rep...”), to amused (“I thought it was cute”) to confused (“It was confusing it felt a little -- I want to produce the right word, it felt very self-indulgent, I would say, and I think that it was meant probably to show a fun and relatable group of people, and I think it came off more unprofessional and self-indulgent than anything because the act of creating a cutout of yourself is not -- It's the opposite of what you are

trying to accomplish because no one has a cutout of themselves. It doesn't make you relatable, it makes you feel like you're so different than anyone else because you are cut out.”).

Some staff members indicated that they did not focus on it at all. “Because the sewing club was there from the (farmworker site) it was much more my focus, of interacting with those folks because that’s part of the people I worked with prior to coming here.” The contrast between the live in-person Cheryl Jacobs and the image of Mary Reagan, Roberta Thompson, and Zeke Benjamin was stark. This has led me to interpret the meaning and purpose of having the cutout at the staff luncheon as an attempt to simulate a connection with the organization and its “grassroots” character on the part of its CEO, its founder, and its CFO. The presence of these cutouts evokes Jean Baudrillard’s “precession of simulacra” in which, over time there is a transition “from signs that dissimulate something to signs that dissimulate that there is nothing” (2017, 6). The large photographic banners of the health center founders I described at the Wilthook site appear to follow a similar course. Occasionally these images were the source of ridicule. At one point a group of staff from Care Center’s event planning department were laughing uproariously at the idea that they might beam in a holographic image of one of the founders to make sure everyone knew that “she was still there, continuing the fight.” These dynamics are representative of how not-for-profits struggle to integrate the abiding influence of founders and legacy staff with pressures to rationalize (Reisman 2017).

The health center actively promotes a sense of connection to its “grassroots” origins in public forums as well. Specifically, Roberta Thompson would regularly attend legislative and community meetings in areas into which Care Center was hoping to expand in order to re-tell the foundation story I briefly described above. She would also repeat the story internally as part of the orientation process. Care Center’s compliance officer noted that “they beat you over the

head with this story – it’s a long part of an even longer orientation process.” Most new employees offered positive feedback on the presentation of the foundation story, but many also expressed a desire to have more time allotted to reviewing specific details on benefits, paid time off, etc. I do not want to read too much into the repetition of the health center’s foundation story beyond suggesting that it aligns with broader attempts to maintain a connection (perceived or real) with the communities that Care Center originally set out to work with in a grassroots fashion. Julie Saxton, a specialist in governmental relations and public affairs, suggested that Care Center “uses the founding mother story or the extreme Cliff Notes version of it to provide a signal about our mission and values.” Saxton’s comment resonated with something FQHC historian Alice Sardell explained to me when I spoke to her earlier that summer: “Community health centers... part of their ideology is community role, community participation” (Pers.Com 7/13/17).

Training opportunities also attempt to retain a grassroots model by emphasizing flexibility with respect to how to go about problem solving and by attempting to reaffirm a connection between all Care Center staff and its patients. In one training that Care Center would periodically offer, staff would “more deeply consider the components of person-centered care including teamwork, innovation, the history of the community health center movement and more.” The innovation component in particular stressed the role every health center staff member had in implementing solutions to address the immediate realities they or their patients were experiencing. It emphasized a “bottom up” approach to problem-solving in which each individual within the organization might contribute to enhanced service delivery. All of this recalls Cheryl Jacob’s “rebelliousness” and what I have described as “informalism” with respect to roles and responsibilities. Another training that attempted to convey a similar message was held in June of 2017. The training was sponsored by the Population Health Improvement

Program (PHIP)<sup>76</sup> operating in Care Center’s service area and in which Care Center was participating. It was titled “Blueprint for Health Equity” and included a poverty simulation designed by the Missouri Association for Community Action in which participants were given a role and asked to “live in poverty” for a month based on the characteristics of each person’s role (Missouri Community Action Network 2012). Participants spent a virtual month in their role, running from one table to another in the gymnasium of a Community College attempting to access various services. I attended the training with Emily “Em” Thompson (Roberta Thompson’s daughter), who was working at Care Center overseeing health education programing. The purpose, seemingly, was to sensitize participants to the realities of poverty (through a simulated reality) in order promote responsive, local, community action, specifically in healthcare organizations that were members of the PHIP. From a Care Center perspective, the training sought to reconnect staff with a simulated reality it might previously have interacted with directly.

I have described these attempts to actively cultivate a “grassroots” sensibility within Care Center’s staff to emphasize the fact that this style of conducting business persists, but the actual proximity that the health center’s administrative staff have to the health center’s roots has dissipated. This separation is tied to broader environmental changes in health care, but unlike developments in other healthcare organizations these changes provoked a “doubling down” on the grassroots style that helped found the health center and drive its activities for much of its formative history. In the final section of this chapter I will attempt to demonstrate that the active

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<sup>76</sup> The New York State Department of Health's Population Health Improvement Program (PHIP) was created promote the Triple Aim – better care, better population health, and lower healthcare costs – through regional contractors, convened stakeholders and established neutral forums for identifying, sharing, disseminating and helping implement best practices and strategies to promote population health and reduce healthcare disparities in their respective regions (New York State Department of Health 2015).

maintenance of this grassroots style or mentality produces unique patterns of implementing and evaluating clinical services.

### **New Lines of Business, Grassroots Implementation**

I previously discussed Urgent Care in terms of the almost whimsical fancy at the executive level that drove the decision to pursue it as a service line. Here I want to describe the process by which the x-ray component of Urgent Care at Care Center was implemented using a fundamentally grassroots approach. Although Urgent Care has a relatively recognizable name, as a business line in the healthcare industry it has not been pulled into a regulatory framework in New York State from a Department of Health perspective. Nevertheless, national accrediting agencies such as the Urgent Care Association (UCA) have, since 2009, established national criteria required to receive certification designation. Additionally, New York State's Public Health and Health Planning Council (PHHPC) put forward regulatory recommendations for urgent care providers governing the usage of the term "urgent care" in a healthcare facility's name, signage, etc. (NYS Public Health and Health Planning Council 2014). It also outlined the manner in which the establishment and certification of urgent care services would (or would not) be subjected to the Certificate of Need (CON) process. One of the recommended obligatory services required for UCA certification and recommended for inclusion in New York State DOH urgent care designation is x-ray, and the consultants who introduced aspects of urgent care to Care Center executives considered it a required service at any urgent care center. Care Center had never provided x-ray services in non-dental settings, and nobody was "officially" assigned to implement the service. My role at the time was to "project manage" the process of starting up Care Center's Urgent Care service, and I regularly was the person who submitted our CON applications and FQHC scope-of-service applications. In reviewing the CON application that

Care Center intended to submit in order to build its first Urgent Care site (a substantial renovation of a former pet-grooming studio), I came across a question asking about the inclusion of “radiation producing equipment” buried in “Schedule 6 – CON Form Regarding Architectural Submission.”<sup>77</sup>

I called Winston Wright, who at the time was overseeing the design development and contracting of construction services for the project, to ask how we intended to address the question, since Urgent Care required radiological equipment, and whether or not he knew what level of drawings and physicists’ report we were required to submit. “I have no clue,” he said, “and why the fuck is the anthropologist trying to figure out what radiological equipment we’re using for urgent care? Aren’t you having calls about this? With Mary? With our CMO? With Abigail (Worthington – the Chief Operating Officer)?” I stammered back that I had been, but implementing x-ray had not been assigned, but it “kinda, sorta, needed to get addressed.”

D.	Project involves radiation producing equipment?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If yes, a Physicist’s Report and drawings must be attached.			

**Figure 3.2. Radiation Producing Equipment. New York State Department of Health (2016). In the public domain.**

Later when I had a chance to interview Worthington, she said something that seemed to answer Wright’s question:

We value the flexibility – “other duties as assigned” is kind of an internal joke about, "Why is it that you're doing this work?" "Because there really wasn't someone else who was well positioned to do it." That might be your only line in your job description. We value that, we've historically valued that. Does that create issues over time because of replicability and how do you pass knowledge, how do you do succession planning? I think that those are really important questions and I think the bigger we get, we have to continue to wrestle with them.

<sup>77</sup> I have copied part of that form (**Figure 3.2**) to offer a sense of the inflexibility associated with Department of Health processes as contrasted to Care Center’s fluid/flexible, grassroots approach to problem-solving.



Worthington's musings reflect Care Center's ongoing challenge to achieve a functional blend of bureaucratic practices that balance extremes of over- and under-organizing (Chen 2009). As Cheryl Hyde (2000) has observed in her study of Feminist Social Movement Organizations, the extent to which organizations maintain this type balance places them along a fluid continuum, in which adjustments to the blend of practices respond to emerging environmental challenges. The wrestling match Worthington describes could therefore be interpreted as a struggle to adjust grassroots techniques within the context of environmental growth.

A few days later Wright and I found ourselves having breakfast in the lobby of a gaudy apartment building with the President and CEO of a medical imaging company to discuss the various professional sports teams that he had worked with on x-ray suite installation. After that meeting, and over the course of the following year, I negotiated the financial terms and lease agreement for the x-ray machines that Care Center would use at its urgent care sites, created a request for proposals for radiological services (reading and interpreting the images), contracted a medical physicist firm to design the shielding for the room in which x-rays would be provided, created an account for dosimetry monitors, ordered lead smocks and safety signs, contacted the Bureau of Environmental Radiation Protection (BERP) to register the equipment and schedule its inspection, authored Care Center's "Radiation Safety Manual" including the policies on patient handling, patient logs, gonadal shielding, etc. and convened the annual meeting of Care Center's Radiation Safety Committee (a certification requirement), and also recorded and distributed the meeting minutes. All of this began from simply attempting to complete a distinctly bureaucratic task (filing the paperwork for an application).

I recount the process by which Care Center implemented its radiology program because, more than any other specific experience I had working with the health center, it exemplifies the

informalism I associate with the organization's grassroots approach to organizing work, and in this case clinical services. There is no hint of anything in my education, resume, or personal experiences that could possibly have been construed as "professional" preparation for implementing a radiology program, yet only one person, Winston Wright, even questioned if it was appropriate for me to be taking on the work. When I described my experience to external medical professionals outside the health center world, they were taken aback, asking why the work was not better suited for a radiology technician or a doctor. I would describe my reaction to this experience in terms that echo the content of my interview with Diana Goodman.<sup>78</sup> In that sense Care Center's approach to radiology is entirely consistent with the manner in which early health center grassroots efforts unfolded. But there is also a difference here: I never had contact with a single patient of the health center before, during, or after the service was implemented.

There is a coda to my account of Care Center's radiology program. Some months into the project a doctor at one of Care Center's urgent care sites had ordered a weight-bearing x-ray in which a patient stood on the x-ray's detector and had broken it. A replacement detector would have cost \$12,000 because when I had initiated the lease I declined the "gold level" service and warranty agreement, which seemed exorbitantly overpriced. I had agreed with Jerry Russo in our finance department to pursue any potential damage through Care Center's general liability insurance – and in this instance the claim was accepted and processed. At the individual site level, the practice manager decided to swap out the broken detector with one from another site because the volume of x-rays was lower and that site was more capable of continuing its operations without x-ray until a replacement detector arrived. When I discussed what had

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<sup>78</sup> "I have to say, the story, grassroots, it was something pretty rewarding. Like I said, I'm being thrown into this... but there's just some rewarding qualities about it, just figuring it out. I felt like whatever hat you had on, you rolled up your sleeve. Everybody who worked in the organization then was pretty much that way...."

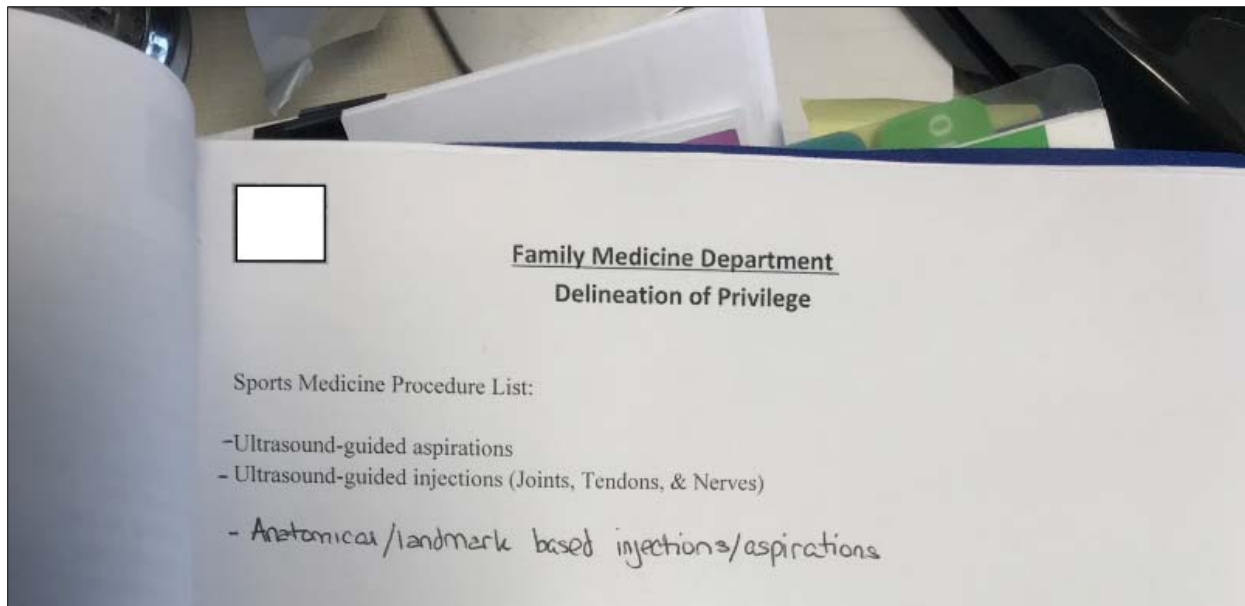
happened with Russo he smiled and said, “Grassroots solution to an immediate problem.” The replacement detector arrived soon after, and the program continued with limited disruption. The involvement of frontline staff in creating this type of “grassroots” solution is indicative of community health center history and recalls the directive of Gouverneur program director Howard Brown to maximize staff participation to solve administrative problems (Shenkin 1975, 16). The participation of frontline staff in problem-solving is characteristic of an “enabling organization” (Chen 2009) in which the identification of solutions is not solely the responsibility of those at the top of an organizational chart. I include this description here because I do not want to imply that a grassroots style inherently produces negative outcomes, but rather to indicate that such a style *does* directly inform outcomes (positive or negative) that are directly tied to clinical service delivery and health center operations.

The implementation of radiology was one of many instances where my work at Care Center utilized an “informal” approach that overlapped with clinical service delivery. On one occasion, Felicia Finley had recruited and hired a doctor for the Wilthook site who maintained a specialty in Sports Medicine. I contributed to the addition of this service within Care Center’s FQHC scope of practice, despite having little to no first-hand knowledge of what the service entailed or what tangible benefits the service would have for the patients at the Wilthook site. The sports medicine doctor, recently returned from treating various collegiate basketball players, had wanted to continue to practice this specialty while also providing basic primary care. “Sports Medicine” qualifies as a specialty from the perspective of the FQHC program, and it is obligatory to add it to a health center “scope of service” in order to (1) receive reimbursement at the FQHC rate for the service, and (2) to give the doctor immunity through Federal Tort Claims Act (FTCA) malpractice coverage. Adding such a service to the FQHC scope of practice

requires a formal application submitted to the Health Resource Service Administration's Bureau of Primary Health Care through an Electronic Handbook (EHB). I wrote an email to Abigail Worthington and Felicia Finley to ask about several of the components required in the application. One of these components was a summary of the typical services/consults/procedures the provider would provide, and/or a copy of the providers privileging list. Worthington's response emphasized that this information was available and indicated that Finley was copied in order to add specificity. Another component was an explanation of why and how the addition of the proposed service would meet the health needs of the population served by Care Center, and how the need for the service was identified. To this Worthington suggested that I talk about new immigrant populations, the nature of repetitive occupational injuries and the limited access to comparable services along with the subsequent negative impact that had on overall health. She did not indicate how this need was identified.

Finley never forwarded the information regarding ultrasound, procedures, etc. and I requested a phone call with Worthington and Finley to help me explain the rationale for adding the service. I sat in Worthington's Canaan Street office while she phoned Finley who said simply "She wants to do injections, joint injections that we don't do in family medicine." I answered that we needed to include a delineation of privileges, and I was not completely sure I understood how to medically describe what they were. She restated her initial answer and added "...and aspirations.... Injections and aspirations." I looked at Worthington helplessly and said quietly, "I guess I should just figure this out?" to which she nodded with a half shrug.

I spent the next two days conducting various Wikipedia-style searches for Sports Medicine and running several reports looking at diagnoses at Care Center. I created a “delineation of privileges” list (**Figure 3.3**) to be included in the change-in-scope application and the doctor’s credentialing file. I spoke to one of our credentialing specialists<sup>79</sup> and requested that



**Figure 3.3 The Sports Medicine Privileging List I wrote for Care Center with handwritten updates**  
Photo by David J.B. Erickson

she have the doctor review the list in order to make sure it actually reflected what she intended on doing.

The final application that I wrote and submitted in order to add Sports Medicine to Care Center’s federal scope of practice included the following overview:

Care Center is proposing to add "Sports Medicine" as a specialty service to its federal scope of practice. This service will support primary care, particularly within new immigrant populations employed in physically demanding occupations, through procedures designed to facilitate the delivery of anesthetics, anti-inflammatories, and other medications. These procedures focus on ultrasound-guided injections targeting joint areas (hips, shoulders, digits) and are not within the purview of family practice doctors who are mostly limited to knee treatments. Please see the attached "Delineation of Privilege" form. Care Center utilizes the "Level II Delineation of Privilege" chart (page 3) to specify additional privileging/procedure list.

<sup>79</sup> A credentialing specialist prepares and maintains credentialing files for healthcare providers covering activities such as accreditation, board certification, memberships or facility privileges, etc.

The application requested a response to the following question as well:

Using the most recent UDS data and/or other data specific for the patient population and/or service area, describe any demographic characteristics (e.g., age range, gender(s), race/ethnicity) and associated risk factors (e.g., occupational, environmental, behavioral, social/cultural, housing status) that demonstrate the need for and/or benefit of the proposed service.

To which I included the following response:

Chronic pain, often associated with musculoskeletal disorders, ranked third in Care Center's top diagnosis from problem list for calendar year 2017. In order to effectively treat these problems Care Center is proposing to incorporate Sports Medicine into its service model in order to broaden the techniques available for treating these cases.

I also included the following description of how the service would support the provision of required primary care services and function as a logical extension of those services:

Sports Medicine is an entirely logical extension of Care Center's required primary care services and support the provision of these services. The specialty broadens Care Center's capacity to address ongoing issues of chronic pain and musculoskeletal disorders commonly associated with repetitive physical occupations in which many of Care Center's patients are employed. This service also increases the diversity of Care Center's ability to address pain management within its patient population.

My purpose in describing this process is not to evaluate whether or not what I ended up writing and submitting with the application accurately describes Sports Medicine or offers a credible rationale for including it in Care Center's scope of practice. The answer to that question would, to some degree, be a referendum on Care Center's balance between grassroots practices and more formal practices. Evaluations of organizations that have blended the two have been both positive (Zell 1997) and negative (Vallas 2003). I am, however attempting to show that I created that description and rationale without formal qualification or professional experience that would enable me to evaluate the submission. The approach is reminiscent of the grassroots style of participation in all aspects of health center operations that Cheryl Jacobs described in our

interview.<sup>80</sup> It also demonstrates the extent to which decisions regarding service provision are heavily reliant on post-hoc justifications using data and informatics reporting generated at a distance from the location where service would ultimately be provided instead of an active “boots on the ground” evaluation of documentable need (or even demand) on the part of health center patients. Perhaps the most striking aspect of my participation in adding Sports Medicine to Care Center’s scope of practice was the seemingly casual approach to the process, given the expectation that all FQHC services be made available throughout the health center’s service (approximately 180,000 patients).

A final illustration of how Care Center developed a unique approach for evaluating clinical activity through an informal, grassroots, system of organization involves the preparation of the health center’s deeming application for Federal Tort Claims Act (FTCA) coverage for malpractice.<sup>81</sup> I have previously discussed the history and ultimate extension of FTCA coverage to health centers, and I have suggested that this coverage had the potential to incentivize particular service expansion efforts (subrecipients) at Care Center. I reference the deeming application for FTCA here because of the specific focus the application has on mitigating clinical risk and ensuring clinical quality improvement and quality assurance. The application asks highly detailed questions regarding risk management systems, reporting, specific operating and training procedures associated with areas of highest clinical risk (OB procedures and infection control), claims management processes, and implementation of credentialing and privileging of clinical staff. For the period during which I conducted my research at Care Center, the

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<sup>80</sup> “I would report to Dan every month what I had done, but I worked right with the clinical team, and I worked in outreach, and did all those things. There was definitely a sense of mom-and-pop like – we were the cowboys and cowgirls...”

