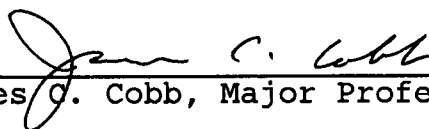
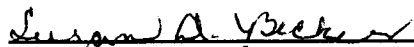


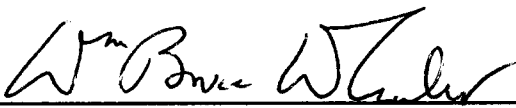
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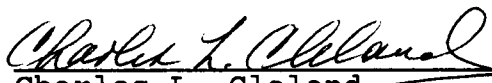
I am submitting herewith a dissertation written by Edythe Ann Quinn, entitled "Delivering Health Care to Rural America: The Community Health Center Program in Southwest Virginia, 1975-1994." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in History.


James C. Cobb, Major Professor

We have read this dissertation
and recommend its acceptance:


Susan D. Becker


William Bruce Wheeler


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Accepted for the Council:


Associate Vice Chancellor
and Dean of The Graduate School

DELIVERING HEALTH CARE TO RURAL AMERICA:
THE COMMUNITY HEALTH CENTER PROGRAM
IN SOUTHWEST VIRGINIA, 1975-1994

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Edythe Ann Quinn
December 1994

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DEDICATION

This dissertation is dedicated to my children

Leah Ann Caro

and

Richard Gregory Caro.

IN MEMORIAM

Harry Jordan

January 9, 1913 - June 25, 1993

עֲשֵׂה שָׁלוֹם בְּמִרוֹמָיו, הוּא יַעֲשֶׂה שָׁלוֹם עָלֵינוּ וְעַל כָּל-
יִשְׂרָאֵל, וְאָמְרוּ אָמֵן.

IN MEMORIAM

John William Shanks, III

March 25, 1951 - March 22, 1994

"And so, my fellow Americans:
ask not what your country can do for you
-- ask what you can do for your country."

John Fitzgerald Kennedy

ACKNOWLEDGEMENTS

I would like to thank my dissertation director, Dr. James C. Cobb, for guidance. I would also like to thank the other committee members, Dr. Susan Becker, Dr. W. Bruce Wheeler, and Dr. Charles L. Cleland, for their assistance. My thanks also go to Dr. Michael McDonald for his encouragement and Dr. John Gaventa for his continued interest. However, throughout, the opinions, conclusions, and shortcomings are mine alone. The University of Tennessee awarded me a Hilton A. Smith Graduate Fellowship for the 1993-94 academic year, giving me time to concentrate on my writing; the History Department awarded me several Bernadotte Schmitt research grants, giving me the means to travel to collect data. To the University and Department, I express my thanks. The Rockefeller Archives Center awarded me a research grant in Summer 1989 that assisted me in starting this project; I thank the Center.

To the residents of the Dungannon-Fort Blackmore area of southwest Virginia and the administrator and health care professionals of Clinch River Health Services, I express my thanks for their cooperation and kind assistance.

My personal debts are great. I thank my children's father, Saul M. Caro, who encouraged me to complete my education and whose support and friendship never failed. To my children Leah and Richard Caro, my deepest thanks for their love, encouragement, good humor, and "advice." For his mentoring and love, I thank Dr. Robert C. Dalglish.

Over the past six years I have been blessed by being part of an informal but very real support system of women, and I wish to express my thanks. I thank my daughter Leah, my closest friend, who has taught me more about feminism than any text; my sister Winnie who made her home my refuge whenever I needed a break; and my minister and friend, the Reverend Shirley Delap who practices what she preaches and is a role model of love and service. My neighbor Linda Wright welcomed me with open heart; her concern has never faltered. Thank you, Linda. Connie Lester, my colleague and friend, has earned my deep respect and affection for she is truly "a woman of valor." To my other friends, I thank them for the gifts they have shared: Janet Krantz, for courage; Carol Kelly, for humor; Margaret Stair, for fortitude and faith; Margaret Brown, for lightness and grace; Jennie Brooks, for forthrightness; Pam Ray and Marsha Martin, for compassion; Rosemary Wakeman, for élan; Chris Moore, forchutzpah; and Susan Becker, for commitment. I thank all for their friendship.

