One could say the stars were in alignment when the nation’s first community health centers were established 50 years ago. The backdrop was the summer of 1964 — a time of great promise...and protest — for change. What became known as “Freedom Summer” marked a groundbreaking moment in American history when participants in the Civil Rights Movement descended on Mississippi and other Southern states to bring attention to the political disenfranchisement, discrimination and gross social and economic inequalities affecting African Americans. They were accompanied by the Medical Community for Human Rights (MCHR), the medical arm of the movement, which had as its members, physicians, dentists, psychologists, and social workers.

One of those physicians was H. Jack Geiger who almost a decade before and while still a medical student, had gone to South Africa on a Rockefeller Foundation scholarship to work in two different health centers and study with Sydney and Emily Kark, physicians who had developed a model...
of community-oriented primary care. In recalling his experiences in South Africa at a December 1964 meeting with the Delta Ministry of the National Council of Churches, Geiger told the group that a similar healthcare model was needed in America.

Acting on his belief, Geiger made a pitch in January of 1965 to the Office of Economic Opportunity (OEO), a brand new government agency that was President Lyndon Johnson’s main weapon in the “War on Poverty.” At the OEO, Geiger found a receptive ear in Sandy (Sanford) Kravitz, head of demonstration projects. He proposed that the OEO fund as a demonstration project a health center in Mound Bayou, Mississippi, which would be administered by Tufts Medical School in Boston. Kravitz agreed to fund the Mississippi project and another health center, Columbia Point, across the street from a public housing project in Boston.

Contrasted with today’s climate when it often feels as if the government is mired in inaction, Geiger says that the quick realization of his proposal was typical of the energy and optimism of the Civil Rights Movement, and of the spirit of the OEO, which was open to new ideas and experimentation.

Very rapidly the OEO, under the auspices of Kravitz and its director, Sargent Shriver, agreed to fund four more health centers in Denver, the Watts neighborhood in Los Angeles, the Mile Square area in Chicago, and in the South Bronx in New York. By the end of 1965 there were 25 neighborhood health centers, as they were called then, in operation nationwide.

**Tough Medicine**

While a medical student in 1968, Dr. Edward Martin started working at a health center. He later served as medical director of the Martin Luther King Health Center in the South Bronx, NY. In 1974, he became director of the Bureau of Community Health Services (BCHS—now the Bureau of Primary Health Care) under the U.S. Department of Health, Education and Welfare (HEW—now the U.S. Department of Health and Human Services) where he would oversee
administration of the Health Center Program for 15 years. Early in his tenure as BCHS director, the Health Center Program, after 10 years as a demonstration program, was authorized for the first time as a permanent program.

Martin says that BCHS implemented significant management initiatives, including health center reporting requirements which were very important in measuring productivity, getting a better idea of the financial picture of each center, and beginning to track clinical performance. “We began to collect quality information from health centers on things such as immunization rates and screening and monitoring hemoglobin A1c levels.”

Before he came on board at BCHS, Martin notes that health centers and other similar programs at that time used the grant application process to demonstrate progress. Successes, however, weren’t easily showcased in what could be a 400-page application and they weren’t comparable. Thus, BCHS established the Bureau Common Reporting Requirement (BCRR) system (replaced in 1996 by the Uniform Data System) that required health centers to submit data on an annual basis so that center performance could be compared to each other, as well as against other types of healthcare providers, in terms of effectiveness, accountability and clinical quality.

This quantitative information was used in the determination of health center grants and in studies that would demonstrate definitively that the costs of total care at health centers were lower than other providers and their patients used emergency rooms for non-emergent care less often than patients who did not use a health center. Because of this detailed data and documentation, Martin says his ability to testify and to defend health center expenditures was easier than directors of other OEO programs.

Equally important was when Martin dealt with individual legislators who wanted to continue funding under-performing centers in their districts. With comparable performance information on hand, Martin was able to help those health centers come up to par with benchmarks. Citing the “Hawthorne effect,” he notes that knowing that they would be measured [against others], those health centers began to elevate quality and improve the way care was delivered. While at first there was some resistance to more stringent recording and transparency standards, by the late 80s all embraced it.

Karen Davis, PhD, has served as the president of The Commonwealth Fund and is currently a professor in the Department of Health Policy and Management at Johns Hopkins University’s Bloomberg School of Public Health. A prominent economist and health policy expert, she served as head of health policy at HEW from 1977 to 1981 under the Carter Administration. During that time she worked closely with those responsible for administering health centers.