<sup>81</sup> An FQHCs must apply for FTCA malpractice coverage by submitting a *deeming application* which, if approved, conveys immunity from lawsuits for medical malpractice upon health center employees and eligible contractors who work within the health center’s *scope of practice*.

responsibility for preparing and submitting this application belonged to Gail Sutherland. The basis for assigning the application to Sutherland resulted from the fact that she had, since the late 1990s, prepared each and every Care Center grant application, award nomination, and request for recognition. At one point, following the execution of multiple subrecipient contracts on whose behalf Care Center would have to submit deeming applications, Sutherland was frantically working on the health center's deeming application late into the evening in the Canaan Street office. "David, I'm not a dumb person, I know how to write, and I know how to make a compelling argument for giving our programs money, but I just don't know anything about managing clinical risk." Care Center was successfully deemed that year on the basis of the application Sutherland created. I asked her how she ended up with the responsibility for securing FTCA coverage, and she shrugged saying, "I suppose we were pretty responsible when it came to getting things in on time." A sense of dedication and commitment rather than formal professional preparation qualified Sutherland for her role in demonstrating Care Center's capacity to mitigate clinical risk.

## **Conclusion**

In this chapter, I have offered a portrait of how the foundation of Care Center and the grassroots feel of its formation persist in the organization's bureaucracy and administration. I have also tried to show that several changes in the healthcare landscape converged on Care Center at the same time, thereby distancing the bureaucratic and administrative activities of the health center from the immediate realities of the organization's service delivery sites. The most prominent change in this landscape had to do with exponential growth associated primarily with George W. Bush's FQHC expansion initiative and the funding associated with it. The distancing effect of these changes certainly altered the relationship that the health center had with its



patients and frontline staff, but it did not generate a more formal system for organizing Care Center's bureaucracy. To the contrary, as this distancing occurred, Care Center actively sought out ways to maintain its "grassroots" identity. In so doing the health center expanded the reach of grassroots informalism (or amateurism), thereby producing comparably informal processes for implementing and overseeing clinical service delivery.

## Chapter 4: Need

“O, reason not the need! Our basest beggars  
Are in the poorest thing superfluous.  
Allow not nature more than nature needs,  
Man’s life is cheap as beast’s.”

*King Lear Act 2, Scene 4*

### **Jackson County Health Committee Official:**

I understand your mission, but as far as just with regards to, you know, if anyone calls up and says, "We want to be an FQHC," -- "Call Care Center, these guys, they'll" -- you know, "they'll take on anything."

### **Care Center CEO:**

We just don't take on anything, that's for sure. Yeah. In our geography, what -- we felt the responsibility in Jackson County, as the only FQHC, to be the solution and to work through the solution with our partners. And in our -- the Uplands service area, we have -- we're located where we want to be in the communities that are in need.

In Chapter 3 I described Care Center’s growth and the implications of that growth on the persistence of a grassroots, informal style of bureaucratic organization. Here I want to explore the vehicle for that growth, and to identify the ways that Care Center’s bureaucratic apparatus contributed to it by looking at the concept of need. In so doing I hope to show how the concept existed within Care Center’s bureaucracy, and the way need offered a unifying principle that facilitated the ongoing activities and efforts of health center executives and administrators. I also will argue that need is malleable and subject to a process of “finessing” or “revision” depending on the desires and situational considerations of those executives and administrators. Often this malleability, aligned with structural features of the FQHC program, produces incentives that expand potential meanings of need rather than narrowing or focusing them. This expansion of meaning has driven and reinforced the ongoing growth of Care Center’s programs.

A brief vignette from my time at Care Center will help to introduce my approach to thinking about need as the justifying principle facilitating growth. On a blustery March morning in 2017 I hopped into my shiny white Subaru Forester and prepared for what I assumed would be about an hour and a half long ride (eighty miles) to the Metro-Southern Population Health

Improvement Program (PHIP) Steering Committee meeting. Care Center operated a substantial number of health centers within the Metro-Southern region, and I had been attending the PHIP Steering Committee meetings as a “stakeholder” capable of helping the group “share, disseminate, and implement best practices and strategies to promote population health and reduce healthcare disparities in the region” (New York State Department of Health 2015). The Steering Committee’s responsibilities were mostly focused on reviewing various reports, documents and policies, and serving as an informal networking group of various hospital and public health officials. A lot of the PHIP’s work appeared to overlap with, or even be duplicative of, New York State’s Delivery System Reform Incentive Payment (DSRIP) program in that both programs referenced “population health” as their primary goal. I had been instructed to attend by my then supervisor at Care Center (CFO Zeke Benjamin), but he seldom inquired about what had taken place. The only exception to this came when I received a frantic early morning phone call from Benjamin and Mary Reagan requesting confirmation that I would attend a PHIP meeting at which a long-term New York State Senator would be present. On this particular morning, I was planning to interview Timothy “Tim” Sutton (Dr. “S” as he was affectionately referred to by his staff), the Commissioner of the Jackson County Department of Health who was also a member of the Steering Committee. I had worked with him and his Director of Health Administrative Services on transitioning the Jackson County system of health centers to Care Center’s operations for about three and half years, and at one point he had suggested that we author a paper on the process of shifting county-run services to the FQHC model.

I was cursing by the time I finally got to the PHIP headquarters, having been delayed by heavy traffic, including several stop-and-go merges as well as debris flying from multiple semi-trucks. I entered the building, a building of tinted glass located in a corporate park, in time to

hear the final part of the PHIP's data analyst, Sean Cullen, displaying a mapping program used to identify "hot spots" for various diseases within the region as well as extensive analysis of various stakeholder surveys. A large, quiet man of about 25, Sean had majored in actuarial science before taking the data analyst position for the PHIP. Often the PHIP project director, looking rather confused, would comment on the fact that some information was beyond her and only accessible in "Sean World." This was the last meeting Sean would attend, because he had taken a job for one of the region's large hospital networks, conducting value-based contracting research. As he completed his presentation, Tim Sutton remarked with a darting look over his bushy eyebrows "and I guess that all goes on the shelf..."

When the meeting concluded, I sat alone in the large conference room with Sutton and asked him a little bit about working for the County health department and the process by which the County had transitioned its network of health centers to Care Center operation.

**TS:** "When I came to the County in 2010, there had been a consultant who looked at us applying for FQHC status as the County. And showed that it would save some money, but it really wouldn't get us out of debt. But the impetus was to continue to apply, which we did in 2010 and 2011, and we were rejected. Once we did not get FQHC status, then we looked at partnering. Care Center approached us prior to our application for FQHC status. Met with the previous administration and made their proposal, to which the thought was, we could do it on our own and save a lot of money that they (Care Center) were requesting for their proposal. After we weren't successful, and under the new administration (County Executive), we went back and started meeting with Care Center. The idea was that, politically, because the new administration had found this \$500 million deficit, that we really had to transition the health centers. Our original approach to FQHC was how can we make them more financially solvent? Now it was – regardless of how well we could run them, and make them financially solvent even if we weren't FQHC, we'd still be in debt for those health centers. So, the decision, politically, was made to transition them. Once we'd adopted that policy, or the County did, then it was just a matter of negotiating an appropriate arrangement and financial deal."

**David:** "I think I recall the County went through a process of submitting applications through its purchasing department, and asking for proposals to run the health centers as an FQHC."

**TS:** "I think, if I remember right, because Care Center was already in the County, they had an almost veto power. If somebody else wanted to do it, it had to get the approval of Care Center. So, we moved into the negotiating arena."

Over the course of three years from 2012 to 2015 Care Center took over the operation of Jackson County's network of health centers, negotiating substantial "Community Benefit Grants" with Jackson County to offset financial losses incurred during the transition period. Characterized in the local press as an effort to "privatize" the county health clinics, the process effectively ended Jackson County's forty-year experiment in the direct provision of primary care services. The county health center system had been created in the late 1960s following intense review of Jack Geiger's original Tufts Medical School grant proposal and the creation of an Office of Economic Opportunity compliant network of Community Action Programs. By 1997 the network was delivering primary care services to approximately 80,000 residents of Jackson County. An early participant in the planning process for the Jackson County health center network described it in the following terms: "There is no level of government with historical responsibilities for safeguarding the health of our population that is closer to the people than is the County level." When I asked Tim Sutton to reflect on the role that his department played and how it had shifted over time, he said:

The role of the county health department, for a variety of reasons, one of which is finances - and as we've downsized - when I started we had 1,400 employees. I have less than half that now in seven years - the role has become more of consulting, education, community outreach, as opposed to direct service. In our department, we have seen this drastic change more than other departments because other departments didn't do as much direct service as we did. The role of public health in one way is diminishing in terms of direct service, but it's also expanding in terms of responsibilities for emergency preparedness, dealing with environmental issues... and every public health department is different.

To a certain extent the financial stresses Dr. Sutton described are a reflection of a broader trend affecting the County since the 2008 recession. By the time I completed my fieldwork in the autumn of 2018, Jackson County had amassed over \$500 million in debt simply to subsidize ongoing operational costs, and it repeatedly borrowed money against pension funds and tobacco securitization bonds. All of this steadily contributed to Moody's downgrading of the County's

general obligation bond rating, reflecting Jackson's tenuous financial status and recurring cash flow struggles. This level of financial uncertainty persisted throughout my fieldwork and often would announce itself in jarring fashion. At one point, following a discussion with the Deputy County Executive about ongoing Care Center projects, all of which were reliant on Jackson bond issues, she concluded that the project might be impossible given the drop in gasoline prices and the subsequent impact that had on the county's tax revenue.

During my equally traffic-ridden and frustrating car ride back from the PHIP meeting and my interview with Sutton, Care Center's operations in Jackson County began to seem increasingly peculiar. How did it come to pass that a tiny grassroots organization, regionally removed from this network of County-run clinics, ultimately assumed their operation, converting them to the FQHC model?

My interview with Dr. Sutton startled me, because I had already spent countless hours driving to and from Care Center sites in Jackson County over the past three years, in some cases project-managing the construction of an entirely new facility that would consolidate two of the County's health centers under Care Center control. None of that work struck me as particularly unnatural or strange and certainly did not seem associated with the "drastic" change Sutton described in the makeup of Jackson County DOH personnel. In revisiting the process by which Care Center expanded into Jackson County, and through the countless conversations I had with Care Center administrative and executive staff and my review of numerous transcripts from Jackson County hearings on the transfer of the clinics, I began to sense that a powerful principle was facilitating this expansion effort, and I began to focus on identifying what that was and how it worked.

In this chapter, I intend to describe Care Center’s expansion into new service areas (the Uplands region and Jackson County) and argue that this growth was facilitated and justified by the use of an implicitly understood, accepted, and effectively deployed organizing principle: that of need. These two examples demonstrate the way need can effectively be used by FQHCs as way to facilitate growth, and the differing outcomes produces by this growth. When I say “need” I do not mean this as some empirical reality that exists “out there” in the world, but rather the way the concept is used within bureaucratic practice, discursively configured using bureaucratic techniques, and circulated, like a token of exchange, as a rationalization for Care Center’s agenda. To do this I shall attempt to frame my use of the term “need” within a broader philosophical/theoretical frame that provides a theoretical basis for understanding the moral dimensions of need, as well as its inevitable association with political and social institutions. I will contextualize the political and social associations of need by reviewing the manner in which need is integrated into several structural features governing health care delivery in New York State and comparable features governing the FQHC program. I have characterized need as an “organizing principle” and a discursively formed object or concept, but in this chapter I also introduce need’s ideological character insofar as it is joined at the hip with a pervasive organizational ethos or mental model that prioritizes growth as an objective in and of itself. I will then review the process by which “need” enabled two Care Center expansion efforts, first into the Uplands service area, the second, a takeover of the Jackson County clinic system. I conclude by considering some of the implications this process has for health service delivery in New York, given the final ends achieved through this growth and bureaucratic configuration of need.

As a final introductory note at the beginning of this chapter, I set a quotation from Care Center’s CEO testifying at a hearing with Jackson County health officials about transitioning the

County clinic system. I did this because her statement succinctly encapsulates the ever-shifting way in which “need” was referenced, developed, and used as a rationale for pursuing projects based primarily on institutional or individual preference. The wording here is striking: On the one hand, it appears to reference a moral imperative to help specific communities “that are in need,” but on the other it references an organizational desire to provide services “where [it] wants to be” with need thrown in as an afterthought. When I initially proposed research into the idea of FQHC bureaucracy, I had suggested that the convergence (or perhaps conflation) of these two meanings constituted a “putative tension between morally-informed service delivery justifications and market-informed service delivery justifications.” Analyzed against the data I accumulated during my time at Care Center, this tension proved to be less prominent than I anticipated, owing mostly to the structural features of the FQHC program that buffer it from typical market pressures. (See **Chapter 2: How Broader Aspects of the FQHC Program and Personalities Reinforce One Another** for a summary of some of these features.) As such, market logics were invoked relatively infrequently as justifications for service delivery. More prominent were service delivery justifications tethered to the concept of need, a concept which carries with it a certain moral tone. I do not want to ignore what Reich (2014) has described as a “general discomfort with market understandings of medical care.”<sup>82</sup> Rather, I want to argue that within the context of FQHC bureaucracy, distinct from Reich’s hospital setting, discomfort resulted from the uses (and perhaps abuses) of the morally-infused principle of need to justify service delivery and expansion.<sup>83</sup>

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<sup>82</sup> Or, in simple terms, a well-documented, apparently inherent tension between neoliberal market forces and morally informed mission forces (Pearson, Sabin, and Emanuel 2003).

<sup>83</sup> By morals I adopt the approach taken by Fassin (2008): “By ‘morals’... I simply refer to the human belief in the possibility of telling right from wrong and in the necessity of acting in favour of the good and against the evil” (334).



## **Need: A Brief (Mostly) Philosophical Introduction**

If, as I shall argue, the concept of need does indeed play a prominent role in the context of FQHC bureaucracy and service delivery, some of the theoretical and philosophical features of need warrant introduction. Patricia Springborg suggests that the concept of need, at least philosophically, “is usually overburdened” and therefore generates fundamental disagreements regarding the metaphysical and empirical senses of the term (1984). These disagreements and debates have produced several philosophical investigations of need (Braybrooke 1987; Wiggins 1988; Reader 2006; 2007; Miller 2012; McLeod 2015). Although I do not intend to offer an exhaustive account of these inquiries, I will summarize a few key features of “need” that these accounts introduce. My purpose is to illustrate the staying power that the concept of need has had in the western philosophical tradition, from Plato and Aristotle to Hegel and Marx, and to suggest that a familiarity with the concept’s intellectual origins helps in framing and interpreting the way it operates within institutions, such as FQHC bureaucracy. Following this summary, I shall review some of the implications that the philosophical treatment of need has on the development and implementation of FQHC programming.

Aristotle’s account of “the necessary” in Book 5, Chapter 5 of the *Metaphysics* (2003, 1015a-20) formally inserts the topic of need into the western philosophical tradition, although Plato had gestured at the subject at various places in the dialogues and the *Republic*. Aristotle straightforwardly indicates that what we call necessary is “(a) that without which, as a condition, a thing cannot live; e.g. breathing and food are necessary for an animal for it is incapable of existing without these; (b) the conditions without which good cannot be or come to be, or without which we cannot get rid or be freed of evil; e.g. drinking the medicine is necessary in order that we may be cured of disease, and a man’s sailing to Aegina is necessary in order that he

may get his money.”<sup>84</sup> Aristotle continues to offer additional examples of how the term is associated with “compulsory” force or logic. Aristotle’s definition of the necessary is significant in several respects. First, it connects the question of need to the metaphysical question of human being (e.g. needs as a precondition for human existence). Second, it opens a pathway for need as a concept to connect with the ethical considerations of achieving “the good” and avoiding “evil.” Third, it presents need in the form of a proposition or claim in which something (medicine, money, etc.) is needed in order to accomplish some specific purpose. As David Wiggins summarizes: “needing is always by its nature needing for a purpose – any purpose at all that may be specified – and that statements of need which do not mention relevant purposes are somehow elliptical (according to some, dishonestly elliptical) for sentences that do mention them” (Wiggins 1987, 63).

In making a claim about need, then, evaluating the answer to the question “for what?” becomes the first step in distinguishing “morally demanding” needs from non-moral or immoral needs or mere desires (Reader 2007, 55). I emphasize the distinction between “needs” and “desires” here because it is precisely this fluidity of meaning and the interplay between the two that characterized many of the bureaucratic practices I observed and participated in while at Care Center. Theoretically speaking, the former category (that of “needs”) carries with it “moral force” whereas the latter (mere “desires”) does not. Soran Reader summarizes the distinction and the potential confusion resulting from it saying: “this diverse talk of needs in everyday normative language jostles with talk of desires and interests.... Matters are not helped by the fact that people making non-need claims understandably tend sometimes to try and take advantage of the intrinsic moral demandingness of need by presenting their claims as need claims” (2007, 53-

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<sup>84</sup> This should not be confused with Aristotelian notions of “absolute necessity” in the sense of something like God whose existence, for Aristotle, depends on nothing other than itself and is itself absolutely necessary.

4). Because I was focused on constructing a social portrait of how bureaucrats conduct the everyday business of primary health care using morally-informed justifications at the outset of my research, I was very attentive to the way FQHC bureaucrats fashion claims about need to “take advantage” of the concept’s moral significance. Bureaucratic processes that respond to the question regarding need’s purpose (“for what is there a need?”) do not merely convey empirical facts. They transmit a message about an adopted moral position. Care Center bureaucratic activities, specifically the preparation applications for funding and/or service expansion, were focused on making specific claims about need and as a result carried with them moral claims as well. “To meet needs,” argues Kate Soper “is to assume political responsibility for all decisions and actions relating to production. And that, in turn, means facing, fairly and squarely, the problem of the criterion of need; it involves decisions about what is ‘valuable’ (needed) and therefore worth producing” (1981, 211).

Apart from his formal definition of needs in the *Metaphysics*, Aristotle also develops an idea introduced by Plato that identifies need as a creative force informing the development of civic and social life. In Book 2 of the *Republic*, Plato suggests that the origin of the city “is to be found in the fact that we do not severally suffice for our own needs, but each of us lacks many things... Its real creator, as it appears, will be our needs” (1963, 369b-c). Aristotle would pick up this line of thinking and develop a system in which needs (or demand) drive formation of the state, and he outlines the various persons in society who should be responsible for ordinary needs (food, water, etc.) and those who would pursue extraordinary – yet not less important – needs (war, politics, etc.). There is one important takeaway from Plato’s assessment of need as far as it relates to subsequent analysis of the concept in western thought (and the way it relates to FQHC bureaucracy for that matter): It presents needs and need-meeting as inextricably linked to social

and civic processes, and therefore to politics. Because human needs have to do with social life, it follows that social institutions (governmental, civic, etc.) maintain an ongoing interest in marshalling resources to meet such needs. The historical development of Office of Economic Opportunity programming and the FQHC movement should be understood as an example of how needs interact with social programming and politics.

There is a final line of thinking about need that explains some of its utility within the bureaucratic process of administering health care delivery. At the core of the passage from *King Lear* that introduces this chapter is the Aristotelian notion that humans inherently seek not only to meet the basic necessities of life but also to transcend them in order to achieve some further state of being. Reason, as far as Shakespeare is concerned, cannot explain why humans develop “needs” that go beyond the basic elements of survival, but Terry Eagleton persuasively argues that the way humans are able to do this is through language itself (1986, 82). This “linguistic inflation” that “constantly outruns the confines of the body” allows humans to surpass or outstrip the basic needs required for sustaining life. I do not mean for this insight to prompt endless deconstructing of what exactly constitutes Lear’s superfluous needs, but rather to point out that linguistic inflation all too frequently co-occurs with discussions of need and is, in essence, the primary index by which we navigate the spectrum between basic needs and everything else. Bureaucratic instruments such as forms, writing, certification, etc. take linguistic inflation and fabricate it into transferrable and circulatable constructs. I intend to look closely at the mechanisms and processes by which Care Center bureaucrats performed this type of inscription.

### **Need in the Context of Health Care Delivery: A Brief Review**

In this brief review, I intend to link some of the philosophical ideas about need that I presented in the previous section to concepts of need that inform health care delivery in New

York State and through the FQHC program. I shall then follow these ideas as they take shape and circulate throughout the bureaucratic environment of Care Center.

### **Certificate of Need Regulation (State)**

In my chapter on “History and Histories” I described the way in which Lister Hill left a lasting imprint on the development of healthcare facilities through the passage of the Hill-Burton Hospital Act of 1946. I suggested that the law’s preservation of “separate but equal” language coupled with its hospital-centric model produced a circumstance of underdeveloped outpatient facilities, particularly for African Americans in the southern states. This ultimately fused the efforts of the Medical Committee on Human Rights with the health center model. I mention Hill-Burton here again because its reference to “planning” and its obligation to promote “charity care” opened the door to legislation governing health service delivery in the states. I present this history because it is in large part the story of how the policy environment in which FQHCs operate developed features that shield them from typical market forces, competition specifically. I am limiting my discussion to state-level policies of this sort, but equally powerful federal regulation governing the expansion of FQHCs (the Change in Scope or CIS process) has had similar anti-competitive effects. CIS regulations limit FQHC expansion into areas where an existing FQHC serves patients, thereby reducing competition between FQHCs within markets. From a state perspective, New York specifically built on Hill-Burton when it enacted legislation in 1964 to determine the specific needs of the community (certificate-of-need, or CON) prior to hospital and nursing home construction (Metcalf-McCloskey Act of 1964).