One dreary day when I was tired and feeling sorry for myself, I found this message displayed at my optician's: "Be thankful for the work you have to do and be thankful that you have the skill, strength, and brains to do it." I am. I close by acknowledging my thanks to God, the Source of all my blessings.

Through many dangers, toils and snares,
I have already come;
'Tis grace has brought me safe thus far;
and grace will lead me home.
("Amazing Grace")

ABSTRACT

This dissertation is a history of Clinch River Health Services, Inc., a federally funded, rural community health center that has served the communities of Dungannon and Fort Blackmore in southwest Virginia since 1978. It is also a concise history of the evolution of the United States Public Health Service's rural health activities from 1900 through its administration of the community health center program, under the Rural Health Initiative policy. The dissertation concludes that the rural community health center program, in general, and Clinch River Health Services, in particular, have succeeded in delivering comprehensive, primary health care to medically-underserved communities. Consistent federal funding through the Public Health Service's Rural Initiative program (with its concept of positive programming) greatly contributed to the success. Also contributing to the success are components of the health care model itself: the inclusion of curative and preventive primary care; the use of health care teams, including mid-level providers; the commitment to community representation in governance; and the promotion of supplemental services, such as health education.

However, the research demonstrates that the community health center program's success is vulnerable: at the national level, it depends on executive and legislative politics and bureaucratic management; at the local level, it depends on socioeconomic conditions; the ability to recruit and retain health care professionals, especially physicians; and the commitment and assertiveness of the board of directors.

The research included a careful examination of Clinch River Health Services, Inc., applications for federal assistance; interviews with health care professionals, administrators, and board members at Clinch River Health Services, and Public Health Services officials; as well as a thorough reading of secondary sources.

The dissertation consists of an introduction and seven chapters: 1. U.S. Public Health Service's Involvement in Rural Community Health Care, 1900 - 1960; 2. Legislative History of the Community Health Center Program, 1960 - 1977; 3. Introduction to Clinch River Health Services, Inc.; 4. Organization and Opening, 1975 - 1978; 5. Service and Crisis, 1979 - 1985; 6. Growth and Decline, 1986 - 1990; 7. Maturity and Success, 1991 - 1994.

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TIME LINE

- Jan. 8
1964 President Lyndon B. Johnson delivered State of the Union Address to Congress, declaring "War on Poverty."
- Aug. 20
1964 Economic Opportunity Act became law, administered through Office of Economic Opportunity (OEO).
- Spring
1965 OEO sponsored first two neighborhood health centers, Columbia Point Health Center, Boston, and Tufts-Delta Health Center, Mound Bayou, Ms.
- Jul. 13
1965 OEO established the Office of Health Affairs (OHA) and funded six additional neighborhood health centers (one jointly with PHS).
- Apr. 26
1966 National Commission on Community Health Services presented its report, Health Is a Community Affair, culminating four years of research and identifying community health problems and advocating solutions in line with those under consideration by OEO.
- Nov. 8
1966 Amendment to Economic Opportunity Act authorized OEO to develop and implement Comprehensive Health Service Program (neighborhood health centers).
- Dec. 5
1967 "Partnership for Health Amendments of 1967:" Amendment to Public Health Service Act permitted PHS to authorize grants for comprehensive health planning and public health services, including neighborhood/community health centers. Broke PHS's traditional barrier between funding curative and preventive care.
- Dec.
1967 DHEW published its report, Delivery of Health Services for the Poor, endorsing comprehensive health center model and proposing 620 centers to serve nation's poor.

- 1970 Vanderbilt University students formed Rural Student Health Coalition (RSHC) to assist rural communities in solving their health problems by organizing health centers.

- 1974 Under orders by Nixon administration, OEO completed transfer of all its neighborhood health centers to the PHS.

- Jul. 7
1975 "Special Health Revenue Sharing Act:" gave PHS's community health center (CHC) program its own separate and distinct legislative authority. Divided services into primary (required) services and supplemental (optional) services.

