The emergence of state and regional primary care associations (S/RPCAs) promoting the interests of the growing number of neighborhood health centers in the early 1970s can be traced to several factors. Many health center pioneers back then belonged to professional societies such as medical and hospital associations, had experience with various community groups and interacted with President Lyndon B. Johnson’s Model Cities Community Action Programs (CAPs) that were founded under the 1964 Economic Opportunity Act as a part of his administration’s “War on Poverty.”

The early health center pioneers recognized that by joining together, advocacy, technical support, and policy analysis could advance the already burgeoning health center movement. This was the impetus for a meeting in Boston in 1971 where 23 activist health committees comprised of over 75 individuals met and strategized on expanding the health center model.

In the notes from that meeting there were many divergent views, but the first conclusion was that a neighborhood health center association for Massachusetts should be formed. Some of these same leaders also worked to establish the National Association of Neighborhood (now Community) Health Centers (NACHC), which was incorporated that same year.

In addition to the Massachusetts League of Neighborhood (now Community) Health Centers, the New York Association, the California Federation, the Western Association, the Midwest Association, and the Southern Association were also formed. Through service to their members these associations together helped lay the foundation of the health center movement to what it has become today.

**Fighting a war on poverty**

Grounded in the Civil Rights Movement, the message of health care access was carried by health center pioneers from the State House to
the White House. As Martin Luther King, Jr. said from the pulpit of the
Ebenezer Baptist Church on February 4, 1968, “Everyone can be great
because everyone can serve.”

There were obvious differences in the 1960s between urban and rural
population needs throughout the country and special populations
groups were being identified through the work of the CAP programs.

To address needs of various populations, the new Office of
Economic Opportunity launched civil rights and economic stimulus
initiatives as research and demonstration projects.

The goal of these “Great Society” projects was to promote numerous
investments aimed at job creation, community empowerment and
reductions in poverty and health disparities. All these approaches
encouraged maximum consumer participation. Examples include the
Head Start Program, the Job and Peace Corp programs, the National
Health Service Corps, and the Health Center Program.

Community health center program founders H. Jack Geiger and Count
Gibson believed that with community participation in health centers,
poor and underserved populations would receive far better and more
holistic care than what they would receive in hospital emergency rooms.
This strategy was readily embraced in Washington by champions
Senator Edward M. Kennedy from Massachusetts and Representative
Adam Clayton Powell of New York, the powerful chair of the House
Education and Labor Committee.

According to Bonnie Lefkowitz, soon after the 1965 opening of Columbia
Point Health Center (the first urban health center in the country),
additional health center projects moved forward including in Mound
Bayou, Mississippi (the first rural health center), New York, Denver,
Watts in Los Angeles, and Chicago. With Kennedy’s support an additional
$51 million was secured from Congress and by 1969, an additional
24 centers were funded with community engagement and support
from medical schools and academic centers in both urban and rural
communities. During an interview I conducted with Senator Kennedy in
2005 he recounted going to Columbia Point in 1966 and telling Jack Geiger
that everyone in Congress wanted a health center.\footnote{1}

\begin{quote}
\textbf{“Gaining victories at the policy level requires building coalitions with other likeminded
groups.”}\\
\textit{— DAN HAWKINS}
\end{quote}

\textbf{Connecting the mission nationwide}

As the Richard Nixon and subsequent Gerald Ford Administrations began
to scale down Johnson’s programs, the nascent primary care associations
through NACHC developed policy and funding strategies to present to
Congress. In 1972 they organized the first, though sparsely attended,
Policy and Issues Forum (P&I) in D.C. (The first national Community
Health Institute (CHI) was held later that year in San Francisco.) What was
striking to Washington lawmakers at the P&I, was the presence of
community board members telling real stories of the struggle to gain
access to health care, enabling services, and social support in the
isolated communities they were from.

\textbf{NACHC served as the body to advocate for additional funding and
smart growth. To encourage the growth of local associations, NACHC
also convened regional “mini” policy and issues forums that activated
grassroots advocacy across the country to formulate what became a
nationwide health center strategy. As NACHC’s long-serving policy director
Dan Hawkins noted at the time: “Gaining victories at the policy level
requires building coalitions with other likeminded groups.”\footnote{2}}

Alliances to support health centers were welcomed by NACHC to join
the effort to make the Health Center Program permanent. Many groups
including the California Federation representing Migrant and Seasonal
Farmworkers, the rural health associations, the National Association
of County Health Officers (NACHO), Association of State and Territorial
Health Officers (ASTHO), homeless councils, foundations, hospital groups
and both the American and National Medical Associations joined with
health center leaders.

Strong ties to public health ensued with health center growth being
showcased at conferences of the American Public Health Association,
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the Association of Asian Pacific Community Health Organizations, and in academic settings and schools of public health including The George Washington University, Harvard University, and the Howard University College of Medicine.

Recognizing the need for analysis of collective impact and joint training, education and data development, the U.S. Department of Health, Education, and Welfare (now the U.S. Department of Health and Human Services) began in the mid-seventies to fund NACHC, the National Rural Health Association, and several of the state and regional associations as a technical assistance network. Initially there were six technical assistance associations funded covering various regions of the country.

Health centers continued to grow under the Jimmy Carter Administration and funding for health center services was expanded through federally supported but state-based Medicaid programs. Just as health centers reflected the needs of individual communities, so too were the coverage, scope, and benefits recipients would receive from the Medicaid programs.

Observed differences resulted in expanded funding for additional associations that could support local analysis and provide data and advocacy. NACHC and the regional technical assistance organizations appealed to the federal government to fund additional associations.

First test against a major threat

In 1981 the Ronald Reagan Administration proposed a series of optional Block Grants under the banner of a “New Federalism” policy giving the states the authority over many health, mental health, and social services programs, including the Health Center Program.

NACHC members mobilized and successfully pushed back against the Block Grant and authority over the program remained with the federal government. This effort made it clear that individual state associations could focus locally and feed the national association with the support it needed in Washington.

As the number of community health centers grew, the number of state and regional associations increased as well. As President and CEO of the Massachusetts League of Health Centers and the first state association leader to be elected President of NACHC in 1985, I championed the growth of the primary care associations and encouraged more funding and NACHC support. By 1986 with federal investments, associations representing health centers spread across the country, in Puerto Rico and the U.S. territories.

The modern era of primary care associations

Working in concert with NACHC, state and regional primary care associations have grown their program competencies beyond building local relationships and into responsive fact and data-based organizations.

NACHC and primary care associations today are capable of providing technical assistance and services, training and education and certification programs, workforce development initiatives and promoting analytics at the local level. Communication and connection have been expanded with technology, and association capacity continues to provide states and the federal government with data and technical support. NACHC’s capacity too has grown along with health centers and S/RPCAs.

The Affordable Care Act (ACA) and optional state-based expansion of Medicaid programs have provided additional opportunities for primary care associations to share and apply best practices and data among each other and through NACHC to inform health center staff and boards and others on strategic initiatives in some states that could be replicated.

With federal support all primary care associations are now focused on outcomes and quality measures sharing data and advancing the impact of health centers serving as patient-centered medical homes.

Value over volume has taken shape especially with challenges now faced during the COVID-19 pandemic. What were once very small and limited associations, NACHC, regional and state-based primary care associations, have all grown keeping pace with the growth of the Health Center Program that now serves 30 million people in all 50 states, the nation’s capital, Puerto Rico and U.S. territories. As one federal official acknowledged the growth and maturity of primary care associations, he reminded that “You’re not puppies anymore.” And as NACHC’s President and CEO Tom Van Coverden says, “We are stronger together.”