The legislation was extended to all New York State Article 28 licensed healthcare facilities (including outpatient diagnostic and treatment centers) the following year.<sup>85</sup> Section

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<sup>85</sup> I have reproduced Schedule 17 from the New York State Article 28 Certificate of Need application (**Figure 4.0**) as part of a sensitizing strategy that reveals the relationship between material things (applications) and concepts

1122 of the 1972 Social Security Amendments tied the CON process to the establishment of reimbursement rates from Medicare and Medicaid, and resulted in twenty-four states adopting CON regulations (Cimasi 2005, 5). The CON process became an accounting mechanism to represent the true costs of delivering care using a formula that would factor in capital and operating expenditures.

<p style="text-align: right;"><b>Schedule 17</b> <b>CON Forms Specific to</b> <b>Diagnostic and Treatment Centers</b> <b>Article 28</b></p> <p><b>Contents:</b></p> <ul style="list-style-type: none"><li>o <b>Schedule 17 A - D&amp;TC Program Information</b></li><li>o <b>Schedule 17 B - D&amp;TC Community Need</b></li><li>o <b>Schedule 17 C - Impact of CON Application on D&amp;TC Operating Certificate</b></li></ul>
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**Figure 4.0. CON Schedule 17. New York State Department of Health (2014). In the Public Domain.**

Health facilities would use the information included in their CON applications to calculate (or appeal) their reimbursement rates. The National Health Planning and Resource Development Act of 1974 mandated comparable programing requirements for all fifty states. In terms of process, CON regulations designate specific agencies or boards responsible for overseeing and approving applications, weighed against specified criteria including need. For FQHCs this is particularly significant in that the United States Congress developed a specific payment methodology, the FQHC Prospective Payment System (PPS), in which each FQHC receives a unique Medicaid rate derived from the represented historical costs associated with

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(need). Schedule 17 ties together my historical introduction to the CON process, a physical schedule mediating that history, and the accumulated meanings that need has acquired throughout that history, and the bureaucratic operations performed at Care Center. As such I treat Schedule 17 as one of many potential mediators that “transform, translate, distort, and modify the meaning of the elements they are supposed to carry” (Latour 2005, 39).

providing services to Medicaid patients (National Association of Community Health Centers n.d.). Although the intent of CON regulations appears to have been focused on controlling costs, the concept driving their implementation had several significant effects, specifically as these relate to the concept of need<sup>86</sup>. First, in much the way that Plato and Aristotle identified “need” as the driving force organizing state activity, CON regulations formally codified that premise into law. Second, CON regulations introduce the idea that need must go through a written (or inscribed) application and certification process, that is, need directly undergoes administrative and bureaucratic review as a criterion for service delivery and expansion. As Akhil Gupta notes: “Forms... enframe and categorize the world” (2012). Third, the emphasis on restricting expenditures actually reorients healthcare facility competition from one based on quality/reduced cost, to one based on exploring and exploiting new markets of “need.”<sup>87</sup> One result is that these regulations limit competition by restricting entry into new services areas. This, from a classical market perspective, is a fundamentally an anti-competitive process.

### **FQHC Applications and the Need for Assistance Worksheet**

The “History and Histories” chapter introduced several aspects of federal legislation and initial programing that ultimately resulted in the emergence of community health centers. One focused on the policy history of the Economic Opportunity Act and on the political viability that the health-specific portions of the law acquired over time. This history reads as a tale of strategic political support and increasing institutional codification, but it also demonstrates the ongoing process by which the concept of need was inserted into the legislative process at the federal

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<sup>86</sup> Most assessments of CON regulations focus on the *limited* efficacy of CON regulations at controlling cost: Conover and Sloan (1998); Rivers, Fottler, and Younis (2007).

<sup>87</sup> See Havighurst (1973): “Since certificate-of-need laws prevent a new firm's entry or an existing firm's expansion except upon demonstration of a public "need" for the new service, they are similar to the laws governing admission to a wide range of regulated industries, including banking, for-hire transportation, generation and distribution of electricity, consumer credit, and communications” (1154). This stands in contrast to neoliberal perspectives in which market exchange constitutes an ethic in and of itself (Harvey 2005).

level, and ultimately into the very DNA of the programs that emerged from the Economic Opportunity Act. This is evident in the example I have given from the House Committee on Education and Labor Hearings on the Economic Opportunity Act Amendments of 1967, where some of the most vigorous questioning focused on how the health center program would define criteria for need. This is the federal counterpart to the state-level insertion of need into the legislative process.

Another piece of the history recounted earlier was the way that OEO bureaucrats worked through initial applications for funding and how they ultimately used proposals (the Geiger-Gibson proposal in particular) that fit their vision to serve as templates for future work. Developing the initial OEO health center programs was a conscious effort to align community-generated descriptions of need with the government's delivery of services. This recalls the frustration I heard during my interview with Lisbeth Schorr (see **History: "Pitching" the Health Center Idea**) when she described the initial applications that the OEO received: "There was no strategy there at all, and we knew that we wanted a strategy, and we wanted a strategy that would change healthcare for poor people" (Pers.Com 4/14/18) and also the desire to fund something that would be "responsive to the needs of residents" (1966, 1143). Application development then can be interpreted as the programmatic expression of the broader political/legislative process. Once the OEO health programs had gained political viability - and indeed once basing service delivery on the concept of need had been more or less affirmed - the administrative organs of the office would over time convert that concept into the application process for potential grantees. When in March of 1968 the Health Services Office of the Community Action Program issued guidelines for submitting projects for funding consideration,



the first requirement for obtaining support would state quite simply: “Focus on the Needs of the Poor” (U.S. Office of Economic Opportunity 1968, 4).<sup>88</sup>

The federal application process had, in a few short years, formally placed need as the basis for awarding applications. Whereas CON laws placed need into an equation for calculating ongoing Medicaid and Medicare reimbursement rates, the OEO application equated need with direct operational funding in the form of grants. Applications, then, are critical - and in fact essential - components of the health center program, but they are also an inscribed record of the transaction entered into by applicants who submit their need in return for financial resources. The very status of a health center as a “Federally Qualified Community Health Center” is first and foremost a description of this transaction. Although as I outlined in “History and Histories,” the sponsoring agency has changed over time (from the OEO to HEW to HRSA) in a process of bureaucratic consolidation, FQHCs are first and foremost defined as “entities that apply for or receive a federal award under section 330 of the Public Health Service (PHS) Act” (Health Resources and Services Administration 2018, 1). That is, they are defined by virtue of their application. Health centers that provide exactly the same type of health care services that FQHCs do, but are not directly placed into this exchange relationship, have a different name: “look-alikes.” Like the Certificate of Need (CON) applications in the states, federal applications to support health centers also must submit need to administrative and bureaucratic scrutiny. For new health centers, “New Access Points” (NAPs), or expansion grants, this process relies heavily

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<sup>88</sup> In three successive years the U.S. Office of Economic Opportunity (OEO) published pamphlets on the health programs it supported. The first (1966) simply listed a few “shoulds” for applicants, the second (1967) included various photographs of patients one of which included a quotation from Jack Geiger: “Without intervention the poor get sicker and the sick get poorer,” and the third (1968) are explicit guidelines outlining various requirements for funding.

on applicant ability to effectively complete a “need for assistance worksheet.”<sup>89</sup> The guidance for this worksheet for a 2016 New Access Point was eight pages long. It concluded with a description of how the worksheet would be converted into a 100-point application score.<sup>90</sup> In time NAP applications came to include additional points for various funding priorities, such as underservice, special populations (migrant farmworkers, residents of public housing, homeless), sparsely populated areas, etc.

Although some details have changed over time, the basic structure has remained relatively constant: One section looks at barriers to access (ratios of population to primary care physician, percentage of population at or below 200% of the federal poverty level, percentage uninsured, travel time, etc.). Another section compares health indicators (cancer, cardiovascular disease, prenatal/perinatal health, etc. and supplemental indicators selected by the applicant) from the applicant’s targeted service area or population to national benchmarks. For example, an applicant might compare hypertension hospitalization rates between a national benchmark and specific zip codes where he/she sought to add services. In summation, requests for federal funding are heavily reliant on a detailed inventory of need within the proposed area wherein the applicant seeks to deliver healthcare services.

I include extensive description of these criteria, and the breadth of the historical circumstances producing them, because I want to offer a sense of how they become “sedimented

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<sup>89</sup> New Access Point applications are different from Change in Scope applications in that NAPs provide direct financial subsidies (\$650,000/year in 2018) for ongoing support, whereas CIS applications are contingent on the individual grantee demonstrating financial sustainability without direct federal support.

<sup>90</sup> “The NFA Worksheet will be converted to a 20-point scale using the following conversion table. The converted NFA Worksheet score will account for up to 20 points out of 100 total points for the overall application score (up to 20 of the available 30 points for the *NEED* section of the Project Narrative). Applicants will be able to view the scores for each NFA section in the read-only version of the form accessible in the Review section of the Program Specific Information in the EHBs. The total NFA Worksheet score can also be found on the Summary Page Form for the Program Specific Information. Applicants should ensure their understanding of the system-calculated score prior to application submission.” (Health Resources and Services Administration 2016).

into everyday routines,” and to emphasize the fact that “even mundane bureaucratic procedures bear the marks of prior ethical debate” (Brodwin 2013, 16). I also want to emphasize that much of the information included in the needs section of a NAP, as well as the data sources that inform completion of the need-for-assistance worksheet, are at the discretion of the applicant. Much of the information that applicants include in these worksheets is not necessarily assembled as a documentary record of facts on the ground. Rather, the information is assembled to serve “the uses of contract rather than description” (Garfinkel 1967, 203). That is, the applicant can seek out the most persuasive sources and indicators given the data available to him or her in order to generate the highest need point score as a basis for awarding funds. The more sophisticated an applicant is at navigating the need-for-assistance form and unearthing particularly effective representations of need, the more likely they are to receive funding. Within Care Center, seeking out these data sources and completing this type of application constituted a core function of the health center’s bureaucracy.

None of what I have described above will sound particularly exotic to anyone with even a passing familiarity with grant-seeking. However, the approach to NAP, and to grant applications in general, within Care Center was striking in that nobody could identify a single time that the health center did not submit an application for New Access Point funding in response to a funding opportunity announcement. Never foregoing such applications implied that there was never a moment at which some concept of need could not be used to facilitate the (successful) application process.

**Care Center’s Expansion through Grants and Applications: “The dream led to a commitment that went beyond ourselves.”<sup>91</sup>**

This section will follow a series of Care Center applications for federal assistance in order to demonstrate how central the principle of need was to bureaucratic activity and how skillfully curating presentations of need facilitated Care Center expansion. I have pieced this section together through interviews with Care Center staff who worked on the applications contributing to this expansion and through review of Care Center archival documents, including the narrative portions of the applications from which I occasionally quote or paraphrase. In doing this I am consciously applying an institutional ethnographic method focused on the ways that institutional efforts are conducted, coordinated, and codified through texts, discourses, and technical language. In this instance I will use the process of developing Care Center applications as a point of entry from which I then map out the network of relationships interacting with, and shaping, that process.

In the early 2000s Care Center was operating six health center sites outside New York City at a budget of about \$13 million. Care Center haltingly added sites since opening its first location in Wilthook, but as the century came to a close, and as George W. Bush committed to expanding FQHC funding, Care Center began exploring areas for potential growth. A small hospital outpatient medical practice in the upper eastern portion of the Uplands region entered into discussions with Care Center about potential affiliation agreements and/or ownership transfer possibilities. The practice, specializing in family medicine, had been operating since the early 1990s and was seeing approximately 13,000 white, mostly elderly patients at multiple satellite locations when discussions with Care Center began.

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<sup>91</sup> A frequent statement made by Roberta Thompson, Care Center founder.

At this point Care Center made an opportunistic decision to acquire the site, subsidizing the process with federal support made available that year. The notice announcing the availability of federal funding reflected mandates of a 2002 legislative reauthorization that required dollars to be distributed at specified proportions to particular types of health centers: community health centers, migrant health centers, public housing health centers, homeless health centers, and school-based centers (Taylor 2004, 5).<sup>92</sup> HRSA historically struggled to maintain required levels of investment especially in migrant health centers, in part because this type of health center, typically rural, often struggles with physician recruitment; given this, HRSA would at times give preferential consideration to applications focused on such populations. Taking all of this into consideration, Care Center produced a remarkable application requesting \$500,000/year in ongoing operational support for “the expansion of services to migrant and seasonal farmworkers (MSFWs) at a new access point” in late 2001.

I say remarkable because when Care Center submitted its New York State Certificate of Need application to operate the site a few months before preparing the federal grant application, it made a passing reference to “a number of migrant farmworkers working on farms in the area.” The federal application made migrant farmworkers the centerpiece, noting among other things that “immediately upon receipt of federal funding, the site will have the capacity to provide primary care services to the 4,610 MSFWs within the Uplands region, as well as the other residents of the area” with a minimum 2,250 MSFWs so be served. Care Center offered the following rationale for requesting preference in the consideration of the application: “*Care*

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<sup>92</sup> “Although the health centers’ statutory consolidation created a single legislative authority for health center grants, the 330 grant program is subdivided into separate grant competitions for community, migrant, public housing, and homeless health centers, thereby allowing communities to tailor applications to their particular needs. HRSA has also funded some school-based health centers, even though the agency does not have an explicit authority to fund school-based programs” (Taylor 2004, 5).

*Care Center* is currently providing comprehensive, culturally competent care to MSFWs and other underserved populations at two MHCs, three CHCs and one Healthcare for Homeless project. In addition, *Care Center* operates as part of a network serving MSFW's through contracts, or letters of agreement with MSFW organizations such as Migrant Head Start, Agricultural Childcare and a rural health network." The application then continued to describe - as prompted by the application's guidance - the unique barriers, service gaps, special needs of MSFWs in general including: lack of participation in benefit programs, substandard living conditions, lack of telephone access, dearth of services currently available for the targeted population, the high need of care for diabetes, hypertension, dermatitis and eczema, otitis media, and the "silent epidemic of oral disease." *Care Center* then described an aggressive outreach plan to target MSFWs using bilingual (English-Spanish) outreach workers. According to *Care Center*, the Uplands practice was "serving the large low-income population of the area," but the site had "not been able to adequately and competently provide care to MSFWs due to lack of outreach, or additional service hours and programs that specifically target MSFW's needs."

Migrant and seasonal farmworkers (agricultural workers) do labor under incredibly trying circumstances. A 2010 profile of migrant health based on an analysis of Uniform Data System (UDS) reporting from 142 migrant health centers (FQHCs) indicates that agricultural workers experience higher rates of poverty, lower rates of health insurance, and are more likely than non-agricultural workers to experience tuberculosis, diabetes, and overweight/obesity (National Center for Farmworker Health 2014). Indeed, the suffering of migrant farmworkers had been widely consumed as an object of popular culture throughout the 20<sup>th</sup> century.<sup>93</sup> *Care Center's* romantic depiction of farmworkers was no exception:

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<sup>93</sup> As a commonly consumed trope in popular culture consider the following: *The Border Incident* (1949), Anthony Mann's film noir depicts two agents going undercover as poor migrants to disrupt human trafficking and human

Coming directly from Mexico, particularly from the rural States of Puebla and Oaxaca, many have left families behind in order to provide for them, intending to work the crops for six months and then return to Mexico. They are heroes in their villages for having braved the long and dangerous trek across the border, moved north to New York to live in housing sometimes made from cold cement block, often with no bathroom facilities, sleeping in a cot next to 30 other men in the same room. While a small number of these farmworkers speak an indigenous Indian Language, Spanish is the first language, and in many cases the only language of most. Virtually all MSFW's in the service area earn annual incomes under 200% of the federal poverty level (FPL).

But these words did not ultimately reflect the reality of the Uplands region. In 2002 Care Center's *entire network* saw an average of 3,070 MSFWs (vs. the over 4,000 promised in the federal application just in the Uplands region). In 2003 Care Center saw ever fewer MSFW patients – 2,393 in total. Of these, approximately 76% had already been established as MSFW patients within Care Center's network, the clear majority receiving services at migrant health center sites on the other side of Care Center's service area and not in the Uplands geography.

I had an opportunity to ask the Chief Operating Officer, Abigail Worthington, about that application, and how Care Center reported on the progress of the project to HRSA's Bureau of Primary Health Care. She explained that they *only* had to report data on MSFWs, and were not obligated to do so in a site-specific way – anyone the health center coded as an MSFW would satisfy the federal requirement. Looking back through the historical data, the Uplands site would never come close to seeing the projected MSFWs identified in the application. In fact, it would never really see a large number of Spanish-speaking patients (285 out of 7,142 total patients in 2002; 557 out of 7,406 in 2003; 532 out of 7,204 in 2004). Only in 2016, fifteen years after initiating services, did the number of Spanish-speaking patients at the site break 1,000, less than half of what was projected. Eventually Care Center walked back the characterization of the

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suffering; *Harvest of Shame* (1960), Edward R. Murrow's expose reveals the conditions of migrant farmworkers; *The Fugitive: Smoke Screen* (1963), David Jansen stars as Richard Kimble toiling in disguise among Mexican onion pickers; *The A-Team: Labor Pains* (1983), Mr. T. and company fight for farmworker rights when a henchman holds them in modern slavery; *The Colbert Report: Fallback Position – Migrant Farmworker* (2010), Steven Colbert spends a day working as a farmworker as part of UFW's "Take Our Jobs" campaign; etc.

Uplands site as a “migrant” health center and the money was simply rolled into Care Center’s total federal grant funding. Migrant and/or seasonal agricultural workers never constituted more than about 5% of Care Center’s patient base, and by 2018 that percentage had dipped to less than 1% percent. In 2018 Care Center saw 6,400, and moved to close one of the practice’s satellite location in a neighboring town. This type of “bait and switch” approach to gaming the requisite signifiers of need appears to impact the demographics of the patients that migrant health centers ultimately end up seeing. I have described this in the Uplands service area. Seth Holmes recounts another similar instance in the Skagit Valley where morphing of a migrant health center’s mission “to treat all the local poor instead of solely migrant farmworkers” led to a correlated decrease in the percentage of health center patients actually engaged in farmwork (2013, 127).

Reactively creating an application in response to funding opportunities (“chasing the money”) is not unique to FQHCs, nor perhaps is the tendency to overpromise on deliverables. What is particular to the FQHC environment is the way that the health center’s administration shaped the description of the Uplands community and mechanized the needs of MSFWs in the service of its application for health center expansion that fit a preferential funding stream. In May of 2017, I asked Gail Sutherland to tell me a little bit about the application process. She threw back her head and laughed. “I couldn’t believe she (Mary Reagan) was asking me to write the thing. I would scream at her: ‘The migrants?! What? All three of them?’ But we did it.” She lowered her voice to add “That’s when I began whoring for Mary.”

I take Sutherland’s reaction to the application process to indicate her frustration at having to somehow navigate what Robert Jackall has described as “an intricate set of moral mazes that are paradigmatic of public life in our social order,” and forcing her to find an answer to the question “how does one act in such a world and maintain a sense of personal integrity?” (1988,



193-4). Navigating the maze in this instance involved answering the Aristotelian question regarding the purpose for which Care Center needed funding with an elliptical answer at best. From a grassroots perspective, having an immediate mission-focused answer to the question what purpose will be served by meeting a need, the move to finesse the answer weighs heavily on the moral conscience (or consciousness) of some Care Center administrators. A couple of senior staff explicitly grappled with the cognitive dissonance of a mission-driven interest to address need with the realities of actual healthcare needs in Care Center's service area.

“Regardless of the mission statement printed on the back of a card, the subordinate goals that are established to meet the mission are not often clearly expressed, or if they are expressed, they're not uniformly understood,” explained one Vice President. “It feels inspiring to think you're working toward the mission as it is written, but in reality, it's discouraging to have your work feel far removed from that mission,” lamented another. One evening I sat in a Wilthook bar after work with Jerry Russo, a sardonic member of Care Center's finance team, who offered a blunt assessment: “The founders [of the health center] actually had an immediate problem they were trying to solve, now the motivations are – less clear.”

The application process, from both the state and federal perspective, allow need to circulate as both a rationale and as a currency driving service delivery. The example of Care Center's expansion to the Uplands site demonstrates the bureaucratic process that discursively fashions need into a format by which it can be exchanged for financial resources. Some types of need may have greater salience in this system, specifically the needs of migrant farmworkers. Through linguistic (and numerical) inflation, Care Center effectively exchanged migrant farmworker need for general operating income. In this instance the patients for whom federal funding was needed to support never materialized and a reduction in service resulted.

## **“The Queen of Jackson County”**

In August of 2017 I sought out the former Chief Operating Officer of Care Center. On the broad American flag-lined main street of a former iron and mill working town about twenty-five miles outside of New York City, Rebecca Taubin met me in the waiting area of her flagship health center and ushered me up to her second-story office. I had sought Taubin out because she had promoted Care Center’s expansion efforts into a new county, again using the need to deliver services to farmworkers as a justification. The background is as follows. In 2003 Care Center had begun to identify more migrant and seasonal farmworkers to whom it would deliver services, this time in geographically distant Jackson County. Through a New Access Point (NAP) application Care Center sought to establish a migrant voucher program to serve approximately 1,500 agricultural workers in Jackson County. The Health Resources and Services Administration had established voucher programs in the late 1980s to enable FQHCs to contract with local providers to serve MSFWs because in certain areas where MSFW populations were concentrated there were few brick and mortar clinics. Early guidance indicates that such programs are viable when primary care capacity is adequate, but other barriers (financial, transportation, etc.) exist in the case of MSFWs (Slesinger and Ofstead 1996, 58). Jackson County seemed to fit this profile. I already have described the breadth of primary care coverage being provided by the system of county-run clinics, but this system was limited in terms of specifically targeting the MSFW population.<sup>94</sup> Care Center was awarded the NAP funding and initiated its “virtual” health center programming in Jackson County in 2004.