- July
1975 PHS created Rural Health Initiative program (RHI) to coordinate federal funding for rural CHCs. RHI incorporated the concept of "positive programming" to fund centers according to "greatest need," based on community's demographic and health status.

- Summer
1975 Rural Student Health Coalition conducted health fair in Dungannon-Fort Blackmore, Va; informed communities of RHI/CHC program.

- Fall
1975 Residents of Dungannon-Fort Blackmore formed a health council and started fundraising to establish a CHC.

- Mar. 22
1976 Health council incorporated as Clinch River Health Services (CRHS).

- 1976 DHEW assigned the classification "community health centers" (CHCs) to neighborhood health centers, family health centers, and similar institutions.

- Jun. 19
1976 CRHS's "cornerstone laying" for CHC building; continued to conduct fundraising and clinic building.

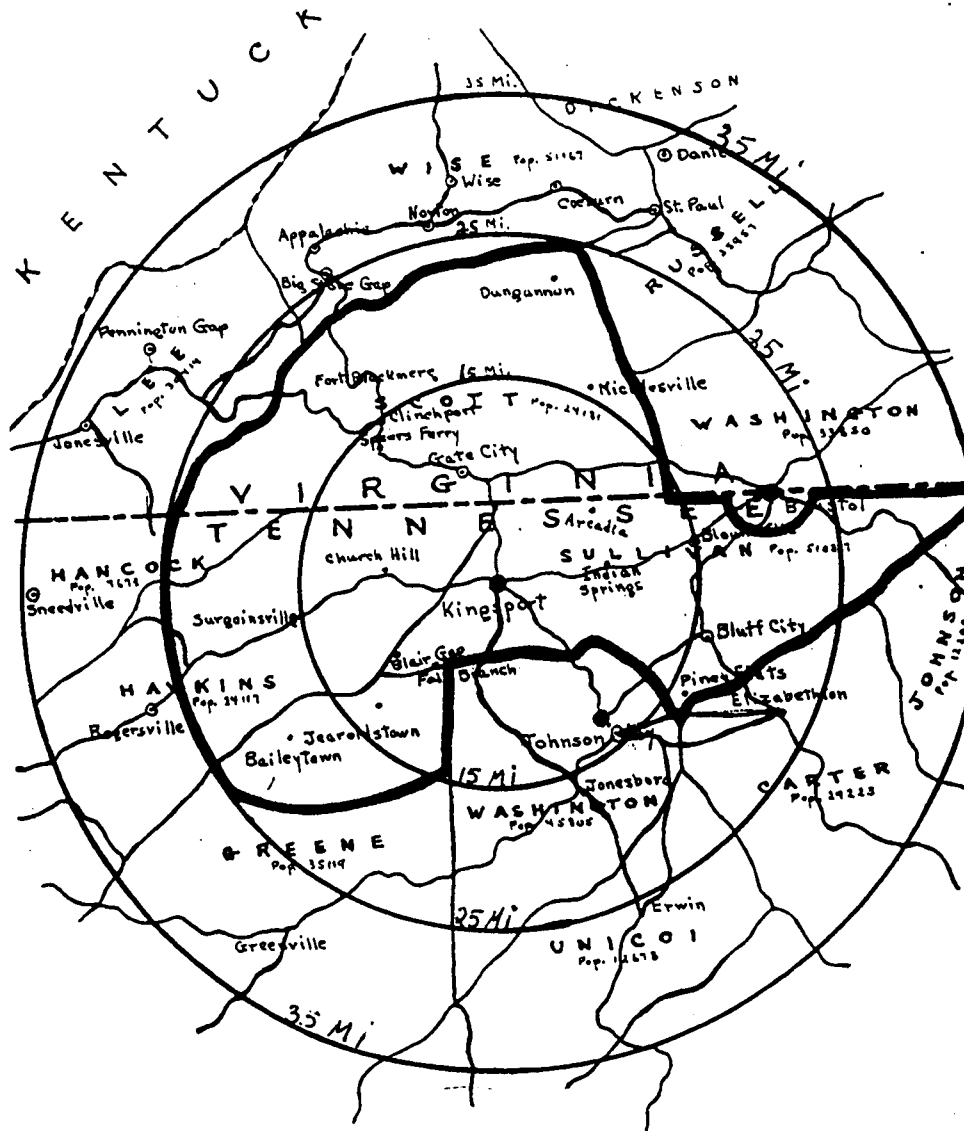
Nov. 29 1976	National Health Service Corps designated Dungannon-Fort Blackmore area a "health scarcity area," enabling health personnel who served CRHS to qualify for loan forgiveness.
fy1977	Carter administration doubled number of RHI projects funded, including CRHS.
Oct. 1978	Community Health Center legislation created the category of "priority supplementary services" to improve funding status of certain services, e.g., dental services and health education.
Dec. 1978	CRHS became fully operational, with 2 physicians and 1 dentist.
1981	Congress placed CHC program in its own "primary care block grant" to protect it from Reagan's (new) New Federalism system of block grants to the states.
1982- 1984	CRHS lost its physicians; struggled to continue services with a nurse practitioner supervised by a team of physicians from Kingsport Family Practice. Utilization rate sharply declined.
July 1984	RSHC conducted a small health fair in Dungannon-Fort Blackmore to promote the clinic.
June 1985	Dr. Todd Cassel started practicing at CRHS. Utilization rate improved.
Apr. 24 1986	Congress repealed CHC block grant and created separate categorical grant program for CHCs.
June 1987	Dentist left CRHS.
Jun. 30 1988	Dr. Todd Cassel left CRHS.