Davis recalls how in those early days some private physician practices opposed health centers and viewed them as a competitive threat; however, the Carter Administration championed community health centers by calling for the first expansion of the program as part of President Carter’s Rural Health Initiative. “Like many of the War on Poverty programs,” says Davis, “community health centers
grew from small scale efforts to well-established institutions with significant funding and therefore significant political support. They truly became an established part of the healthcare system landscape in the late 70s and early 80s.”

The Fight to End Health Disparities

Having been born into poverty, Dr. Marilyn H. Gaston was driven early in her medical career by a passion to fight healthcare inequality and increase access to quality healthcare for the medically underserved. She understood firsthand the challenges poor people faced and as a new physician, she helped to develop and serve as medical director of Lincoln Heights Health Center in Lincoln Heights, OH, just outside Cincinnati. She went on later to lead groundbreaking research at the National Institutes of Health on sickle cell disease in children.

In 1990, Gaston took the helm of the Bureau of Primary Health Care. Expanding on Martin’s quality measurement and improvement efforts, she ushered in a major focus on improving healthcare quality and eliminating health disparities among poor and minority populations.

During her tenure at BPHC, HHS set forth a major public policy direction in the form of the Initiative to Eliminate Racial and Ethnic Disparities in Health. As a leading champion of this transformative policy, Gaston launched BPHC’s “100% Access, Zero Disparities” campaign.

In reflecting on healthcare inequality and its effect on health outcomes, Gaston explains, “Even if you have access to care — if that care is not of good quality — it doesn’t matter. If you don’t have good outcomes and a population does not get better, you haven’t really done anything.”

Moving forward with objectives to improve chronic disease management at health centers and improve health outcomes of their patients, BPHC joined forces with Dr. Don Berwick, then director of the Institute of Healthcare Quality Improvement (IHI), to create the Health Disparities Collaboratives to improve the quality of care and examine disparities in outcomes in the top chronic, but manageable primary care diseases and conditions such as heart disease, hypertension, and diabetes. The Collaboratives were structured to allow for the examination, sharing and discussion of data and information among health centers in order to identify best practices in managing and controlling chronic diseases and improving health outcomes.

Gaston notes that prior to launching the Collaboratives, most healthcare programs, including community health centers, did not maintain a registry of patients grouped by health conditions. She says that making a simple change such as tracking disease cohorts made a difference because health centers could then examine and evaluate for example, how well care was being managed and how many patients were receiving high quality care.

Another key improvement made by Gaston and the BPHC staff was that all health center staff received intensive education from experts using a management model of handling chronic diseases developed by Dr. Edward Wagner. She says that everyone from receptionists to lab techs received this education, not just physicians, because patients ask questions at numerous points in an office visit. For example, she says, “If a lab tech is asked: ‘What is this blood test for?’ — having a proper answer provides one more point to help inform the patient.”

The Collaboratives proved to be very successful. For example, studies showed that health centers participating in the multi-year program improved the quality of care for their patients, improved health outcomes (such as diabetes control and reduced diabetes complications), and reduced health disparities in quality of care. Participants in the Collaborative improved their rates in providing A1c tests
at appropriate intervals for patients from about 20% (the national average at the time for most programs) to 60% in three years. “We were very proud of that,” Gaston recalls. The results drew the attention and applause of major healthcare foundations and research organizations such as the Commonwealth Fund.

In spending her entire career working with medically underserved populations, Gaston says that one of her biggest challenges was battling the general misperception that healthcare for poor people was poor quality healthcare. She commissioned Johns Hopkins University (JHU) to do a study comparing the quality of care at community health centers with other providers. What they documented was that the quality of care at health centers was excellent — as good if not better — compared to non-health center providers. The study also pointed out that a contributing factor to the superior care provided by community health centers was government support for enabling services such as transportation and translation services — the lack of which can affect healthcare outcomes. Once the JHU study was done, Gaston recalls, many of her staff said, “I’m going to stop where I’m going [for healthcare] and go to a health center.”

**Policies in Support of the Mission**

As community health centers refined their operating model throughout the years, major changes in legislation also played a major role in shaping their development. **Jacki Leifer, JD**, NACHC’s general counsel, got her start working with health centers when she worked in the general counsel’s office at HEW during the Carter Administration. There she helped counsel federal officials responsible for the health center grant programs through a period of dramatic growth.