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<sup>94</sup> The Jackson County Department of Health subsidized its programming for MSFWs through a New York State DOH grant supporting outreach activities, health education, and health/supportive services.

By 2006 Care Center was again seeking assistance to expand capacity within Jackson County and did so through a HRSA funding opportunity for “Expanded Medical Capacity for MSFWs and/or Homeless Persons.” The application<sup>95</sup> stated that:

The need for care for MSFWs in the target area continues to grow, both due to an increase in the number of MSFWs in the region, as well as a change in the work patterns of those farmworkers already in the area. The National Agricultural Worker Survey (NAWS) indicates that there has been an increase in the number of farm workdays in the last year, indicating an overall growth in the volume of farmwork.

This expanding “need for care” resulted in demand exceeding capacity.<sup>96</sup> In response Care Center requested financial support to increase the number of voucher dollars available for contracts with local providers, but it also sought to “upgrade” a contracted community care site in Jackson County into a Care Center-operated brick-and-mortar location in Riverside NY, staffed by a nurse practitioner and allied clinical support staff. The conversion of the practice was completed in 2006. Of the Jackson County voucher program, and the subsequent establishment of the site in Riverside, she said quite simply: “There was no question that that voucher program was planting the flag.” I asked her to tell me a bit more about the process of expanding into Jackson County and how need factored in:

**David:** When the County finally decided that it wanted to move toward an FQHC model, it explored doing it itself, issued in RFP for contractors to operate the sites as the FQHC – it happened after you were gone.

**RT:** Right. I think [pauses] need is an interesting question. What is minimally acceptable access and what is it that we, as evangelical, health center people can do? Yes, there were county clinics but it seems so obvious that if we could transform them that we could improve the system for tens of thousands of people. That was not necessarily a rigorous needs assessment that we ever did in a formal way. It was a way of saying if they have 30,000 people that are coming to these clinics and we know these clinics are not doing after-hours care, we know that these clinics have a bunch of non-board-certified physicians, we know they don't really have a specialty network... Why wouldn't we want to do this if we had the

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<sup>95</sup> The application was authored prior to my employment/research time at Care Center but was referenced by my direct supervisor during an interview I conducted with her. I tracked down the original application in the Care Center archives (files).

<sup>96</sup> Evaluating population estimates of MSFWs is notoriously difficult. Jackson County's agricultural acreage did, however, remain stable from the early 1990s until 2014.

resources to make that work? If it was win-win for everybody, right? Enhanced Medicaid payments, FTCA coverage, economies of scale, come on David, we all know that we were looking at Jackson County which didn't have any FQHCs and wondering why the hell not? And how do we, both from an organizational empire-building point of view but also once again, I call it evangelical, believe in this model? We believe that it's the best model out there. We believe it can help thousands of people in a fiscally responsible, sustainable way. Why would we not do that and Jackson County had nothing? We were hearing a little about the farmworkers out in Jackson County in the vineyards or whatever it was they were doing. Why would we not try to provide that if we could? Why would we not want to grow the organization and be the queen of Jackson County? At one point, Mary and I were talking about a possible position for me which I used to refer to as the Queen of Jackson County. That was going to be my unofficial title, "Queen of Jackson County." We were going to make Jackson County Care Center territory.

Taubin leaned forward and gestured forcefully as she questioned me, cocking her head to one side and squinting her eyes at me and making me feel slightly foolish. Why *wouldn't* I try to move into Jackson County? Why *wouldn't* I try to deliver services there? Why *wouldn't* I want to grow and expand organizational reach? She herself had grown her new health center from 4,000 patients in one county to about 35,000 patients in six. What struck me was how insistent Taubin was on the *belief* that pursuing expansion was the right thing to do. From a business perspective Edward Hess (2010) has convincingly argued that growth is a "pervasive mental model" (12), accepted implicitly despite limited studies "testing the validity of the assumption that a business must grow or die" (13). In many instances this growth mental model has had unintended negative consequences in terms of efficiency and long-term stability. In the FQHC setting growth has been correlated with decreasing technical efficiency (Amico et al. 2012). Growth then, and whatever justifications accompany it, has a tendency to become managerial dogma, and an end in and of itself. Gail Sutherland had had expressed a similar idea when she told me about describing the Care Center's services and the expansion of them in grant applications: "I'm not repeating sound bites. Triple Aim, patient-centered, PCMH<sup>97</sup> -- all those things have become sound bites. When I'm talking about them and we're writing about them, I

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<sup>97</sup> Patient Centered Medical Home

believe it. [laughs]. It matters to me and I want it to be a good read because I want you to get that. I want you to get that.”<sup>98</sup> Equally striking was how unimportant a clear articulation of need actually was in comparison to the litany of broader objectives. The purpose was not necessarily meeting the needs of MSFWs, in fact it was not necessarily clear who those people were, or what they were doing (“farmworkers out in Jackson County in the vineyards *or whatever it was they were doing*”), nor was it necessarily important to conduct a rigorous assessment of need prior to entering Jackson County (“There was not necessarily a rigorous needs assessment that we ever did in a formal way”). The assumption was that growth was good, and that need existed somewhere “out there” and that only by expanding the reach of Care Center would it be met.

As I prepared to leave, I explicitly asked Taubin if she had any thoughts about health center bureaucracy and she emphasized how significant preparing applications was to Care Center’s work: “What was a concern at Care Center was a very strong health center, not just because the services were actually good, but because we were really good at grant writing.” I replied, “It still is.” Taubin nodded and continued, “The strong get strong and the weak get weaker. We could have a staff of grant writers. We could hire consultants to do it. Some health center somewhere in Backwater, Bronx may not have been able to afford to hire a decent grant writer and the CEO didn’t have the time. Therefore, they wouldn’t get more grants, and it really became very unfair. The need-for- assistance worksheets, still you have to know your way around how to get those statistics and how to make those statistics work.” The existence of need was not enough, but the successful and aggressive navigation of the grants process with regard to claims about that need ultimately was. “Making statistics work” in this instance means

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<sup>98</sup> I have suggested “need” in the Care Center context carries with it a certain ideological character. Both Taubin and Sutherland’s narratives call to mind Louis Althusser’s concept of interpellation, the process by which certain values are internalized and accepted as given (Althusser 2001).

fashioning application components into a recognizable form readily consumable by funding agencies. The process by which this was accomplished echoes Analise Riles' description of the development of intergovernmental agreements at the United Nations: "The objective was not so much to achieve transparent meaning but to satisfy the aesthetics of logic and language" (1998, 10). Familiarity with procedural knowledge and the conventional presentation of statistics counted for more than the substantive content they might convey.

The rest of the story of Care Center's expansion into Jackson County can be quickly summarized here. In the five years following the establishment of Care Center's "planted flag"<sup>99</sup> in Riverside, Mary Reagan continued to discuss the possibility of transferring the Jackson County clinic system. As I have previously described, the County initially attempted to field an application to convert the sites into an FQHC but was unsuccessful. The Jackson County purchasing department issued a perfunctory Request for Proposals (RFP) for administrative and management services for its clinics. It included, among other things, that the proposer describe their plans to comply with FQHC standards, indicate their capacity to operate an FQHC, and describe their philosophy and approach to operating an FQHC. Jackson County rejected all proposals and then initiated a waiver process to begin direct negotiations with Care Center to transition the clinics. Care Center executives attended various hearings with Jackson County officials (the exchange quoted at the opening of this chapter was at one such hearing). The County eventually voted to approve the transfer of the clinics to Care Center control and awarded Care Center site-specific multi-million-dollar subsidies in the form of administrative services agreements. These agreements were negotiated to offset losses that Care Center

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<sup>99</sup> The contrast here between an aggressively planted flag and the "grassroots" origin story of Care Center is noteworthy.

assumed it would initially take on in running the sites; they were supplemented by the County continuing to provide lease payments for the various facilities.

I spoke to Rebecca Taubin about the impact of transitioning the Jackson County sites on the social fabric of the community:

**David:** I ask, "What does that do in terms of the social life of, say, Jackson? Does it help to dismantle the remnant of unionized labor? Does it help to absolve the civic government of their responsibility to actively care for patients?" This is the type of question I ask about it, and does it impose a-

**RT:** Yes. It's exactly the same question that the hospital consolidation is hanging in communities. It's exactly that question, and I think it's a valid question. I don't have any answers for you, but I think we see that with – certainly with our hospital systems, consolidating, taking over what had been community-based, smaller institutions with local control and into feeder systems for giant tertiary hospitals. It probably is better medical care, but there is something lost. Yes, absolutely, I think so.

Taubin's assessment of the potential impact of transitioning the Jackson County clinic system was strikingly apt. In 2015, shortly after transitioning clinic services, Care Center's HIV director received a harsh letter from the New York State AIDS Institute.<sup>100</sup> The opening of the letter expressed deep concern regarding programs most recent HIV performance data report, specifically the performance on viral load suppression which fell below the 25<sup>th</sup> percentile among New York State providers. The viral load suppression scores were indeed alarming (56% average; n=163) while the New York statewide mean score rested at 73%. But by 2018 Dr. Quinn's program had tripled the number of patients in care, and had improved the viral load suppression average by 30 percentage points (86% average; n=361). This improvement is undeniable and absolutely constitutes better medical care.

Other shifts in Jackson County government's perceived role in health services also began to surface following the clinic transfer. Following the clinic transition, Care Center had gained

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<sup>100</sup> I have summarized this correspondence here to stitch together the county-level efforts by Care Center with respect to HIV to the broader New York State network of bureaucratic actors (the AIDS Institute in particular) that serve as complementary factors contributing to the expansion I have documented.

assurances from the County Executive that he would support a measure to match a series of capital projects with county funds if the health center was awarded New York State Capital Restructuring and Financing Program (CRFP) money. Care Center would purchase new buildings and would use the money to renovate them. The County had not invested heavily in maintaining its various clinic sites, and they were certainly in less-than-perfect condition. The cheap cementitious “brickface” stucco of one facility was literally crumbling into dust, and the electrical ballasts were so ineffective that exam room lightbulbs would frequently burst, among other things forcing clinical staff to read PPD (purified protein derivative) test results in the hallways. Care Center was awarded the CRFP funds, and late in 2017 the County Executive, in order to ensure that the process could be completed before the end of the legislative year, presented a measure to bond the matching funds using a “Certificate of Necessity.” Although the measure passed, it provoked bitter responses from several of the legislators. Legislator Susan Kilroy complained about the process, saying, “I just have a question. All these came to us as certificates of necessity, which means they did not go through committee, we didn’t get to discuss them, we didn’t get to time them, we didn’t get to do anything. Could this wait until the next meeting? Is that an issue? Because let me tell you, I am done with certificates of necessity at the last minute. And for this large amount of money – I’m really angry.” Kilroy’s frustration seems to point to a perceived separation from arbitrating the grounds on which “necessity” for supporting enhancements to Care Center’s health centers was based.

A more vitriolic response came from Legislator John Rizzo:

Who got into these contracts? Who signed these ridiculous contracts? So, you want us to borrow 10 million dollars and give it to them (Care Center)? Have you seen their tax returns? I have them in front of me, they have over 100 million dollars. We’re flat busted broke, and the six people sitting over there [Care Center CEO and staff] probably made 3.5 million dollars last year. This is sickening that the taxpayers of this county would be paying for this. There’s not a chance in the world I will support this in any form. And you want to talk about campaign finance reform? In my five seconds of sitting here I see that they just gave \$5,000 to the



Jackson Democratic committee which could be funneled to everyone here. The entire system is broken and corrupt.

Rizzo would later release a Facebook video that leveraged typical populist techniques of sowing distrust in government and emphasizing the corrupt nature of “the system.” Despite the fact that payment on the debt service for the bonds would ultimately be less costly to the County than the current lease payments for the facilities, Rizzo scowled into the camera, asking “Why are we paying their rent? We’re two billion dollars in debt, we have serious problems. What’s going on here?” The whole process of bonding money to support the facility renovations, according to Rizzo, was simply the result of a pay-to-play scheme in which Zeke Benjamin, Care Center’s Chief Financial Officer, gave contributions to the Jackson County democratic committee in exchange for favorable votes on the bonding issue, and gave an individual contribution to the County Executive’s campaign fund in exchange for presenting the measure through a certificate of necessity. Rizzo also made sure to express his outrage at Mary Reagan’s \$700,000 salary.

At issue here is not so much Rizzo’s cheap political rhetoric or his criticism of Care Center staff salaries, but rather the way his characterization of the project completely ignores the historical purpose the County had in having a clinic system in the first place. As I described at the outset of this chapter, the County had previously embraced its immediate and intimate role in safeguarding the health of its citizens. Transitioning the clinics to Care Center’s operation altered that role, and shifted the focus of elected officials like John Rizzo from asking about how to best deliver health care to poor people in Jackson County to criticizing perceived corruption and seeking to further limit any further County participation in supporting health service delivery to its citizens. At one level Care Center’s expansion into Jackson County simply illustrates the changing relationships between private not-for-profits and local government and way that relationship may limit government interest and capacity to deliver services on behalf of its

citizens (Wolch 1990). This changing relationship also reflects neoliberal trends in the United States that push municipalities to privatize as many of their services as possible. It also suggests the unanticipated consequences of using need as a justification for expansion, in the absence of “facing, fairly and squarely, the problem of the criterion of need” (Soper 1981, 211).

I had a chance to sit with Zeke Benjamin at his condo one evening, sipping a glass of single malt scotch. He reflected on the political circumstances surrounding the capital projects, in Jackson County saying: “If we had to be reductive about all of it, I would say – more than anything – we have managed the political risk horribly. We’ve let others assess political risk. Now we may have had a hunch about that, but we didn’t test it. We didn’t test it, we just took it a priori, but we didn’t do the kind of political risk assessment that we should have, and so, anyway...” It seemed frank and honest assessment, but also at odds with a saying Benjamin had fixated on while I worked with him: “What’s the shortest distance between two points: that’s what we need to know.” Testing the facts on the ground was secondary to Care Center’s “hunch” or “belief” about needs in Jackson County, and quickly bridging the distance between a decided-on objective took the place of a more refined evaluation of those needs and the moral quandaries involved in meeting them.

In describing some of Care Center’s expansion, I have tried to illustrate some of the ways that bureaucratic processes, grant applications specifically, can bend need to suit corporate objectives, growth among them. Care Center leveraged the needs of migrant farmworkers to establish itself in Jackson County and ultimately used its presence there to transition the County clinic system to its control. I have attempted to offer an even-handed account of the effects that Care Center’s expansion had on aspects of health care delivery in Jackson County, not so much to criticize it, but to emphasize the magnitude of the changes the clinic transition had on the

relationship between Jackson County government and its citizens vis-à-vis the provision of health services. This is documented by the fact that prior to the expansion, Jackson County directly paid for and provided the services that subsequently were transitioned to Care Center operation.<sup>101</sup> As in the Uplands expansion, the process was facilitated by a skillful bureaucratic manipulation of need.

I discussed parts of this chapter with Julie Saxton over coffee in Wilthook one afternoon in 2018. She cocked her head and said, “God, you’re such a downer. Everything you say just makes me feel terrible.” I replied to her that I never really intended to opine on whether or not what I described was “good” or “bad.” Thinking about Foucault, I added “And I never said everything was terrible, just dangerous.”<sup>102</sup> But Saxton’s statement, as I thought on it further, circles back on an ongoing tension associated with conducting research in a professional community of which I was also a member. My discussion of the chapter with Saxton was my attempt to review the ethnographic representation of Care Center that I had produced, but she immediately tried to put that representation back into a social relationship with ongoing life at Care Center. In describing this phenomenon David Mosse writes that “the power of ethnography lies in the fact that not only anthropologists, but also their texts are active agents in the worlds they describe, enlivening action in particular ways” (2006, 952). In this instance my text depressed more than enlivened, but it did have a definite effect on the “action” I was both a part of and was attempting to describe. In writing about Care Center’s expansion into Jackson County and sharing with Saxton my conclusion that it resulted primarily from a dogmatic pursuit

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<sup>101</sup> A committee charged with evaluating the Jackson County health centers in the late 1990s concluded that there was no level of government with responsibilities for taking care of the health of our population closer than that of the County. The evaluation emphasized the importance of having services at these health centers provided directly by the County. The deaccessioning of the health centers to Care Center replaced the County with a private not-for-profit.

<sup>102</sup> “My point is not that everything is bad, but that everything is dangerous, which is not exactly the same thing. If everything is dangerous, then we always have something to do” (Foucault 1984, 343).

of growth facilitated by the strategic configuring of need, I was attempting to “walk the line” between enmeshment within the micropolitical world of Care Center and a research objective that depends on separation from that world (Gottwald, Sowa, and Staples 2018). In the final section of this chapter, I shall provide a few examples of how deeply integrated the management of need was to daily activities within Care Center’s bureaucracy.

### **“A Bridge Too Far”**

In late 2017, I accepted a new position within Care Center’s administration and transferred from the executive office building in Nickerson, NY, to the Wilthook Canaan Street offices, approximately twenty miles away. The work included ongoing preparation of Care Center’s Certificate of Need (CON) applications (a responsibility that followed me to Wilthook from Nickerson), changes to Care Center’s Federal Scope of Service (Change in Scope or CIS applications), evaluation and development of grant proposals, preparation of Care Center’s FTCA application, and various associated tasks. I worked closely with Gail Sutherland (Vice President of Administration) and Kyle Ochs (Grant Program Administration) on several projects. One of these involved preparing Care Center’s Service Area Competition (SAC) grant application, a periodic “open competition” for any applicants meeting FQHC requirements and capable of covering the existing service area. The Health Resources and Services Administration *intends* to fund applicants through this process in pursuing the agency’s first (of five) primary goals: to improve access to quality care and services. At one point, we were sitting together in my office reviewing a section of the application that Mr. Ochs had been working on. The section requested simply that the applicant describe the most significant causes of mortality and morbidity within the service area. “It feels so weird to simply put the numbers in,” Mr. Ochs said to me, “I mean, it’s really hard to make it look bad. I’ve put some of the numbers in Bold Face if

they exceed the rate for the State to try and finesse it a little.” I asked Sutherland and Ochs if that was really necessary since the application guidance simply asked for these numbers in an informational way. “Oh, I know,” said Sutherland, “but we always want to justify Care Center’s work.” Simply stating the numbers would not have been sufficient.

This approach to describing data often characterized my work with Sutherland and Ochs. At one point I was researching information on opioid-related deaths in one of Care Center’s regions and showed Sutherland an article on the subject. “That’s just great! Really good stuff there, you can just copy that over to our [online] folder and start banking all of that need.” Again, need here is a justification, and an asset, in pursuing Care Center’s funding. I asked Ochs if he liked putting together the needs section of Care Center’s grant. “I do if the numbers are there, it’s really tough when I’ve got to scrounge around to come up with something.” I asked him if that happened frequently, and he grinned and nodded.

The relationship to producing need in this type of application demonstrates the way Eagleton’s notion of “linguistic inflation” operates in conjunction with need’s qualities of floating signification, wherein its undetermined, contested quality is receptive to many meanings. When this type of inflation occurs, the after-effects can be jarring. In 2014, before my move to Wilthook, Care Center sought to establish a new health center site through New Access Point funding, despite the fact that the area in question scored consistently better than New York State and National Benchmarks in healthcare indicators, health literacy, income level, unemployment, and lack of insurance coverage. Furthermore, the site had been selected to house an Urgent Care component in addition to basic primary care. I worked extensively on the planning stages for implementation of Urgent Care (see radiology), and I had researched some of the basic business considerations to account for when opening this type of facility. I make no claim to having had

any formal business training when I did this research, but two resources (*The Textbook of Urgent Care Management* and *Flipping Health Care through Retail Clinics and Convenient Care Models*) pointed to the three most salient conditions that would produce a successful urgent care location: 1. Be within three miles of 50,000 people with demographics between 18-44, 2. Be located in a shopping center next to a large big box style anchor store, and 3. Be located on, or near, a road with traffic of at least 20,000 cars/day (Kaissi 2014, 69). Using an Esri-generated GIS analysis, Google maps to identify retailers, and the New York State Department of Transportation traffic viewer, I determined that none of these conditions was close to being met at the new site. I provided this information to Care Center's executive staff during a recurring phone-call about Urgent Care held at 8:00 AM on Monday mornings. Care Center moved forward with implementation and opened its new site in 2016.