July 1988	Dr. Henry Tam started practicing at CRHS. Utilization rate held steady.
June 1990	Dr. Tam left CRHS. Carolyn Bowen joined CRHS as administrator.
Sept. 1990- June 1991	CRHS was without a physician; depended on a nurse practitioner, supervised by team of physicians from ETSU's Family Practice Department. Utilization rate sharply declined.
1991	PHS initiated Clinical Performance Measures for all CHCs.
July 1991	Dr. Gary E. Michael started practicing at CRHS. Utilization rate slowly improved.
Nov. 1991	Campaigning on health care reform, Democrat Harris Wofford defeated Republican Richard Thornburg for vacant U.S. Senate seat for Pennsylvania, igniting national health care debate.
July 1994	Dr. Todd Cassel joined Dr. Michael to practice at CRHS. Utilization rate at highest point in CRHS's history.

LIST OF ABBREVIATIONS

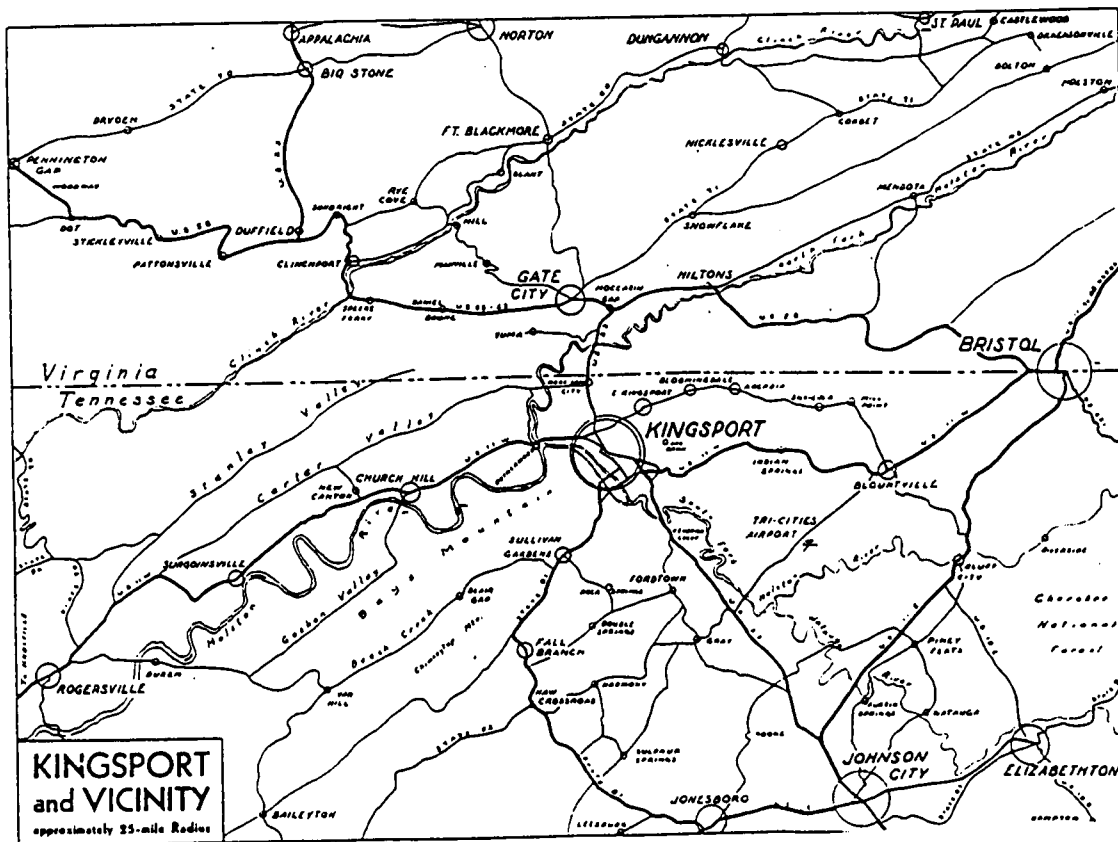
AFDC	Aid to Families with Dependent Children
AMA	American Medical Association
APHA	American Public Health Association
ARA	Area Redevelopment Administration
ARC	Appalachian Regional Commission
BCHS	Bureau of Community Health Services
CCDB	County and City Data Book
C/MHCs	Community and Migrant Health Centers
CPM	Clinical Performance Measures
CRAN	Clinical Regional Advisory Network
CRHS	Clinch River Health Services
DHEW	Department of Health, Education, and Welfare
DHHS	Department of Health and Human Services
DDC	Dungannon Development Commission
EMIC	Emergency Maternity and Infant Care Act
ETSU	East Tennessee State University
FSA	Farm Security Administration
HVCH	Holston Valley Community Hospital
HVH & MC	Holston Valley Hospital & Medical Center
IHS	Indian Health Service
LENOWISCO	Lee-Norton-Wise-Scott Planning District Commission
MIHOW	Maternal and Infant Health Outreach Worker program

NACHC	National Association of Community Health Centers
NCCHS	National Commission on Community Health Services
NHC	Neighborhood Health Center
NHSC	National Health Service Corps
NRHA	National Rural Health Association
OEO	Office of Economic Opportunity
OHA	Office of Health Affairs
PHS	Public Health Service
PHS-IHS	Public Health Service-Indian Health Service
RHI	Rural Health Initiative
RSHC	Rural Student Health Coalition
SMHS	Stone Mountain Health Services
TVA	Tennessee Valley Authority
UHI	Urban Health Initiative
UMWA	United Mine Workers of America
WIC	Women, Infants, and Children program