Martin recalls Leifer worked aggressively to support and strengthen health centers serving underserved rural communities. The commitment to reach rural, as well as urban, medically underserved communities was later codified and today funding for health centers in rural areas is roughly equivalent to funding for health centers in urban areas.

A key piece of legislation affecting health centers was passed in 1989, amending the Social Security Act to require that “federally qualified health centers” (Section 330 grant and sub-grant recipients and “look-alikes”) be paid their reasonable costs of serving Medicaid beneficiaries. Similar amendments were made to the Medicare statute in 1990.

“It was a very dramatic change,” says Leifer. “No longer having to cover shortfalls in payments from the Medicaid and Medicare programs, these payment requirements made it possible for centers to use their Section 330 grant funds for their intended purpose — to cover otherwise uncompensated care costs associated with serving low-income, uninsured and underinsured patients, as well as to pay the costs of enabling services such as case management, eligibility assistance, transportation and translation — services that are considered central to today’s patient-centered medical home strategies.”

Another legislative highlight was passage of the Federally-Supported Health Centers Assistance Act in 1992, which allowed Section 330-funded health centers and their employees and boards to be deemed federal employees for purposes of medical malpractice coverage under the Federal Tort Claims Act (FTCA). While health centers collectively had a malprac-
tice claims experience that was a fraction of other primary care providers, they were still, collectively, paying about $50 million a year in premiums. Extending FTCA coverage has enabled community health centers to expend the savings on more services to their communities’ vulnerable populations.

Also in 1992, Section 340B of the Public Health Service Act was enacted, requiring pharmaceutical manufacturers to give health centers Medicaid best price or better on drugs, which has made it possible for health centers to dispense drugs to low income patients at far lower prices.

Leifer also notes the significance of the fact that throughout the grant program’s 50-year history, “the commitment to community-based governance has remained constant.” Congress and HHS have consistently required that patients dominate health center boards of directors. Geiger points out that patient-majority boards are a key factor to health centers’ success. He says that these boards truly understand the patient populations, which leads to a highly successful model of care. “Community health centers are the only part of the American healthcare system where patients, through a majority rule, have a real voice in the healthcare services they are going to get. They are the most democratic corner of the entire American healthcare complex.”

Leaders in Primary Care Delivery — Now and in the Future

It’s easy to wax nostalgic for the 60s. While it was a turbulent time, marked by unrest, protests, and assassinations, it was also an era when, out of those fires, America forged some of its most progressive and idealistic programs. It was a time when widespread news coverage of poverty and social injustices moved and energized vast numbers of Americans, appalled by what they were seeing, to do something about it. Given the cyclical nature of movements, Geiger feels that today the time is ripe to refocus on poverty and socioeconomic inequality: “I think we are just on the cusp of another wave, and community health centers will be one focus.”

After 50 years, Davis cautions health centers “to not just rest on their laurels but also to continue to change with the times.” She points to current demonstration projects such as the new Comprehensive Primary Care Initiative, which is helping community health centers become even more patient-centered by helping patients get appointments more easily with the same doctor for continuity of care.

And, under the Center for Medicare and Medicaid Innovation, new methods of payment are being tested. A payment model whereby centers not only receive fees for services, but also receive a per person-per month care management fee, is being assessed. “It’s a style of practice where the early results find that it’s better care,” says Davis. “People are more likely to get preventive services and get better chronic care management. There’s also evidence that these services save money through reduced emergency room use and reduced hospitalizations; so I think it’s a very promising model of care.”

Projecting 50 years out, Davis anticipates that health centers will still be very much needed. She projects that America will continue to become more diverse and that health centers will be there to meet the needs of different communities and to do it in a way that is culturally sensitive. Also, the population as a whole is aging, which means that health centers may have to figure out ways to serve older patients at home. This will certainly be in keeping with other innovations that have sprung from community health centers such as pioneering the use of nurse practitioners and physician assistants.

While Geiger is happy to have been at the confluence of the Civil Rights Movement and the War on Poverty and to serendipitously have had knowledge of the model that would inform and serve as a catalyst for this nation’s community health centers, he says, “If you think about these past 50 years, there are probably hundreds of thousands of people — several generations of physicians, dentists, pharmacists, technicians, community health workers, patients, consumer board members and others — that have made this movement what it is today. And it is a movement,” he says, “and not just another set of health facilities.”

1965—2015