When the site did not generate a significant number of patients, the Monday morning calls increasingly focused on volume, and how Care Center's community relations and affairs department might generate additional patient flow. After one of these calls Rex Thompson, the departmental director whose office was adjacent to mine, spoke with me in a frustrated tone. "I can't invent the people to go to the site," he told me. I said I did not think there were enough people to generate the type of volume that was initially projected, and I told him about the preliminary analysis I had prepared. "Who knew about this and still decided we would go ahead with it?!" he exclaimed. I shrugged and replied that I did not think it was necessarily a decision based on data. That said, a 2014 letter from Mary Reagan to a partnering agency on the NAP application made one thing very clear: "we recognize the great need for community health care services for the area's uninsured and medically underserved. The proposed New Access Point will increase access to comprehensive, primary, and preventive health care services."

I interpret Rex Thompson’s frustration with the implementation of Urgent Care and Kyle Ochs’ discomfort in preparing needs assessments as the significant impact of what happens when the linguistic inflation associated with Care Center’s characterization of need clashes with externally produced (often “data” oriented) definitions of need. Toward the end of my formal period of fieldwork, a particularly jarring instance of this type of confrontation occurred.

The Health Resources and Services Bureau of Primary Health Care released a notice of funding opportunity (Nofo) for New Access Points (NAP). Shortly after the Nofo was released, I received an email from Care Center’s Chief Operating Officer with “options” listed as the subject line. In it she had pasted a table with a list of towns and a summary of the

programmatic ideas she had developed for each of them. It looked something like this:

Town 1 (Stabroek)	High Need Another site in the center of town Supportive and helpful community partners Large City
Town 2 (Montellier)	Re-field the application Community pushing project on their own Low need data
Town 3 (Bayport)	Local interest Information on need is unknown Capital needs will be very costly
Town 4 (Alexandria)	Other company FQHC location in service area Good project Project specifics available
Town 5 Eastern Region	???

Unbeknownst to Worthington when she wrote this email was a change that had taken place in how HRSA intended to evaluate the needs portion of the application. The Nofo indicated that the “Need for Assistance Worksheet” had been replaced by “the Service Area Needs Assessment Methodology (SANAM).” This would be used to calculate an Unmet Need Score (UNS) for each proposed service area. The basic tool used to deploy the SANAM was an Excel file in which the applicant could simply enter a zip code (or series of zip codes) at which

point the file would calculate a UNS using a 20-point scale with higher unmet need generating more points. This in turn would translate into approximately 20% of an applicant’s score.<sup>103</sup> It is replicated as Figure 4.1.<sup>104</sup>

	A	B	C	D	E	F	G	H	I	J
1	Table 2. Calculate Unmet Need Score									
2	ZIP Code	ZIP Code Tabulation Area (ZCTA) Map	ZCTA Validation	Hot Spot	ZCTA UNS	Population Size	Population-based Weight (ZCTA Population as Percentage of Service Area Population)	Population-based Weighted UNS	Service Area UNS	Service Area UNS Converted to 0-20 Scale
3										
4										
5										
6										
7										
8										
9										

**Figure 4.1. The Service Area Needs Assessment Methodology (SANAM). Health Resources and Services Administration (2019). In the public domain.**

Previously, since applications scoring below 95 points were seldom if ever funded, achieving a high point value on the “Need for Assistance Worksheet” or the “Unmet Need Score” was essential for fielding a successful application. Now the system for scoring had changed dramatically.

I spoke with Ochs about this, and he immediately wrote an email in response to Worthington’s “options” email. To it he attached a copy of the UNS tool and summarized some critical changes to the Need for Assistance Worksheet. In describing the UNS Excel sheet he commented that there were substantial advantages to using it in that it saved a huge amount of time when evaluating project locations. But the downside, he continued, was that the tool totally eliminated the potential for Care Center to “get creative” and pad the score. He concluded by mentioning that he would run various potential project areas through the scoring tool. He also

<sup>103</sup> I say approximately because the NAP application often includes “preference points” for certain types of applicants, those applying in sparsely populated areas for example. The inclusion of this these priority points would have the potential to have an application scored out more than 100 potential points. Care Center was not eligible for any of these priority areas and therefore had a maximum possible score of 100 points on the application.

<sup>104</sup> The inclusion of this Excel file, like the reproduction of Schedule 17 of the New York State Certificate of Need application, is an effort to connect the activities of the health center to broader networks of actors including federal bureaus. The simple inclusion of this workbook as a required component of NAP applications had the effect of immediately reconfiguring a pre-existing system of alliances between Care Center staff and effective narrative presentation of need that had, for an extended period of time, proved effective at securing grant funding.



described a county in the Uplands region in which Worthington had not expressed initial interest. It had no FQHCs in the county and qualified for an additional 5 “Hot Spot” preference points.

Ochs’ email is revelatory on multiple levels. First, it summarizes Care Center’s typical approach to generating points on NAP applications by getting creative and padding (or inflating) the score of a Need-for-Assistance worksheet. Second, it highlights the absence of an area not listed on Worthington’s initial options table, although it produced a high score (15 plus an additional 5 in preference points totaling 20). When we ran the other options through the UNS tool, the first city on h’s list (“High Need”) scored 10, the second (“Low need data”) scored 12, the third (“Unknown need data”) scored 8, the fourth (“strong project”) scored 8, and the fifth (“TBD”) include multiple zip codes of which the highest score was 15 (10 plus 5 preference points for being a “hotspot” according to the UNS tool.

When I reviewed the results of our analysis with Worthington in her Wilthook Canaan Street office, she seemed genuinely surprised by the analysis. “Stabroek scored a 10? Really?” She peered at me from behind several piles of multi-colored folders that had accumulated on her desk as I nodded. “And there are no preference points for special pops?” The Nofo did not offer additional points for applications predominantly servicing homeless patients, residents of public housing, or migrant farmworkers, but I let her know that HRSA reserved the right to award funds out of ranked order if they saw fit. Worthington indicated that she would have to consider this information, and I slipped out of her office. About a week after our meeting I received a follow-up email from her regarding the NAP in which she said that she spoke with the National Association of Community Health Center (NACHC)<sup>105</sup> about the preference options for special populations. NACHC indicated that there were no special processes or preferences for

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<sup>105</sup> National Association of Community Health Centers – the national advocacy group for FQHCs.

applications focusing on special populations, but that migrant grantees were in short supply. This would mean that it was possible that lower scoring applications focused on migrant and seasonal farmworkers could possibly be funded. She concluded by suggesting that I characterize one of the areas we analyzed as a potential location for a migrant and seasonal farmworker health center but then, as an afterthought, questioned whether such a characterization would be “a bridge too far.”

Ironically, I received this email four days after Worthington requested that I prepare a closure plan for one of the Uplands satellite locations that had been added to Care Center’s scope of practice as a MSFW site through the NAP process I described earlier. I did not object to this request, but when I mentioned it to Jerry Russo, he jokingly, perhaps cynically, suggested that I should simply close the site, then apply for NAP funding to reopen it. In a Marxist line that has become so cliched, I will cite the Engel’s iteration of it here for the sake of variety: “it really seems as though old Hegel, in the guise of the World Spirit, were directing history from the grave and, with the greatest conscientiousness, causing everything to be re-enacted twice over, once as grand tragedy and the second time as rotten farce” (Engels 1851).

Kyle Ochs and I eventually processed every single zip code in Care Center’s service area and presented this information to Mary Reagan, Zeke Benjamin and Abigail Worthington via conference call. As I began to list out the scores from one of Care Center’s regions on the call, Reagan interrupted to ask: “What about the urban zip codes? Can’t we have a health center there? I’m not interested in the Uplands region.” I indicated I had analysis for the urban zip codes, but that there were a couple of zip codes that scored very highly. I began to describe Sparta (scoring a 15 and 5 preference points for being a “hot spot”). “Didn’t you hear me, David?” snapped Reagan, “I don’t want anything in the Uplands region!” I quickly moved on to

the other areas. Eventually Benjamin summarized some of the options Worthington had previously identified, including re-fielding an application for Montellier. The previous application had contemplated a collaboration with a hospital system. The application had been rejected (it received the lowest score that Care Center had ever received on a NAP), and the partnership ultimately had not panned out. “You’d get to stick it to the hospital,” said Benjamin. Reagan agreed, and Kyle and I began the process of preparing the application. In his study of funding proposals at the International Monetary Fund (IMF) Richard Harper argues that the process of converting “raw numbers” into “useable” information is not simply an arithmetical calculation, but part of a moral transformation (2000, 47). A similar transformation accompanied Care Center preparation of its NAP application. Apart from the technical merits associated with successfully filling out an application, the process asked bureaucrats at Care Center, myself included, to struggle with the criterion of need, and of taking, one way or another, a moral stand. Questioning whether the process of finessing such an application constitutes a “bridge to far” is indicative of this struggle.

I have described Care Center’s decision-making process regarding the NAP application to illustrate the fact that regardless how rigorously external entities develop and distribute metrics for representing need (in this case the Service Area Needs Assessment Methodology), the response from Care Center was unlikely to take that into account. It was highly unlikely that the Montellier application would be funded on the basis of the SANAM unmet need score it generated, but Kyle Ochs and I initiated the process anyway. “At least we can recycle some of the needs section,” he told me as we reviewed the outcome of our conference call.

## **Conclusion: Re-Interpellation**

In this chapter, I have tried to describe some of the ways that Care Center used bureaucratic processing of need in order to respond to specific funding opportunities and ultimately to fuel its expansion and growth. I have also attempted to show how fervently Care Center staff believed in the idea that need implicitly existed, and how diligently they worked to “get creative” in their use of need as a justification for funding various grant applications. Through the case study of Care Center’s expansion into Jackson County I have suggested that the power of need as a vehicle for entering new service areas ultimately had incredible power to remake the relationship between government and citizens with respect to health care.

When I read back over my description of Care Center’s bureaucratic engagement with need, I realized just how deeply I had internalized an operational knowledge of how to finesse a characterization of need. Just a few weeks after the conference call to review the unmet need scores of Care Center’s service area I had a project meeting with Abigail Worthington and Carlo Marchesi, the project director for a planning grant, to confront opioid use in Care Center’s service area. We met in Mary Reagan’s over-heated Canaan Street office in Wilthook. For several years the office had been a bit of time capsule to the moment Reagan had moved several staff members to the executive offices in Nickerson. Several yellowed folders dating back to 2011 seemed to mark the moment of departure and a motley assortment of photos, mugs, and various commemorative items and awards festooned the seldom-occupied corner office. The administrative staff in Wilthook had taken to using the office for conference space, or various birthday celebrations or potluck lunches. But on the morning when we met with Marchesi, all that had changed. Mary Reagan had been appalled by the disorderly appearance of the office as she viewed it through the room’s teleconferencing device, and she decided it required substantial

painting, carpet replacement, and redecorating. Gone were the bookshelves and the photos, and only a few bare filing cabinets surrounded the large glass conference table in the center of the room.

We quickly ran through Marchesi's workplan; we reviewed some of the next steps he would take in evaluating the state of opioid use in one of Care Center's counties and in identifying perceived gaps in services. After our formal review, we chatted about the state of affairs in the county, what businesses, if any, had set up shop there, and what type of thing HRSA might fund as part of an implementation grant following the development of a county strategic plan. "You know what Independence needs?" Worthington asked, referencing a town that Marchesi had mentioned, "Independence needs a health center." I jumped in: "It only scored a 12 when we ran it through the needs assessment tool."<sup>106</sup> She turned to Marchesi and asked if there was public housing in Independence, and he described several public housing projects in the area. I glanced at Worthington and, as if it were the most natural thing in the world, said: "Public housing's special pops... Might be able to get it awarded out of ranked order." She nodded at me with what might have been a half smile.

In considering and writing about the growth of Care Center into Jackson County and the mechanisms by which that growth occurred, I have one overwhelming concern. At a fundamental level, I admire and respect the work of FQHCs in New York and across the United States. I do not intend my description of Care Center's bureaucratic practice with respect to need to repudiate the numerous successful efforts undertaken by Care Center executives, bureaucrats, and clinicians to deliver primary and preventive health services to thousands of mostly poor and disenfranchised people throughout its service area. I also do not want to minimize the challenges

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<sup>106</sup> UNS score of 12 for Independence's zip code.

these individuals face in providing these services, nor devalue Care Center's effort to improve the health and quality of life for its patients. Having had the chance to observe the complexity of the FQHC program and the sometimes-precarious financial basis on which the program rests, I recognize how complicated decision-making at strategic and operational levels can be. Care Center's skill in navigating these challenges attests to the commitment and effectiveness of its leadership and staff. In writing about the process by which need becomes an instrument of the ideological context in which FQHCs deliver healthcare, I am hoping to move beyond "blaming" or "condemning" a specific health center's approach to service delivery. I instead would like to open up a broader awareness of how easy it is for bureaucratic processes to contribute to the cultivation of an ideological code that can direct the conceptual basis informing delivery of health care to poor people in the United States.

## Conclusion

### Four Research Aims Revisited

This dissertation sought to address the overarching goal of opening up Federally Qualified Community Health Centers to ethnographic research and analysis by focusing on the system of administration and administrative work undertaken in non-clinical, office-based settings within one such organization: Care Center. In doing this I have tried to address four specific research aims which have been the basis for the four chapters of the work. The first extends commonplace historical accounts of the emergence of FQHCs to include a broader history that (a) explains certain structural aspects of the programs' ongoing operations and success; and (b) explores the patterns of organization on which FQHCs would base their bureaucratic style. The second chapter outlines Care Center's organizational structure (including potential alternate patterns for diagramming that structure) and some of the impacts that structure had on health care delivery. The third explores how the grassroots character of Care Center's bureaucracy interacted with ongoing organizational growth, and some of the after-effects associated with that growth. And the fourth looks at the bureaucratic operationalization of the concept of need as an ongoing vehicle for enabling Care Center's growth and as justification for its existence.

These research aims have led to several immediate conclusions, some of which I will briefly reprise here. My investigation into FQHC history (research aim 1) has led me to conclude that FQHCs have typically cultivated their histories in such a way as to limit engagement with broader trends in the history of health care in the United States. This self-contained of narrative has allowed FQHCs to dodge embroiling themselves in larger, more contentious healthcare debates such as universal coverage and/or plans for a national system of

health care. Additionally, this history has had the effect of limiting what some might term “FQHC self-awareness” or “FQHC exceptionalism” wherein the heroic efforts of a few founding luminaries explains the birth and growth of the health center program. The history I have written was not intended to diminish the efforts of these early health center advocates, but rather to outline the broader contours of the landscape that FQHCs entered into, as well as some of the structural features responsible for creating the markets that FQHCs exploit and the financial incentives that motivate them to do so.

Research aim 2 has built on my discussion of FQHC history in that it associates some of the historical templates demonstrated in early FQHC programming efforts to Care Center’s organizational form. This form emphasizes individuals and personalities over strict hierarchies and is best summarized as an ongoing balance between conceptual categories marked by “wetness” and “dryness.” The “small p” politics I referenced in my history chapter foreshadow this balance, which is indicative of hybrid organizations characterized by “organized dissonance” (Ashcraft 2001) and a blending of practices so as to avoid extremes of under- and over-organizing (Chen 2009). Articulating the structure of a given bureaucratic form is, to some degree, a conclusion in and of itself. In the case of Care Center this articulation also demonstrates the potential impact this form can have on the way health care services, such as Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD), are delivered. The fascinating thing about this type of “hybrid” organizational form is that it is extremely “messy” in the sense of the word as used by Law (2004) and elaborated on by Ney and Verweij (2015). I quickly summarize this concept here in order to offer a descriptive account of how organizations like Care Center may be well equipped to produce “messy” solutions to particularly intractable, wicked, environmental and social problems. As Ney and Verweij recount, these so-called



“wicked” problems are often unique, subject to uncertain causes, open to multiple solutions, demanding of participation from many domains, requiring major investments to promote large-scale changes, productive of novel challenges in implementing solutions, and are multi-faceted and enduring (1679). Climate change is one example, the opioid epidemic is another. Ney and Verweij conclude that “messy” institutions are far less likely to fall in lockstep with a single discourse, problem-solving approach, or epistemology. As a result, they may be more adept at dealing at generating clumsy, “polyrational,” and ultimately more effective resolutions to wicked problems (Ney and Verweij 2015, 1683). Thus, by virtue of their “strategic union of forms presumed hostile” (Ashcraft 2001, 1304), Care Center, and FQHCs with comparable organizational features, are more likely to confront “wicked” public health problems like Opioid Use Disorder effectively than more linear, hierarchical institutional forms. And indeed, this is the conclusion reached by several evaluations of the role of, and the approaches taken by, FQHCs in responding to the opioid epidemic (Watkins et al. 2017; Zur et al. 2018; Hunter et al. 2018).

My third research aim prompted me to show how Care Center, as an institution, maintained its grassroots origin and simulated the connections to that origin as it expanded and grew. This aim recalls Ethan Canin’s short story “The Palace Thief” in which he illustrates the extent to which “a man’s character is his character” and how, even when given multiple opportunities to change that character, individuals often do not (1994, 205). Research aim 3 revealed the extent to which a highly personal/personalized organization will fight to retain the connections to its founding character. Even as separation from the grassroots origins of Care Center took place, prompted primarily by the pressures of FQHC environmental forces such as President Bush’s expansion initiative, substantial efforts were made to maintain connections to these “grassroots” when possible, and to simulate them when it was not. This chapter reveals the

challenges Care Center faced in continuing to maintain a potable blend of rational organization and ongoing grassroots informalism when experiencing institutional growth. Integrating practices in this setting, “managing amidst the mosaic” as Reisman puts it, requires significant attention and tweaking to the appropriate suspension of under- and overorganization [sic] (2017). Conceptualizing this process as an ongoing series of “tweaks” is helpful because it frees Care Center and institutions like it from an overly constrictive analysis. It also is indicative of the flexibility so highly prized at Care Center, both individually and organizationally. At the same time the identification of shifting practices cannot be reduced to the internal dynamics of a single FQHC. I have used FQHC bureaucracy as a specific point around which many relationships and environmental forces converge. I have sketched out some of these forces: FQHC history, structural features regulating healthcare service delivery, large-scale policy developments, etc. Maintaining an institutional equilibrium between the rich grassroots legacy of Care Center and demands to “become more business-like” (Maier et al. 2016) will force the organization to retool the previous dimensions or metrics on which “success” is judged. The free-form, conversational approach of Care Center’s various executive bodies may be well situated to buck conventional wisdom that ties organizational efficacy to ever-increasing levels of formalization (Polletta 2002). In this regard, the grassroots character of Care Center and other FQHCs like it will certainly shape their collective fate and the fate of those they serve.

Research aim 4 allowed me to understand the growth of Care Center as a process facilitated through the bureaucratic configuration of need. As an organizing principle, need offered a justification for expansion, despite the sometimes-fuzzy (or potentially non-existent) empirical basis on which that need was described. This aim reveals much about bureaucratic practices in FQHCs, and in Care Center specifically. Expertise in this instance involves the

aesthetically convincing presentation of need as the justificatory handmaid of organizational growth. As a core component of Care Center's rationale for its expansion, the concept of need has served the organization's purpose(s) well, but the mixed final outcomes of Care Center's expansion suggest something problematic about the use of need as a criterion for growth. Uneasy moral quandaries and transformations follow, particularly at the level of individual employees navigating these "moral mazes" (Jackall 1988) in an effort to ethically face the process of using need as a criterion for service delivery (Soper 1981). It is easy enough to "game" a system that prioritizes need as a marker of deservedness for funding, but it is not always as easy to deal with the moral consequences of those practices. I have interpreted Gail Sutherland's disgust ("whoring") at preparing a funding application for Care Center's Uplands region that leveraged less-than-empirical statements of migrant farmworker need as one such struggle with the moral consequences of this work. Jerry Russo's cynical suggestion that I simply re-apply for funding to support one of the Uplands satellite sites that closed when the purported needs in the area fell short of the initial projections can be interpreted similarly. Russo's suggestion also reveals how increasingly difficult it becomes to see different ways of justifying the pursuit of corporate interests once an effective method (e.g. using the concept of need) has been identified. In this regard FQHCs are fundamentally conservative institutions in the sense of "being conservative" popularly attributed to Robert Conquest: "Everyone is conservative about what he knows best" (quoted in Derbyshire 2003). To a certain degree this conservatism results from environmental and structural advantages that have been favorable to the FQHC utilization of need. This historical reliance on the bureaucratic uses of need points to a critical area for further attention: acquiring greater familiarity with core logics informing the

bureaucratic actions of external, non-FQHC, *for-profit* entities that seek to deliver health care to the poor.

### **Significance of this Study and Suggestions for Operationalizing the Findings**

The novel contributions of this study are twofold. First, the level of participation and access I had to Care Center's bureaucracy has produced an account that diverges significantly from other treatments of FQHC history, operations, and practice. Acquiring this access during a period of dramatic change for Care Center, and certainly for FQHCs more generally, offered the unique opportunity to observe FQHC bureaucracy evolving in response to external stimuli. I have tried to contextualize this period of change historically in order to generalize some of the very specific data I collected in the Care Center setting. Gaining expertise in FQHC administrative practice is time consuming and does not necessarily lend itself to welcoming "professional strangers" who do not actively contribute to organizational efforts. I have been fortunate to have one foot within the Care Center world, a position that helped in generating an insider perspective, but still (hopefully) keeping the other foot engaged in the world of systematic data collection and analysis of academic practice. This model of research adds to a growing number of anthropological studies that explicitly, and productively, mix work (as in employment) with research (Garcia 2010; Mulligan 2014; Gottwald, Sowa, and Staples 2018).