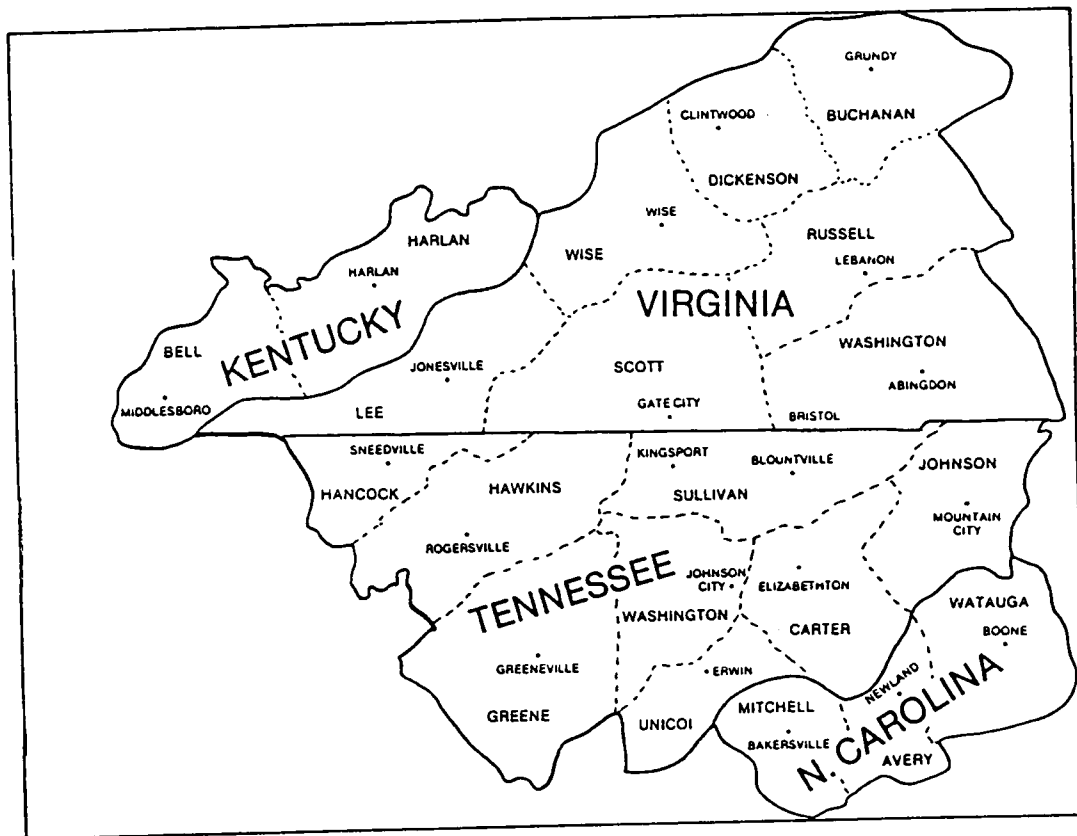
ROCKEFELLER ARCHIVE CENTER

Map submitted with 1933 hospital application from Kingsport, Tenn., community leaders to the Rural Hospital Division of The Commonwealth Fund. The map showed the proposed hospital's service area. Note Dugannon is within the twenty-five mile radius. Rural Hospital files. Box 58. Folder RH801. The Commonwealth Fund Collection, Rockefeller Archive Center, North Tarrytown, N.Y.



Map from Bennett & Edwards' "Map and Guide to Kingsport, Tennessee," submitted by Holston Valley Community Hospital board of directors to the Rural Hospital Division of The Commonwealth Fund, on January 16, 1947. The map showed the hospital's service area. Note Dungannon is within the twenty-five mile radius. Rural Hospital files. Box 66. Folder RH893. The Commonwealth Fund Collection, Rockefeller Archive Center, North Tarrytown, N.Y.

XX



Holston Valley Community Hospital, We've Grown to Serve You Better, 1977-78 Annual Report, (Kingsport, Tenn.: Holston Valley Community Hospital, 1978), n.p.; Local History Collection, Kingsport Public Library, Kingsport, Tenn. Note: Dungannon is northeast of Gate City, Va.; it would be located just below the last "t" in Scott [County].

INTRODUCTION

In 1987 the "congressionally mandated" Rural Health Research Agenda Conference issued this statement, "There is a need to identify, evaluate, and disseminate information on successful innovative rural health care models."¹ In 1994 in the midst of a health care debate, there is an even greater need for such research. This dissertation is an attempt to identify, evaluate, and disseminate information on one such successful innovative rural health care model, the rural community health center program.