While this dual role of work and research promises certain advantages, specifically gaining access to the domains of bureaucracy within large organizations while using a reconfigured ethnographic methodology, there are aspects of this approach that have been discomfiting. When I describe the bureaucratic world of Care Center, I am not fully able to disentangle my own participation (or perhaps complicity) in that world. In fact, I was paid a salary while conducting my research precisely because I was an employee capable of effectively

participating in Care Center's bureaucracy, and my advancement as an employee was directly linked to my ability to master Care Center bureaucratic competencies. I have tried to avoid condemning the bureaucratic activity I have described in this dissertation as "good" or "bad," but re-reading my descriptions has made me question whether I have done that to avoid placing similar condemnation on myself. It is here that my characterization of bureaucracy as an "inhabited institution" (Hallet and Ventresca 2006) has been most valuable in that it has allowed me to raise this question, but also to sidestep it by introducing a less formal appraisal of the ethical/moral dimensions of Care Center's bureaucratic world. This approach turns away from an immediate evaluation of bureaucratic practice and its "good" or "bad" ethical/moral costs/consequences and instead seeks to contextualize it within its meso-level position, a position wedged between macro-level forces (FQHC history, financial structure, and market position, etc.), and the street-level interactions between frontline staff and the patients these health centers endeavor to serve.

The second contribution of this study has much to do with the first in that the findings suggest that FQHCs could benefit from active engagement with the reflexivity associated with anthropological research. If mixing research with work (as in employment) has benefits with respect to the study being undertaken, mixing academic conclusions back into the work setting may also generate productive outcomes. In this scenario, using ethnographic descriptions and analyzing them within the FQHC workplace setting would have the effect of "enlivening action" in that it could increase the awareness FQHC bureaucrats have about the way their business conduct can be described and interpreted (Mosse 2006, 952). Reflexively analyzing how and why work is performed the way it is within FQHCs, Care Center specifically, is not a typical workplace activity. The pursuit of FQHC objectives as a health center employee is demanding,

exhausting, and often confusing, and just getting through the daily grind seldom leaves time to reflect on what has transpired. But if my research aims, particularly research aim 4, have revealed anything of importance to ongoing FQHC practice, it is that there are hidden dangers of bureaucratizing the mission-oriented pursuits of FQHCs by using need as an organizing principle. Bureaucracy in the FQHC setting is a vehicle for accomplishing certain things, but it cannot answer the question of whether or not those things are worth accomplishing. Nor can it help FQHC administrators prioritize their efforts, particularly when the organization is in large part insulated from the negative consequences associated with imprecise analysis of potential initiatives. This insight does not lead me to suggest that FQHCs simply do away with “need” as a rationale for service delivery, but rather that they critically and reflexively interrogate the meaning of need in the context of their programming prior to operationalizing it as part of a tactical, bureaucratic process. Engagement in reflexive dialogue regarding the bureaucratic practices I have described may assist FQHCs in adjusting administrative processes, thereby enhancing organizational performance (Chen 2009). Although I have had limited experimentation through member checks/informant feedback with how or if my own written account might facilitate such an engagement, I understand it as an ongoing responsibility to promote interaction between my findings and the informants whose accounts I drew on to make them. That said, I did not begin my fieldwork with the intent of producing a written report for Care Center, and from the outset I cautioned Care Center staff interested in the potential “benefits” my work would have on organizational performance that as a researcher I was not primarily interested in improving Care Center’s work environment as a business concern. But this has not completely erased some anxiety about the entanglements I have with Care Center, and my own struggle to navigate the aftereffects of using ethnographic methods that do not rely

on a strict separation between the “field” and the “anti-social“ (in the sense of being removed from the field setting) process of writing (Mosse 2006, 937).

This second contribution extends beyond the FQHC space to other safety-net healthcare organizations that must substantiate need through bureaucratic operations such as the Certificate of Need (CON) process. Academic medical centers and safety-net hospitals enjoy protections and supplemental payments that offset losses and shield them from market forces, in much the way that the Prospective Payment System and the Federal Tort Claims Act shield FQHCs. But these protections should not be interpreted as a free pass to pursue whatever projects seem “doable” within existing bureaucratic parameters. As transactional businesses, these organizations must actively interrogate “need” as a strategic planning activity that can predict the long-term viability and sustainability of the programming that they purport to deliver on behalf of vulnerable populations “in need.” Failure to critically attend to this strategic discussion in favor of deploying tactical (and in many cases flexible) bureaucratic operations can open the door for other negative outcomes, both in terms of stated organizational goals and in organizational capacity to provide ongoing medical services.

### **Future Directions: Disruption in Bureaucracy**

When I initially designed my proposal for the research project that has informed this dissertation, I had anticipated exploring the distinction between morals and markets, presuming an innate tension between profit-driven, market forces in healthcare and moral considerations associated with the formation of community health centers. Much of the literature I reviewed prior to submitting my proposal and commencing my fieldwork focused on this type of tension (Muehlebach 2012; Reich 2014). The major thrust of these works emphasizes the evolving balance of moral (read here as synonymous with ethical) concerns with the consistent

encroachment of neoliberal market forces into the social service space (Muehlebach) and into the hospital healthcare space (Reich).<sup>107</sup> These studies draw heavily on E.P. Thompson's now famous formulation in which the weighing of market economies against moral economies is cast as a dichotomous, almost Manichean, conflict between categorically incompatible ideologies (Giroux 2008). The market and the new political economy, so the narrative goes, are "disinfested of intrusive moral imperatives" and subject only to laws of supply and demand (Thompson 1993, 202). During my initial interviews in the field, questions designed to probe this subject did not generate data consistent with the overall findings of these of studies. More intriguing, and indeed more typical, were descriptions like those from Rex Thompson who was fond of describing Care Center ethos as one dominated by "that very rich aunt, you know, the one who had never had anyone tell her she couldn't buy this or do that." I began to explore why this relatively carefree attitude toward market constraints might persist at Care Center, and as a result I have dedicated much of this dissertation to explaining the historical and environmental/structural features of FQHCs that have insulated them from market forces of the type that drive other actors and institutions (hospitals, for example) in the healthcare sector. The depth of this point was driven home to me when I asked a senior member of Care Center's finance team what type of policy development would be most detrimental to the organization's financial well-being. He replied simply: "universal health care." The reason for this, as I have documented, is that the Prospective Payment System (PPS) protects FQHCs that serve large Medicaid populations while crowding out other actors who simply cannot compete. This type of financial safeguard, FTCA coverage, and requirements to situate FQHCs in "medically

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<sup>107</sup> Some have argued that market is in fact "moral" (Zak 2011). Regardless of whether or not one accepts this conclusion, this so-called "market morality" would enter the morals vs. markets antinomy I describe here on the market side of the equation.



underserved areas” has allowed health center bureaucrats to develop expertise in the competition for new markets of need. The neat dichotomy of morals vs. markets did not fully capture the rationales driving FQHC leadership, the bureaucrats working within such organizations, and the external bureaucracies that govern them.

Instead, given the relatively insular nature of community health centers, it made more sense to focus on the institutional structures, arrangements and dynamics at Care Center, and to interpret their constitution and evolution as an outgrowth of their contextual setting within the broader historical and structural forces which I have described (Murmann 2013). In doing so, I have tried to stitch together street-level, meso-level, and macro-level impacts shaping bureaucratic practices within a single FQHC in an effort to ultimately trace out some of the potential impacts this can have on the way health care is delivered by this type of institution. One effective way of seeing the connections between these various levels is to trace out the way bureaucrats at Care Center navigated and molded need as a malleable token that could be used in justifying service expansion. Need is transferrable within and between multiple bureaucracies and systems (FQHC, New York State, Federal, etc.). When coupled with some insights from Actor-Network Theory, this transferability illustrates the continuous movement and transformation of need as it passes among various actors (Latour 1999). But within the bureaucratic setting the various configuring practices used while working with need make moral/ethical demands on those involved in the configuring. Opportunities for growth in this setting are paired with opportunistic ethics, ethics here being understood as something like Paul Brodwin’s “first order theorization about decision-making and its local context” (2013, 199). I focused heavily on the bureaucratic practices (and decision-making) involved in formulating

need as a justification for health center expansion while suggesting that these practices simultaneously impact the contours of moral thinking as well.

I made these observations from my vantage point within Care Center's offices, but outside them, I began to notice trends in the broader healthcare environment that made this work timely and relevant. Some of this I have touched on, for example in my discussion of how Care Center sought to pursue emergent forms of health care delivery such as Urgent Care. National news coverage has recently been peppered with stories documenting the rise of mega-institutions that collapse healthcare insurers, providers, pharmacies and medical equipment companies, the \$70 billion Aetna/CVS merger being one of the most prominent (Livingston 2018). Another noteworthy endeavor is "Haven," a joint venture among JP Morgan Chase, Berkshire Hathaway, and Amazon to better manage healthcare costs of employees and their families (Modern Healthcare 2018). Within FQHCs it is relatively easy to lose track of these efforts because they primarily seek to improve health care for individuals with employer-sponsored/private insurance rather than the patient populations predominantly served by community health centers: individuals on Medicaid or those who are uninsured.

But several other initiatives that marry technology, geographically dispersed workforces, and in-person care may be creeping into what has been the historically cloistered (and need-bound) province of FQHCs. Google's parent company, Alphabet, recently initiated a pilot project called CityBlock Health. This effort has begun with one healthcare clinic, located in the Crown Heights neighborhood of Brooklyn, that combines predictive analytics with direct primary care services as well as virtual care that patients can access in their homes or other neighborhood locations (Romm 2018). Recently, CityBlock Health announced a new partnership with Coordinated Behavioral Care (aka Pathways to Wellness Health Home), a New

York State designated Medicaid Health program that delivers care management services to high-cost, high-need Medicaid patient populations (CBC Monthly Bulletin 2018). This marked the first time New York State has opted to offer such designation to a for-profit institution. Other companies like *Healthify*, *NowPow*, and *UniteUs* are offering technology platforms that help health systems and patients assess, rate, and access social supports to complement healthcare services. At a very simple level, almost limitless capital and investment in emergent technologies are enabling for-profit companies to find creative ways to reach, often virtually, underserved patients and meet their healthcare and social service needs and wants.

This shift in focus of for-profit firms into low-income, medically underserved service areas and patient populations will likely disrupt the “market advantage” that FQHCs have held in providing health care services to low-income and uninsured patient groups. And FQHCs have exploited that advantage to full effect, primarily due to their bureaucratic efficiency at configuring need. But now companies can lean on technology to connect to rural patients or patients in poverty, and they are beginning to do so at relatively low unit and low transactional costs. For-profit companies operate on a very different logic than FQHCs, and they demonstrate that capturing patients whom community health centers traditionally have served is not a specialized enterprise premised on effectively operationalizing the concept of need. It is simply one component in the diversification of portfolios and an overarching play for market volume. “These technology companies look at [community health centers] or academic medical centers and I don’t think they want our brick and mortar facilities,” said one New York-based healthcare executive; instead, “they want our data.” It is impossible to completely predict how these dynamics will evolve, but it seems likely that with the advance of for-profit companies into medically underserved markets, a reckoning between two very different bureaucratic forms is

near. This course of events will force FQHCs to act differently within the isolated environments they have long operated in, and it may bend or eventually break the bureaucracies that shaped them. Beyond prescriptions for change, a greater fluency in these emergent bureaucratic forms is fundamental to recognizing where care delivery for the poor has been, and where it will go.

### **A Few Final Words**

I mentioned at the outset of this dissertation that social science research, with some notable exceptions, has tended to avoid focusing on bureaucratic worlds. The same cannot be said of fiction. Honore de Balzac (*The Bureaucrats*), Charles Dickens (*Martin Chuzzlewit*), Joseph Heller (*Catch-22*), Franz Kafka (*The Trial*), David Foster Wallace (*The Pale King*), Helen Phillips (*The Beautiful Bureaucrat*), and Aleksandr Solzhenitsyn (*In the First Circle*) all fashioned novels that draw on bureaucracy for setting and subject matter. David Graeber has suggested that this is because great writers feel completely at home working within a vacuum whereas social theory abhors it (2015: 53). In this dissertation, I have tried to break one bureaucracy out of its vacuum and place it within a broader historical and societal frame. I did this because I think that examining Federally Qualified Community Health Center bureaucracy is pivotal in reaching a greater awareness of the factors determining how 27 million patients, most from disproportionately low-income and/or vulnerable populations, receive medical care. On one side of the coin, ethnographic work conveys the rich, lived experience these patients have, particularly as it relates to the absurdity and stupidity of their interaction with a vast structure beyond their control. It has been my effort to provide a similarly rich account of the reverse side of the coin: the world of bureaucracy that contributes to that structure. If it seems absurd that so much bureaucratic time and effort at Care Center was directed at fashioning need to suit organizational purposes, this is just because portioning out medical care based on arbitrary

designations of need is even more absurd. As Zeke Benjamin mused when I first mentioned my interest in researching need as a rationale for delivering services to patients: “We need them a lot more than they need us.”

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## **Personal Communications**

Bamberger, Lisbeth Personal Communication 4/13/18

English, Dr. Joseph Personal Communication 1/26/18

Geiger, H. Jack Personal Communication 2/9/18

Geiger, H. Jack Personal Communication 8/8/17

Klores, Noel Personal Communication 4/6/18

Khosrovi, Carol Personal Communication 2/13/18

Rugge, John Personal Communication 8/25/17

Sardell, Alice Personal Communication 7/13/17

Van Coverden, Tom Personal Communication 3/5/18

### Appendix A: Care Center Interviews

<b>Pseudonym</b>	<b>Position</b>	<b>Age</b>
Alexandra Bacall	Chief Medical Officer	44
Zeke Benjamin	Chief Financial Officer	56
John Bewley	VP of Technology Services	44
Alison Cartwright	Regional Practice Manager	56
Robin Esther	Administrative Assistant	75
Felicia Finley	Chief of Clinical Planning and Development	59
Claudia Foley	Chief of Community Collaboration Development and Strategy	66
Mike Foss	Director of Financial Analysis	27
Diana Goodman	VP of Financial Operations	61
Sheila Hodges	VP of Operations	43
Cheryl Jacobs	Chief of Training and Patient Activation	64
Alan Johnson	Former CMO/Medical Director and current VP for Practice Evolution	66
Jane Medcalf	VP of Clinical Informatics	47
Bill Meisner	VP of Information	52
Gregory Mills	Chief of Clinical Integration and Graduate Medical Education	61
Mary Reagan	Chief Executive Officer	68
Roger Ross	VP of Human Resources	62
Jerry Russo	VP of Financial Reporting	48
Erik Santos	VP of Operations	47
Julie Saxton	VP of Government Relations	36
Robert Shelding	Chief Dental Officer	60
Gail Sutherland	VP of Administration	70
Rex Thompson	Director of Community Relations and Affairs	51
Roberta Thompson	Founder and Executive Vice President	81
Bob Wilkinson	Director of Informatics	38
Abigail Worthington	Chief Operating Officer	42
Winston Wright	VP of Capital Projects	53

## Appendix B: Key Legislative Moments in FQHC History

Date	Bill Number	Law Number	Title	President	Comment
10/11/96	S. 1044; HR	104-299	Health Centers Consolidation Act of 1995. An Act to amend title III of the Public Health Service Act to consolidate and reauthorize provisions relating to health centers, and for other purposes	Bill Clinton	As stated by William Jefferson Clinton upon signing the bill on October 11, 1996: "The bill reauthorizes and consolidates four Federal health primary care and prevention programs: community health centers, migrant health centers, health care for the homeless, and health care for residents of public housing programs. By empowering communities to design and develop their own local solutions to their health care access problems, this legislation will help to improve the health status of our Nation's medically underserved, low-income populations. The Nation's health centers, comprised of over 700 organizations and 2,100 service delivery sites, provides health care services to almost 8 million people annually. They act as the safety net for millions of people who are disproportionately poor and have inadequate or no health insurance" (Weekly Compilation of Presidential Documents Volume 32, Number 41 (Monday, October 14, 1996) [Pages 2041-2042].
10/24/92	H.R. 6183	P.L. 102-501	Federally Supported Health Centers Assistance Act of 1992; To amend the Public Health Service Act to provide protection from legal liability for certain health care professionals providing services pursuant to such Act.	George H.W. Bush	<p>Federally Supported Health Centers Assistance Act of 1992: Amends the Public Health Service Act to include entities receiving Federal funds under provisions relating to migrant health centers, community health centers, or health services for the homeless, or health services for residents of public housing, and officers, employees, or certain contractors of such entities who are licensed or certified health practitioners, in the coverage of provisions regulating civil actions for injury resulting from medical or related functions against commissioned officers or employees of the Public Health Service. Makes such actions the exclusive remedy against such entities and individuals. Subrogates to the United States any insurance claim such an entity or person has. Terminates such inclusion after a specified date.</p> <ul style="list-style-type: none"> <li>• Prohibits deeming such an entity to be an employee of the Public Health Service unless the entity has: (1) implemented policies and procedures to assure against malpractice and the risk of lawsuits; (2) reviewed the professional credentials, claims history, and other information regarding its licensed health care practitioners; (3) no history of claims against the United States under these provisions, or has cooperated with the Attorney General in defending against such claims and has taken corrective action; and (4) has cooperated with the Attorney General in providing information relating to an estimate of expected claims.</li> <li>• Empowers the Attorney General, if certain conditions are met, to determine that an individual physician or other practitioner not be deemed a Public Health Service employee for purposes of these provisions.</li> <li>• Prohibits hospitals from denying admitting privileges to an otherwise qualified health care provider who is an officer, employee, or contractor of such an entity.</li> </ul> <p>Officially established a new provider type "Federally Qualified Community Health Center" or "FQHC" to describe community health centers. Establishes Medicaid payment designation for FQHCs taking into account 100% of "reasonable costs."</p>
12/19/89	H.R. 3299	P.L. 101-239	Omnibus Budget Reconciliation Act.	George H.W. Bush	

7/29/75	S.66; H.R. 4925	P.L. 94-63	An Act to amend the Public Health Service Act and related health laws to revise and extend the health revenue sharing program, the family planning programs, the community mental health centers program, the program for migrant health centers and community health centers, the National Health Service Corps program, and the programs for assistance for nurse training, and for other purposes.	Gerald Ford	<ul style="list-style-type: none"> <li>• Title V: Community Health Centers: Defines the term "community health center" as meaning under the Public Health Service Act an entity which provides primary health services and referral to providers of supplemental health services for all residents of the area it serves.</li> <li>• Authorizes the Secretary to make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations.</li> <li>• Requires primary health services to be available and accessible in the area served by the center promptly, as appropriate, and in a manner which assures continuity.</li> <li>• Provides that the governing body of a community health center shall have at least a majority of its members being served by the center and who as a group represent the individuals receiving services from the center; shall meet at least once a month, shall establish general policies for the center, shall approve the center's annual budget, and shall approve the selection of a director for the center.</li> <li>• Authorizes the Secretary to make grants to public and nonprofit private entities to assist in: (1) the establishment and initial operation of community health centers which will service a medically underserved population; and (2) meeting the cost of the continued operation of such centers.</li> <li>• Authorizes appropriations for the payment of grants under this title for fiscal years 1976 and 1977.</li> <li>• Section 314 (e) of the Public Health Service Act is repealed.</li> </ul>
6/18/73	S.1136	PL 93-45	A bill to extend through fiscal 1974 certain expiring appropriations authorizations in the public health service act, the community mental health centers act and the developmental disabilities services and facilities construction act, and for other purposes.	Richard Nixon	<ul style="list-style-type: none"> <li>• Title I: Amendments To Public Health Service Act</li> <li>• Extends appropriations through fiscal year 1974 for the following programs under the Public Health Service Act: (1) Health Services Research and Development, (2) National Health Surveys and Studies, (3) Public Health Training, (4) Migrant Health, (5) Comprehensive Health Planning and Services, (6) Assistance to Medical Libraries, (7) Hill-Burton Programs for Construction of Medical Library Facilities, (8) Training in the Allied Health Professions, (9) Regional Medical Programs, and (10) Population Research and Family Planning.</li> </ul>
11/8/66	S.3164; H.R. 15111	PL 89-794	Economic Opportunity Amendments of 1966 "Kennedy Amendment"	Lyndon Baynes Johnson	<p>The Director is authorized to make grants to, or to contract with, public or private nonprofit agencies in order to provide assistance necessary for the development and implementation of (comprehensive health services programs focused upon the needs of persons residing in urban or rural areas having high concentrations of poverty and a marked inadequacy of health services. \$61,000,000 is authorized for carrying out section 211-2; the Director shall formulate and carry out programs for the prevention of narcotic addiction and the rehabilitation of narcotic addicts. Such programs shall include provisions for the detoxification, guidance, training, and job placement of narcotic addicts. The Director shall also provide for studies of the nature and characteristics of health problems particularly significant to low income persons.</p>



11/3/66	S.3008	P.L. 89-749	To amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and services, and for other purposes.	Lyndon Baynes Johnson	Block Grant for Comprehensive Health Planning: Section 314 (c) "Project Grants for Health Services Development" There are authorized \$62,500,000 for the fiscal year ending June 30, 1968, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance, (2) stimulating and supporting for an initial period new programs of health services, or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services.
8/20/64	S. 2642	PL 88-452	An Act to mobilize the human and financial resources for the Nation to combat poverty in the United States.	Lyndon Baynes Johnson	The Economic Opportunity Act
9/25/62	S. 1130	PL 87-692	To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.	John F. Kennedy	Statement by Senator Williams of New Jersey on Health Bill S. 1130: The 18th century philosopher, Dennis Diderot, perceptively observed that "it is far better to work at the prevention of misery, than to multiply places of refuge for the miserable." This legislative body in the last session, and the House yesterday, in passing the health bill, S. 1130, transformed Diderot's abstract wisdom into a realistic legislative program designed to eliminate the substandard health conditions among our migratory farm families. In brief, this program provides Federal funds for a 3-year period, to stimulate State and local health programs in areas seriously affected by the seasonal influx of migrant citizens. In a few days President Kennedy, who strongly endorsed this legislation, will make an immutable mark in the history of this great Nation. By the enactment of this bill, the Congress will have achieved a historic breakthrough for migratory farm families. These citizens who reap our health-giving harvests have long been denied this Nation's achievements in medicine and science. In 1939, John Steinbeck's "Grapes of Wrath" electrified a nation still convalescing from the depression. More recently, La Follette fought long and hard to make democracy a reality for these people whose daily lives mock our notions of equality. And although their health problems have long been recognized, the Congress has never passed legislation of immediate, practical help to the men, women and children in our domestic farm labor force. If, as President Kennedy has said, the true measure of a nation is its success in fulfilling the promise for a better life for each citizen, then each of us here today should welcome this opportunity to make this promise a reality and this Nation the embodiment of justice.
8/13/46	S.191	PL 725	To amend the Public Health Service Act to authorize grants to the States for surveying their hospitals and public health centers and for planning construction of additional facilities, and to authorize grants to assist in such construction.	Harry Truman	The purpose of this title is to assist the several States: "(a) to inventory their existing hospitals (as defined in section 631 (c) ), to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people ; and "(b) to construct public and other nonprofit hospitals in accordance with such programs .

8/2/46	S.2177	PL 601	To provide for increased efficiency in the legislative branch of the Government	Harry Truman	Subject to the limitations of this title, authority is hereby conferred upon the head of each Federal agency, or his designee for the purpose, acting on behalf of the United States, to consider, ascertain, adjust, determine, and settle any claim against the United States for money only, accruing on and after January 1, 1945, on account of damage to or loss of property or on account of personal injury or death, where the total amount of the claim does not exceed \$1,000, caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant for such damage, loss, injury, or death, in accordance with the law of the place where the act or omission occurred.
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## Appendix C: Catalogue of “Wet” and “Dry” Terminology

### WET:

Barrel of brandy  
Wishy-washy  
Bubble  
Fluid  
Flow  
Scrub  
clean  
when it rained the rain  
would come right through  
the walls  
we absolutely missed the  
boat / we’re missing the  
boat  
flexible  
cauldron  
well-oiled machine  
cash flow  
floating around  
float up to the top  
stay afloat  
where’s the pond and  
where to fish  
small fish in a big pond  
rather than a big fish in a  
big pond  
drunk the Kool-Aid  
muddying the water  
we’re drowning in it  
blobs  
pool  
funding streams  
sponges  
absorb  
bleed / blood  
navigate the waters  
tread water  
boils down  
alphabet soup  
wound  
fester  
fresh  
rowing  
pissing match

cough up  
gravy

### WET AND DRY:

organic  
get eaten up  
grassroots  
umbrella  
freezes  
paved with gold  
gold plated

### DRY:

Crumble  
Burning  
Held their feet to the fire  
Put out fires  
Concrete  
Dry  
Cut and dry  
Nitty-gritty  
Burnt  
Cookie-cutter  
Anchor  
On the ground / grounded  
Siloed  
Burn out  
Scratched my head  
Plant the seeds  
Sprout up  
Elements  
Pulling the scab back  
Healed  
Absorbed  
Hair’s on fire  
Granularly  
evaporated

## Wet and Dry Phrases in Context

**Alan Johnson:** I simply don't see in the quality improvement literature, any real support for that and my experience is that what you get is you get the [unintelligible 00:43:38] you get a few stars who respond to it and a lot of other people just don't give a damn about that as a motivator. It does not work any harder or try any harder whether you paying for it or not. Those who worked hard before, keep working hard and those who didn't work hard just crumble about the new pace, test scale and don't really change their way very much.

**Alan Johnson:** There's the insiders and the outsiders and the truth is, nothing gets done without both those populations existing. If you don't have some people who can work the system and the pressure that the outside is for the-- doesn't resolve in anything because the insiders don't know where it's earned. What you need is, people burning down the health center [unintelligible 01:08:05] say, "What are you going to do about this bill Senate burning down?" He knows where to turn to solve this problem.

The two are going to see each other as diametrically opposed- the insiders and the outsiders- the outsiders I think the insiders are sellouts. The insiders will think the outsiders are naive, too. They don't have each other and nothing gets done. There'd be no civil-- there be no war on poverty if the cities in America weren't burning.

**Alan Johnson:** But if all that happened, was the cities were burning and there weren't people who are policy folks working on legislation, nothing would have happened either. You need them both.

**Alan Johnson:** I don't sit in the smaller groups anymore, so I don't know if, you know, XXX and XXX and whoever else is on finance now held their feet to the fire about what-

**Alan Johnson:** A giant saint Bernard.

**David:** A giant saint Bernard. Why?

**Alan Johnson:** Because we help people. We're big and shaggy and we move in the odd direction sometimes but got the barrel of brandy to help people when they need help.

**Alexandra Bacall:** So, in the last two years, I've been really fortunate to be able to grow the quality team so that we now can deploy resources. I felt as a site director when first coming in to the organization that we measure lots of information but what we didn't do is provide concrete ways for teams to achieve it. It was, "Here's your performance. Good luck with that." That was my feeling and I felt like that's not sufficient. I need help. I mean, site directors still seeing a full panel of patients. They may not understand some of the details of what it takes to improve quality and so the last two years it's been really a challenge but a tremendous opportunity, so rewarding to say to team, "So, I see that your hypertension rate is not high. Here's XXX [unintelligible 00:13:32], she's going to spend X amount of time with you to talk about possible ways or strategies to improve that."

It's been how taking the rolled up number of hypertension, reporting at the individual provider level, then at the department level we are looking at what's happening at those sites. We not only look at the data but we do the site visits as part of the traveling quality team and we talk to the

individual leader so they can help to provide insights to why our performance is the way it is and then we can deploy **concrete** resources.

**Alexandra Bacall:** It's interesting because when you ask the question does compensation really drive quality? No, but I am advocating for us to-- let's put adequate quality dollars there knowing that it's not going to **dry**, it is going to help systems and it's funny because now I have to rethink about what I've been driving for this equal amount. I feel like if we put all the money in the productivity bucket we as an organization are out of balance because we're putting quantity over quality. I want quality to have an even place at the table and in some respects it has to be at a greater proportion of quality than quantity because if you see a lot of patients and you do crappy care, you've done really nothing but if you've seen a small number of patients and you've provided great care you've actually done something.

**Alison Cartwright:** XXX guided me in some of my duties, responsibilities, but I felt a lot of it was - I figured it out for myself which I don't mind, in some of the steps and things like that. There's definitely some clear guidelines with HR policies, those things in that management but some things are a little **wishy-washy**, can you see my hands on that [laughs]?

**Alison Cartwright:** That's what I found. I think, when we see the variety of nuances at health centers, at each of the health centers -- again, personalities, stronger managers. Medical directors can lead to a stronger health center. People interpret things a little bit different and not everything is **cut and dry** about what you can do even working in XXX, all different things have nuances that come within that that aren't necessarily **cut and dry** of, "This is how--"

**Alison Cartwright:** Well, again I would just say, it's like what I explained to you in being delivered the message, "Okay, this is what we're going to do boom." Then I'm trying to manage this with those folks that -- because it's not -- there's some things -- it's getting better **cut and dry**. There's provider expectations where those things maybe didn't exist as strongly as they do now, I don't know what it was like. If I've seen a change or I've seen this gradual increase in provider expectations, which I don't think used to be as **cut and dry** as they are now, but even then I still see wiggle room in some of that.

**Alison Cartwright:** It could theoretically exist, but the functionality of it is not anywhere near smooth, or patient-friendly because the length of time it would take to handle something like that -- To hear him have an idea, and it makes me concerned when you think about that **bubble** at the top, and really trying to understand the **nitty-gritty** of really hands-on stuff, and again that's why I think by each health center, sometimes again, just depending on its leadership, and who's guiding, a stronger site medical director will probably have a little bit stronger site because they're really a guider or many things.

**Bill Meisner:** I would say most of this is simple project management and having a beginning, middle, and an end. Some things don't end but a lot of what I do, I try to project manage with a beginning, middle, and an end, so it doesn't cycle back to an indefinite loop of infinity. Other things like just managing accounts receivable in an FQHC, it's first-in first-out-

**David:** And it will continue.

**Bill Meisner:** -and it just refreshes itself with new data; same thing with informatics and whatnot. Those are more **fluid**, technical, same workload different day but there are other things such as building an urgent care center that isn't-- there's a beginning, a middle, and an end where it's open and you are operating as a normal business from that point forward.

**Bill Meisner:** Well, I think we've learned from experience. All of our collective experiences being pennywise and pound foolish has got us **burnt** in several instances over the years. Although that might not meet XXX requirements or XXX policy which are bureaucratic, fixed [laughs].

**Bill Meisner:** I was saying, there are some decision points who are enablers. I consider me being able to answer that question I'm not creating a bottleneck. I've given a **concrete** answer, take it or leave it. You either want an interface with us or you don't but we're not changing our races. It could have backfired but there was some interpretation necessary between I make some, you make some, XXX, XXX. All make these **concrete** decisions based on fuzzy regulations that just don't align from XXX County requirements to XXX County requirements.

**Bill Meisner:** Right. This is a big data generalization phenomenon that's occurring that-- Google does it with their clients, Amazon does it with their clients and we're doing it with ours and the Feds are doing it with theirs. There are a percentage of error in the formulas and the greater need assessment is accomplished and budgetary outcome managements are beginning to formulate and we're in the infancy stage. In the end we may come to a very uniform system but we're infants in trying to do what we're doing.

As much as those in Europe compare their architecture to our architecture, I don't think we're that much more sophisticated in health care delivery systems. I think there's still a lot to learn and it's **fluid**.

**Bill Meisner:** -and each of-- it would be ideal to have perfect health center where all software implementation was turnkey; all grant deliverables like title ten were turn-key and extremely **cookie-cutter**. There was no room to interpret or negotiate.

**Bill Meisner:** Yes, more **cookie-cutter** in its training program and software utilization. One could say the A system is uniform though it's got some real problems-

**Bill Meisner:** Yes. I'm a big fan of cookbooks and whether it be XXX measures for clinical quality measures. We, as an example, had trouble just defining a diabetic. One would think that that is **cookie-cutter** in uniform. However, based on different interpretations of measures if someone has a high glucose it doesn't necessarily mean they're diabetic. For the population they could be gestational diabetic or it could be they tested high on a glucose test but it was an incident that wasn't recurring or they're not our patient. Those factors aren't quite as uniform as one would like. I find a lot of my time is spent helping people make the question more structured and uniform. A lot of people in the industry or in this organization need help interpreting the deliverable.

**Bill Meisner:** Absolutely, and some others—Care Center definitely has a personality. Others aren't as quite as strong and their personality isn't quite as strong, so it doesn't come across that

there are **organic** decisions being made of right and wrong based on history where others don't have 40 years of history to even compare, they have months of history-

**Bill Meisner:** Well, I think that the **organic** aspect of Care Center is, our leadership likes to hire smart creative people and that's part of our History. That we collect different specialties, whether it be IT reporting or revenue cycle in me or marketing from someone else. I think that collection, in a large organization but specifically this one has **organically** forced us to evolve and not kept us idle in re-evaluating or keeping up with current trends and current needs in the environment. I think that that helps us and keeps the environment dynamic and not mundane and as bureaucratic as other places where they don't have that. I think that's another aspect of bureaucracy; is the mundane, there's only one way to get a bill passed.

**Bill Meisner:** Yes. We associate many things with an individual talent versus a department assignment over a mundane routine task. I think that that's part of our **organic** way of approaching different things because there are specific skills sets we've collected. For good and bad, I think there's weakness in that and I think that we've realized that although we have built our culture on having individualized talents like a XXX or an XXX or a XXX. We're talking about XXX and the operating certificates and we said, " There's no one more qualified in this organization than XXX to tell you whether cardiology is covered under your operating certificate or not. Having him gone through like 45 operating certificates probably in his career, no one else has done that here. Don't talk to anyone else."

**Bob Wilkinson:** There's another gap in there with their understanding of what that really means and there's a step in the middle so we have your XXX whatever it might be, we work with two currently. That's your data source. That's what the staff interacts with everyday, our interfaces interact with lot of things happening in there. That actually goes to an intermediary step, we use sequel but during the sequel data transformation, we normalize **scrub**, **clean** the data to make it more reportable and more accurate- [crosstalk] to XXX.

**David:** I'm interrupting you, I'm sorry. An example of something that you would **scrub**.

**Bob Wilkinson:** Sometimes if you're **scrubbing** something, if the XXX is storing some value that's very important somewhere but the way that it's storing it or the way you're interacting with it isn't reportable. If they are free texting something, but really we want to know the value of what they're free texting, is there a date in there, is there a number in there, we have built scripts that can extract for that value itself convert to a number **[unintelligible 00:07:28]** therefore you can measure it.

**David:** I write January 12th or something and it's --

**Bob Wilkinson:** Yes and somebody else will write one slash 12, yes. We have scripts that can **clean** that up and **scrub** it and form it to the way the way that it was intended.

**Bob Wilkinson:** Go and see. There's been a lot of interest in my department in that. It helps them understand the data **flow** better even, so not only can they can see what are these other people experiencing in their day to day lives and what does it mean to be a patient at the health center and come in. Not only that, but you actually get to see the data **flowing** into the XXX and understand the clicks that they're moving through the screens and what not. We are planning on having each one of our staff members shadow some key areas.

**Cheryl Jacobs:** I remember it really, really well. It had to be, it was like 28, 29 years ago. I had been working for another agency that provided migrant health care. We have been delivering health care in this trailer behind the XXX. The trailer had an outhouse which staff and patients had to use. The trailer was in a really poor condition. It had, when it rained the rain would come right through the walls.

**Cheryl Jacobs:** We were telling as administrators, telling people to keep on putting these up with no connection of what the exam room was looking. It's just one example. We have a facility contract that we we're chiseling down, chiseling down, chiseling down. That's the one of the major drivers of patients coming back. If a place looks dirty, they feel the whole service is bad. What I'm trying to tell you is that we absolutely missed the boat. In my opinion, we're missing the boat because we don't clearly-

**Cheryl Jacobs:** No, I know you're right so then we also look at provider measurements. One of the things you were saying everybody's cookie cutter. Well not really this is a data from a whole year. So we look at just our medical providers. This gives us overall rankings and you can see. This is based on a whole year of data so now we start to see trends, it's not that they're bad every single, it's only it's not that you're bad with just a single tour this is a trend. So how we use this data now, we never had this so this is an example of how data and structure become more and more needed because we have 150 providers, how do you track who's doing a good job This is the voice of the patient. There's also clinical data, but in 1998-1989 we didn't have this capacity. Now we do, we have it. So in some ways, the sophistication has drawn a better product, right? As long as we use the data to make sure that we're getting it right. When we look at this we're looking at how are we doing as a program and how is it when we look at the national score. How low-- how are we? What are the areas that we're doing great in? Provider explanation, provider-- medical and the all staff courtesy is something we'd want to work on and this one is prone attended. This is the phones, not the receptionist because that's a different score and then this one is Center cleaning this in appearance. So you see that tableau report also gives us some good information but we're able to drill down and that ends my time with that. If you want we can actually schedule additional with.

**Claudia Foley:** They're not often engaged in [unintelligible:19:47] practices. So, I sort of get that for the XXX it's greater, they need greater accountability and they might get eaten up by people like us. Everyone's eating each other up. The hospitals eating up the hospitals and they're going to someday, maybe eat us up or maybe we're going to eat up the XXX, but size matters. Right? So, will local community no longer have access or gateways into flexible, resilient, caring, smaller community-based organizations that might be more culturally, religiously, linguistically confident than the larger institutions? I don't know. I don't know. I don't feel well based on how our nation is going. I don't feel terribly hopeful for a lot of community-based organizations that are grant funded because the funding streams are going to change.

**Claudia Foley:** I don't know if this is correct as a metaphor for -- as an anchor. An anchor. In my mind's eye, I see an anchor or something that helps to reduce destabilization, that can help route us, that is the soul or the heart of, let's say, it could be the soul or the heart of a community. I'm falling back. This is where XXX is right. I'm nothing but an old fucking hippie, excuse me,



because I do have the aspirational sensibility that the dynamism of a community health center is this **anchoring**.

It can be this **anchoring** experience in community and embody the best of what we are, the aspirations of what we hope to be, is both **concrete** and spiritual, and keeps us secure, and can provide security in community for populations, individuals. So that's my -- I don't know if that's what you're looking for.

**Claudia Foley:** And to the extent that we say that we hire from within the community, I think we have a greater obligation to mentor and coach young people and to be a little more flexible with them, with what they might need. So if they wanted to go back to school, I believe we have to work with them to come up with schedules that are **flexible** so we not lose them.

**Claudia Foley:** I feel like we're in a **cauldron** of all different things going on, of growth, of people saying we're going too fast and we don't have the infrastructure support for this, when someone deeply personal like XXX who is loyal in so many ways to what was, to what is, what ought to be and I think it's difficult. But we're living in a very difficult time, so very, very dark days, I believe. So, this is to me -- Well it's not the panacea of an organization, to me, a safe organization, because I've experienced XXX 's loyalty. I don't know how much longer, but for the time being, I get that, I'm fine.

**Diana Goodman:** I think we're more professional if that's the right word. I don't know if that's the right word. I think we've just grown. Yes, what word am I looking for? When you start with **grassroots**, not that everybody aren't professionals but it's more of a machine that has-- A **well-oiled machine**, I think. It's changed but it still attracts the same heart that people come here. That's probably what always attracted me that I am amazed at the people. How bright and how talented the people are that we work here? I think part of it, I attribute and I know for myself, is XXX 's leadership in that there was always **flexibility**. I realize she was able to get talented people, smart people. It wasn't about the money because we really didn't have the money. I've also realized that it really isn't about the money. Everybody likes to make money but that's really not the most important reason why people take a job. Some people do but I think most people who are satisfied. It's about more than that. It's about the mission. It's about satisfaction at work. I've just always enjoyed working with very dedicated and even now, when I look at my staff these many years, there's not a big turnover. These are all self-motivated people.

**Diana Goodman:** Yes, I think I can still remember XXX saying, "This is not a deli where you go into the register, you push the button, the draw opens and you hand the bread guy 20 bucks." You have to have a check request. We have to have a check run. You can't get money and we can't write checks everyday or we can't do manual checks. We can't run it like a Mom & Pop Grocery Store. We were that way. We literally were that way when we started. I had helped you **put out fires** so yes, there are some pains, even not just in finance because we were actually HR at that time because there was really no HR Department. Bonus to staff and all those because it was a small family and you picture a family business would be.

**Diana Goodman:** The plan is to bring the budgeting down to the lower level to the sites, to the people who are **on the ground** and managers, to be able to manage their budget. It makes more

sense to work on positions and not because people come and go. I don't know what the turnover rate is? I don't know what XXX told you? I know it's at least 15, 17, 18%, something like that. You can imagine trying to track that but it's easier to say, "Look, I have three nurses and I can manage it that way."

**Diana Goodman:** It was an amazing transformation. We could take over. I also would have said, "Oh my God. Why would we take all these sites and [unintelligible 00:25:27]?" These people are losing millions of dollars and even though, we're getting XXX. Thank God. Like I said, I could never have XXX 's job. I'm the one who'd have the brakes on all the time because I'm a scary cat. Having money in the bank, knowing that-- Not that I didn't think we could be successful because I always had confidence we could be successful but **cash flow is cash flow**. Would we be able to make it?

**Diana Goodman:** No, no, no, because I think of my heart. For instance, where I struggle sometimes, I get a call from someone. I find out all these cash. Controller's job and finance and to protect the assets of the corporation. That's what we do. Cash is big. You can't have cash **floating around** and cash unaccounted for. When I hear sometimes with these nightmares because as I say, we have grassroots organizations. I can pick XXX as an example. They have things in the community. People go when they want to raise their money on their own. Then, they want to do this and they want to do that.

**Diana Goodman:** I like to think about it whether it's real or not. I like to think about it as being under one **umbrella** but that they are-- I can't remember the numbers now, the 28. How many health centers do we have?

**David:** XX.

**Diana Goodman:** XX. Okay, that it's 30 grassroots organizations that are under one **umbrella** because I'd probably choose not to think of it as being a large corporation even though, I think we still have that. I think we still have that but I'm not sure. Then, I think of it as XX smaller entities that roll up into one. I think it is a vital and again, I haven't been in other. I can only go by XXX. I've always looked at XXX as-- I always have to use way too many words now. I think of it as a lifeline for some.