Since 1966, through its community health center program, the United States Public Health Service has succeeded in bringing comprehensive, primary and preventive

¹Larry Patton, "Setting the Rural Health Services Research Agenda: The Congressional Perspective," Health Services Research 23 (February 1989): 1009. The National Rural Health Association and the Foundation for Health Services Research sponsored the Rural Health Research Agenda Conference (San Diego, California, December 13-15, 1987); the National Center for Health Services Research, Health Care Technology Assessment, and the Health Care Financing Administration provided support. Patton, p. 1005.

health care to poor, medically underserved communities. With the establishment of its Rural Health Initiative policy in 1975, the Public Health Service has greatly improved the program's ability to serve rural America. Since 1978, Clinch River Health Services, Inc., a community health center established under the policy and funding of the Rural Health Initiative, has successfully delivered comprehensive, primary and preventive health care to the people of the Dungannon and Fort Blackmore area of southwest Virginia.

However, the success of the rural community health center program has depended on the ideological currents of national politics and on the workings of the Public Health Service bureaucracy. Clinch River Health Services's success has depended on both the program's success at the national level and on socioeconomic conditions and community and professional commitment at the local level. While the communities served have more control over forces at the local level, they have less control over forces at the national level. Therefore, the rural community health center program and the centers themselves, such as Clinch River Health Services, are successful but vulnerable.

The success of the rural community health center program may be attributed principally to consistent federal funding and administration by the Public Health Service.

The Public Health Service created the Rural Health Initiative, an innovative, bureaucratic policy with the advocacy concept of "positive programming," to coordinate federal funding and assist the community health center program to penetrate rural areas of greatest need, for example, the Dungannon-Fort Blackmore area of southwest Virginia. Unfortunately, the community health center program's dependence on federal funding has made it vulnerable to attacks by the President and/or Congress.

The community health centers' success may also be attributed to components in the model itself. For example, the centers' health professionals deliver not only preventive care but also primary treatment; that is, they treat the majority of a community's health problems. In administering the community health center program, the Public Health Service officials fully overcame the careful distinction earlier public health program administrators maintained between diagnosis, referral, and preventive services and actual treatment. In order to offer comprehensive, primary treatment, the centers operate through the team approach, utilizing the services of a variety of health care professionals, including mid-level providers such as nurse practitioners.

For its community health center program, the Public Health Service mandates community representation and partic-

ipation in the formation and governance of the centers, thus aiding the program's local acceptance and adaptability. The Public Health Service also encourages the centers to offer supplemental non-medical services addressing social and environmental problems that affect the health status of the community. Although important to the community health center program's overall success, these last two factors have had a more ambiguous and controversial history.

Despite Public Health Service guidelines, community participation, especially by the lowest-income members of the population served, often falls far short of the ideal. And the degree of local success in governance and outreach depends on a board's dedication, attitude, and actions. In response to political dictates, the Public Health Service compromised the status of non-medical services from mandatory to supplemental.

In conclusion, the rural community health center program has succeeded, but its success has depended on funding, policy, and design factors that are vulnerable to national and local forces.

This dissertation is a history of the Public Health Service's rural community health center program as it operates through Clinch River Health Services, Inc., a rural community health center serving the Dungannon-Fort Blackmore area of southwest Virginia. To provide historical back-

ground, Chapter One is an analysis of federal programs -- in particular, those under the auspices of the Public Health Service -- that delivered health care to rural communities from 1900 to 1960. By tracing the development of federal health care programs in general, and in particular Public Health Service programs for rural communities, we gain an appreciation of the Public Health Service's readiness to assume responsibility for the community health center program in the early 1970s. Several commentators on federal health care reforms, for example, Alice Sardell, Karen Davis, and Cathy Schoen, lamented the transfer of the community health center program from the Office of Economic Opportunity where it originated as part of Lyndon B. Johnson's War on Poverty to the Public Health Service.² They criticized the Public Health Service's conformity and bureaucracy and its stress on cost containment and efficiency in contrast to the Office of Economic Opportunity's operation, which they described as innovative and guided by

-----² Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986 (Pittsburgh: University of Pittsburgh Press, 1988). Karen Davis and Cathy Schoen, Health and the War on Poverty: A Ten-Year Appraisal (Washington, D.C., The Brookings Institution, 1978). Although the Office of Economic Opportunity originated the program in the mid-1960s and referred to it as the neighborhood health center program, the later title and broader identification, community health center program, will be used throughout.

a social justice mission. A closer look at the Public Health Service's record in rural health delivery, however, will demonstrate its long history of innovation and openness to concern for social issues.