**Erik Santos:** Yes. At least our friend for example, she's our master with [unintelligible 00:38:53]. I said, "XXX, we need this report. Find me the mapping." I always say to the practice manager or nurse manager, "I am going to show you," and this is the phrase that I use all the time, "I'm going to show you **where's the pond and where to fish** and I'm going to help you to fish the first time, but after that you have to learn yourself."

**Gail Sutherland:** Well, it has. I can't say the changes for the worse, given who we are. We have grown huge, so you can't give it at XXX, or whatever, or the XXX Diner. You have to deal with the reality; I think that there has been a healthy concerted effort to have less talk and more fun. I am deeply disturbed that not everyone is respectful when XXX is speaking. I think it may be a product of that we are missing that piece of -- somehow they haven't **drunk the Kool-Aid** yet, and I'm sorry, because they don't get it. We're better when we're all on the same page that we are passionate about what we do, and who we are, and honor that that woman is a large part why we are that.

**Gail Sutherland:** If you had a structure like that for our kind of organization, not a corporation in general but healthcare, with emphasis on the need for preventive health, how do you structure that so that it's not **siloed**, so that it is, indeed, integrated, without **muddying the water**, stepping on toes, crossing the lines; where it's effectively integrated and still clearly defined?

**David:** I'll give you just a simple example that I found in interviews and I found in different ways we described things. If something is more community oriented, it's a **wet topic**. If something is more systems and more monetarily focused or something like that, it's a **dry topic**. For what it is **organic**, this comes out of how we do it. This is a structural anthropological interpretation. It's so classic it's almost embarrassingly so. It's ripped off many other people who've done this far better than I would ever do. But if it's **wet**, it's community, it's personal and it's **[unintelligible 01:00:20] watering plants, wet paint**.

**Gail Sutherland:** That's interesting because it removes all of the judgment. **Is it good or bad to be wet? Is it good or bad to be dry?** It's just a way, whereas I was trying to think of another way. Well, why didn't you say this is Yin and this is Yang? Well, because there actually is a context that places a certain amount of judgment on the characteristics that make it such, whereas **wet is just wet and dry is just dry**. I like that, I like it, yes.

**David:** It's just a way of organizing how we think about things. You'll find yourself doing it. My heart, from 30,000 feet not dealing with whatever. Even all these minutes from exactly-- Well, we got to get down in the weeds on this sort of something. **Whenever it seems like it's getting wet, this is where things are most personal**.

**Gail Sutherland:** [laughs] I've had nothing **that wet**.

**David:** It seems like there are a lot of wet topics. If you wanted to look at it as maybe there are recommendations that would come from that, it would be, depending on how you're speaking about something is telling people what is important about it, or how you're trying to explain something. **If I'm explaining to a project officer, I don't want to be discussing wet issues, I want them to be dry. I want them to be absolutely desert like in whatever.**

**Gail Sutherland:** That is one area where less is better.

**David:** Your narrative structure. I could probably go back, look over your grants, and look at how you write, depending on what level you're dealing with.

**Gail Sutherland:** They need sections a little wet. [laughs]

**David:** Sometimes you'll throw it in but there are other times when you could go back and read. I've increasingly gone back and stripped down to the driest possible form, anything that I say about anything, in any state application, **dry as can be**.

**Gail Sutherland:** I think that works, I think that's very effective.

**David:** Of course, because they don't touch and feel in the same way you want.

**Gregory Mills:** That act has now prevented me from developing the relationship where someone wants to actually talk with me about their life goals. I can now produce an organizational report that says we've done life goals in 79% of our encounters. Patients and clinicians are not really talking. They're checking the boxes. We all talk about checking the boxes. The technology is choking us because it allows so many things so easily. **We're drowning in it**.

**John Bewley:** Then over the years, what has stepped up those requirements is the need to be able to do a couple of things with structured data. Report on it, data-mine it and find correlations

among the data. It went from having **blobs** of information that's pretty much what they would be called from the database standpoint is your purview would go in and you would tell your provider, "I had this problem and that problem." and they will just type it all out, then it would just become one huge paragraph that would be impossible.

**John Bewley:** Template building is XXX. It may take the provider the patient and extra 10 minutes to go through that. From a pure technical standpoint that has no impact on my day to day **[unintelligible 00:34:50]** I will just correct myself a little bit. Is if the work **flow** that is built causes an increase in calls to the help desk. "I don't how to do this." or "It **freezes.**" or something happens--

**Julie Saxton:** Oh, yes, yes. Well, but I mean sure, we're big in the **pool** in which we operate but compared to that **[unintelligible 00:09:29]** or **[inaudible 00:09:31]**. So the application, as it was structured required such-- It's almost like running a health plan because you had to manage a network of providers. You'd have to be able to have sufficient financial infrastructure to manage, not just the **flow** of money to yourself but out to all of those parties and on and on. Because of that requirements were structured in a way, really just practically only health systems could apply participate. Anyway that's the-- Yes. It's totally insane. It's very frustrating. It's really stupid.

**Julie Saxton:** Well, I think there are so many different definitions of population health. You ask one person at XXX and you ask a different person at XXX and you ask a different person at XXX, they all give you a wildly different answer. Yes, I think at XXX, that is probably how they would define it. They put geographic bounds. But before these people came into the White House, there were some efforts. There was this initiative, I forgot what it was called. I don't know, it had some silly name, but it basically it was trying to come up with a model of total cost accountability because you have to bring together **funding streams** to the work that you're describing.

**David:** Absolutely.

**Julie Saxton:** You have to bring together your justice **funding stream**, your education **funding stream**, your health **funding stream**.

**Mike Foss:** I do feel that way, I do feel disconnected, certainly. I feel more connected after-- there was a time about two years ago where I really-- I was starting to put together a lot more detailed budgets on sites. And I really didn't understand what it was that people actually did at the health center. So I worked as a front desk staff person for a week, just doing a patient rep job. That really helps to make me understand where the patients were coming from and what their issues were, how patients would **flow** through that. Health center, you know, what the environment was like, and it helps you to appreciate that a lot more. I have since done, a few different times, I have gone over and actually seen what the providers go through, not sat in an actual clinical room but I have sat and just seen how an Internal Medicine Department would **flow**. What I will say is that, that's not nearly enough for me to not feel disconnected. I still-- That was one site for a few-- handful of times, and all of **[unintelligible 00:07:40]** different and they come with their different issues in different patients. But I do definitely feel a disconnect between our admin offices because even with my minimal experience on the clinical side of things, I mean, extremely minimal, that's far more than most of our administrator staff have seen

at the health center. That just speaks to the fact that we were very disconnected from the real nuts and bolts of the operations.

**Mike Foss:** In an effort to try to control that process, we've tried to look at, not people, but positions in saying, "Your site requires this many people to run your operations." It's not about individual performers, it's not about names, it's not about personalities, it's about, "For this many doctors that are seeing this many patients, we need this many support staff," and that's cut and dry.

**Mike Foss:** I am currently leading a patient retention committee that's going to attempt to assess walk-in volume at XXX and whether they are effectively earmarking enough time for walk-ins or if they need earmark more time, and doing a study of their operations. I think by anyone's job description of what I should be doing that would fall into that category. Sort of what happens is that we have certain sponges that sort of just absorb projects, and then once they're yours, they never go away.

**Rex Thompson:** I think cynically speaking organizations are driven by need primarily. In our, we don't have a need to make money, so market-based decisions are irrelevant. We bleed patients so to speak. Every year we lose employees, but we still get the same amount of money. We have to account for certain things, but if we were a full profit organization that bled money for a number of years in a row, that would be fucked. We would be out of business.

**Robert Shelding:** That's part of the struggle especially when you get into an organization of our size. Even when I started maybe two or three sites, you work with various people you learn their personalities, you know how to navigate the waters so to speak and I think the bigger we are its like. It's like you're in a rowboat you have a set of rows and perhaps somebody to help guide you. If you're on a cruise ship, the boat goes equally fast in some respects but to make a turn requires a lot more effort and approvals and its just a lot more coordination.

**Robert Shelding:** I feel as if I would love to be a hundred yards ahead of that boulder somewhat feel like I could provide more direction but these days with our staff and its limits and trying to navigate I feel like I'm on top of the ball as it's traveling. Not under it but feeling like if I don't keep pedaling on top of that ball you could slip. I feel there's a need to find a way to add more staff to help me lead on a managerial level and allow me to be able to plan ahead more. I feel like that's one element that is lacking. I feel I can tread water but I'd like to be able to plan ahead to figure out what's the best path the journey down.

**Robert Shelding:** The health center values those of us who truly embrace this as a career, a profession and the ability to put in extra time beyond what you are paid for. Just because of your own inner passion to want to do it right, to want to come up with things that might be a little outside the box, to help the greater good of the organization. With that comes the need to be weary of burn out and other things in your life that have equally strong demands.

**Robert Shelding:** It's saying to me that they think that this is not an important thing to them but meanwhile if the revenue drops and we start going in the red, then it boils down, its going to be an important thing then much rather address it preventively and prevent that from happening.

**Robert Shelding:** Yes and no. Some folks that don't have the clinical hands on at times do not feel that but I honestly feel that the team that we have as much as they can be immersed sometimes in so many different things at the same time insurance-wise health on wise everything that we do, value-based care the whole **alphabet soup** of acronyms that were in. At the same time I do know that they appreciate the executive council's composition where it's myself, it's XXX, it's XXX, XXX.

**Robert Shelding:** I'm saying, "Well, that doesn't mean that it isn't. It just means that there's not enough research." I remember my earlier years here, we would get grants across the table that we would go after. Haven't **scratched my head** a little bit and say, this goes back to your question about the mission. Are we getting the grants to help us **stay afloat** even though the grants are necessarily in an area that we truly are should be focusing on? It's like there's an art to this.

**Roberta Thompson:** Once we were able to prove we were an underserved area then later, I don't know how many years, could have been maybe four or five years we were on the network that we then later got our own certificate to say, but they were the ones who said to us, "You all have got to work together you kind of find a way to get through that."

**David:** I did recall here reading a little bit about in the Congressional Record about **[unintelligible 00:32:54]** saying, "I don't really care, a poor person's a poor person whether it be some poor guy in arsoning or some poor" he had a seeming -- and I interviewed him a little earlier. He had a very seemingly flexible way of understanding what would be important in his district.

**Roberta Thompson:** They help to **plant the seeds** and we just had to go ahead and make sure they've awarded a nurse so they could **sprout up** and we gave away, they needed us to give them away for them to then get the funding in.

**Roberta Thompson:** I guess that that comes from as a **grassroots** organization and knowing that the **elements** in our community-- If you even look to our communities today, we haven't grown too far away from some of the things that socially, economically divide us. There's that sensitivity about how something is being presented because while you want for the access to be there, you have to be mindful that is presented in such a way that you don't lose something. It's always that potential to lose, and that's much like what we're dealing with in our country now.

**Roberta Thompson:** Now, is it all over? No. We got **[unintelligible 00:55:55]** about when it's going to be on this side of the track or that side of the track because things always continue. Again, going back to the **grassroots** of how it came up and what people remember from those days foregone that they can't let go because they don't know what's going to really happen. Because that's the sense of this country. That's a sense of this country. I say XXX and I'm almost preaching to the choir now because it's so deep in me is that sometimes you need unfortunately a Donald Trump to stir up, and it's like **pulling the scab back** and here's the **wound**. The wound has never been really tended to be healed.

If you don't pull it back and expose it, you're not going to know it's there. It just continues to **fester** underneath, and that's all what he did. People in this country woke up one morning and Barack Obama an African-American is president.

[laughter]

**David:** I genuinely believe that a lot of people had an incredible freak out about this and was just whatever reason--

**Roberta Thompson:** That's part of the backlash of that. If we don't ever get to see where the wounds are to really help them, then they never get healed. As it is painful as all of this, maybe the fact that the exposure is there and now we've got to look at it. When we were able to look as people looked on TV to see what was happening in Texas and other places and how communities and people came together, that's how people make change because you come together and come in scenarios, "Hey, all of us are in here hurting. We got to help one another."

**Roberta Thompson:** It's right across the street from the church where the first meeting was held. It's six blocks from where the second meeting was held. This is really the genesis of our program. Being able to stay close to that it really not only has a foundation, but it makes me centered and grounded, if you will, that it is here, and making it even more to be even prouder, if you will, of where it's gone out from here. When I think of XXX, as far north as XXX and then as far south as XXX and all points in between. You could give a XXX shout out when they say about each area is the next stop, each destination.

**Roger Ross:** Actually, I think you're probably a direct report to XXX, so you're probably boxed under that. Because he does your appraisal. If you look at the boxes, it looks very structured and organized. The way the actual decision making is done is a little different. I would say, more decisions have to float up to the top, I would say to the top, it means, either the Executive Council-- mostly XXX, XXX, XXX, XXX group, floats up to their end or all the way up to XXX. More of the decisions are made at the top than I've experienced in this size of organization. I think that's part of the evolution of the organization, number one, that XXX 's been here forever--.

**David:** For the duration--.

**Roger Ross:** For the duration. XXX has been here a really long time, so they grew up with the organization, they just have it totally let all those things happen, they have pushed down the decision making as much as they might have if you walked into an organization fresh off the street.

**Roger Ross:** You know what? Where I feel the distance a little bit is just, it's a little more challenging to take, physically, out and about and around to all these places. I think that's a challenge, administratively, for us to be out and about. For me, I see the difference is more in relationship to the management of the areas and the regions and the sites. I attribute less of it to geography. I attribute-- when you talk about how much is heredity and how much is your culture--.

**David:** Environment.

**Roger Ross:** Environment. I attribute it maybe 25%, 35% to heredity, the culture and things that you absorbed. All these people came over from that county or we bought the site from the county or something like that. Then, 75% is the folks that are managing the place.

**Sheila Hodges:** Absolutely. Inserting myself into nursing has just blown that all apart. Not only for me but for half the organization. Again, I want to come at nursing within clinical service, which lives under the umbrella of operations, in almost a myopic way because we constantly just

hand things to the people who will get them done. Organizationally, in a lot of senses, in the health centers, that's the nurse manager.

**Sheila Hodges:** I actually think it's incredibly multifactorial. I think that some of it comes as a result of our growth phase. We're moving so fast our **hair's on fire**. We have to just keep moving, moving, moving. "Hey, do you have a millisecond to deal with PACS archiving downtime? Great. All right. Here's a resource. Here's an article. Talk to somebody. Great. Get it done. I need it by Tuesday." Some of it is the momentum that we live in. Some of it, again, reverts back to an imbalance amongst teams. There's a huge communication piece to it. I think the other part relates to what I talk about as locus of control. Who's in charge of this? Are they a distributive leader? Or, are they-

**Sheila Hodges:** But here's where we're headed let's get there together. I'll give you as much autonomy as you want as long as we're all increasing XXX or treating Zika or ordering the right bandage or whatever it is.

Like to me there's it's not specifically formulaic it's every health center has their own personality, every leader has their own personality if we're all **rowing** in the same direction we'll get there even if there's a little bit of variation.

**Sheila Hodges:** Yes, there was the happy chance of, "Oh here we are" And we're strategically and geographically positioned for this opportunity to come out at us from XXX county, but on the other hand it's just that overall strategy. Like I said I'm probably looking at it a little bit more **granularly** than you.

**Sheila Hodges:** Yes. I feel it tremendously and I said earlier we're here to run a successful business. I temper that with we're here to run a successful business because otherwise, our mission doesn't make any difference. If our door isn't open because we can't fund ourselves anymore it doesn't matter how much we want to provide access to anybody. We won't be here and when healthcare, the roads were never **paved with gold**.

**Sheila Hodges:** I absolutely want to help people, absolutely I'm committed to every health center we have and the fact that we'll take care of anybody, that's the greatest thing ever. It's not having a **pissing match** with XXX because our reimbursement rates aren't rich enough. They do a little bit of that, but we turn the lights on, we answer the phone so that we can give people quality health care not so that we can create a barrier. The only way we can continue to do that is to run it as a successful business in my estimation.

**Sheila Hodges:** -15 years ago the margins were much easier to make in healthcare. The reimbursement was completely different you could not with all the negativity that's attached to it, you could pay your bills, you would send the insurance company a billion or a 1000\$ for a sore throat and they'd send you back 80% of that fairly routinely for whatever your bill was. Your patients had to **cough up** some money and that stuff, as that kept clamping down and then all of the financial structures changed.

Everybody had to stop and think, "Hmm we're not getting all the **gravy**. Okay, we have to tweet this a little bit and do that a little differently" Again I've worked mostly in hospital administration, it's a little bit different, but conceptually it's the same. I worked at XXX through



the collapse of the market stock market. That was an organization that never ever in the history of the organization had looked at cost.  
had looked at cost.

There's was no budget work that was ever done, the money just kept rolling in. We were the Peron's [laughs]. Money just kept rolling in and we could get grant funding, we could get single case rates on our groovy things we did, we have a ton of grants and there was research money and their endowment **evaporated** by 67% overnight, literally overnight when the market crashed. There was **blood** in the streets because nobody knew how to budget, no nobody knew how to do anything.

I opened a unit there and there's a very highly specialized unit, I could've order anything, I couldn't like **gold-plated** the faucets and they would have said, "Oh it's for the moms, well yes, but do you know how much this costs" I wasn't even used to it. We had room service, but chef based room service a chef would come up and talk to you, ask you what you wanted and you'd celebrate for dinners. They would go anywhere in XXX to get what you wanted.

**Winston Wright:** Yes. I don't know if it's founderitis to me that implies this idea of cult of personality, and there is some of that, except the personality isn't around the founder. There is a homage to the founder, but on a practical level there isn't. I think it's more, again, I think it is a self perception issue, there's insecurity based on the idea of **small fish in a big pond** rather than a **big fish in a big pond**.

**Winston Wright:** I think it is been incredibly complicated. I'm very curious to see where you get as far as conclusion because there's a lot of information and --. One of the things that drives me nuts about the XXX Center is it raises important and **burning** questions but it doesn't answer any of them. Just one other -- as you're talking about bureaucracy and public health versus individual health, I'm required to get a XXX once a year because I work for XXX. I have no patient contact.

**Carol Khosrovi:**

**Carol:** Well, you're right that it was the least bureaucratic. It's nothing like working-- I later worked in the Department of Treasury when I was head of the men's **[unintelligible 01:10:00]** those old wine -- they're just terrible. You can't get anything done because everybody knows you'll only be there for four or eight years and then you're gone and so they can outlive you long and let's just do whatever you say please to so and so and they just smile and go ahead and do what they've always done. It's just terrible. We did not have that at OEO because even though we disagreed with at least the employees but we had strong disagreements with them.

They were all committed to trying to solve the problem of poverty. They weren't loyal to us being Nixon Republicans but they were loyal to the cause and really did care and worked hard hours and that sort of thing. I, of course, having come from the Hill where you just have a small office and you and your boss relate to one another every day, it was very different for me to go into a bureaucracy but I have to say that looking back, I think I really didn't suffer much from that because I had a very good relationship with Don. I could go in and talk to him anytime I wanted. We spent a lot of time together on the Hill.

I believe that the other people- you're talking to them so I could be wrong but I think that they had reasonable amount of respect for me, so if I had to talk to someone in one of the other

departments, I'd go to their boss, I'd go to the other senior staff person but I never had any trouble when getting anything I wanted done because of bureaucracy. I just didn't get caught up in any of that. Don Rumsfeld also used to tell a funny story. **Have you heard the story about the faucet?**

**David:** No, I don't think so.

**Carol:** Well, this has to do with bureaucracy. Rumsfeld once said that when he was a congressman and various secretaries from various departments would come up to testify, **in his own mind he envisioned that when they went back to their office that they had this desk which had all kinds of faucets and when they wanted to do one thing, they turned it on and when they didn't they turned it off and they had all this power.**

He said, "Now I am head of an agency and I have a big desk and I have these faucets but what I've learned is that when I turn to the right, turn it on or turn it off, **that the faucets aren't connected to anything. Nothing ever happens.**" I think that's the best definition of what bureaucracy can be like that I can think of. There were certain people at OEO that just really couldn't stand him and he didn't like them and he just didn't let their programs move very much. I know that there was frustration down below me but I personally didn't experience it because even though I was a woman, I was sort of a fair head person there, I was head of- and people knew that I had Rumsfeld's ear so, I didn't really have that kind of trouble.

**Tom Van Coverden:**

**Tom:** But there's no question in my mind or anybody else's, I could find a thousand witnesses who would say, "The proof's in the pudding Tom." When you look at it or you look at the **[unintelligible 00:44:13]** funding and what's happened to it, you know what's going on now I assume.

Again, I try not to get too partisan at all. We've got great bipartisan support which has been-- you go back to Kennedy and Waxman very key to our success, it's not always been easy to do but even when I use, for example, as we use to senior people Mike Leavitt and Tom Daschle, again the speeches and we could send you copies **they thought health centers should be the oasis in the desert.**

**The place where peoples of all kinds, colors, races, religions, political can come and get a drink of water.** I think that's if you will, it maybe simplistic but really how we've been able to really get the bipartisan support that all of a sudden, people-- **[unintelligible 00:45:01]** our previous chairman, you talk to him about Hazard Kentucky or some of the small towns there.