Chapter Two is a presentation of the legislative and bureaucratic history of the community health center program from 1960 through 1977 when Clinch River Health Services was funded. Although community health centers were not protected by legislation until 1966, the historical analysis begins in 1960 with John F. Kennedy's election to the presidency. Concepts important to the program appeared in legislation and bureaucratic programs during his administration. For example, the concept of community action and participation appeared in juvenile delinquency prevention programs originating in the office of Attorney General Robert F. Kennedy. Also, policymakers in the administration discussed the writings of John Kenneth Galbraith, Michael Harrington, and Harry Caudill, social critics who had recognized the link between poverty and illness, between lack of economic development and lack of health care facilities in poor communities. Important pieces of Kennedy proposed health care legislation, for example, the Migrant Health Care Act of 1962, featured concepts and services that later appeared in the community health center program. Also, beginning in 1962, the Public Health Service was one

of the major contributors to the National Commission on Community Health Services's four year study.³ The Commission's report addressed many of the concerns and concepts embodied in later health care reforms, especially in the community health center program.

The neighborhood health center program -- from which the community health centers evolved -- originated in the Office of Economic Opportunity, an executive agency established by Lyndon B. Johnson in 1964 to administer his War on Poverty programs. Therefore, this second chapter briefly recounts the roots of the program in Johnson's administration. The analysis then focuses on the 1967 legislation that allowed the Public Health Service to authorize and fund community health centers, and continues its focus on the Public Health Service's administration of the program.

The transfer of the community health center program from the Office of Economic Opportunity to the Public Health Service in the Department of Health, Education and Welfare occurred early in Richard M. Nixon's first term. During the New Federalism of the Nixon and Ford administrations, the executive branch attempted to demolish the Office of

³ National Commission on Community Health Services, Health Is a Community Affair: Report of the National Commission on Community Health Services (Cambridge, Harvard University Press, 1967).

Economic Opportunity programs, including the community health centers. Meeting the challenge, allies in Congress, bureaucrats in the Public Health Service, and supporters in the rural communities and their associations prevented the destruction of the community health center program. But in the course of the attacks and defense, the program changed, with reduced emphasis on non-medical services that addressed social and environmental problems and with increased focus on medical care.

However, in response to the negative pressures from the executive branch, program defenders designed two important protections. In 1975 under the Special Health Revenue Sharing Act, Congress gave the centers their own separate legislative identity. Also in 1975, bureaucrats in the Bureau of Community Health Services in the Public Health Service designed the Rural Health Initiative, an administrative policy that has integrated the funding and support for the rural community health centers, and through the practice of positive programming has allowed the program to serve communities with the greatest need. These measures, along with continued federal funding, are responsible for the success of the program.

Chapter Two concludes with a discussion of the community health center program's status during Jimmy Carter's presidency. While the Carter administration was a window of

opportunity for the growth of the centers, it was not a reversion to the idealistic and experimental climate of the Office of Economic Opportunity. Efficiency and cost effectiveness, rather than experimentation, became the bywords. However, there was an increase in funding and in the establishment of new centers, including Clinch River Health Services, the center under study.

Chapters Three through Seven present the history of Clinch River Health Services; beginning with its community organizing in 1975, through its incorporation and funding in 1976 and 1977, to its opening in Autumn 1978, following its operation through to Autumn 1994. Chapter Three begins with a review of the community health center model and the concept of primary care, reiterates the components of a successful health center, and explains the reasons for choosing Clinch River Health Services as a representative rural community health center operating under the Rural Health Initiative policy in the Public Health Service.

Two other institutions that influenced the health status of the area, Holston Valley Hospital and Medical Center in Kingsport, Tennessee, and the Dungannon Development Commission, are introduced here. Holston Valley Hospital has been the communities' choice for tertiary care since its opening in 1935. The Dungannon Development Commission is an excellent example of a grassroots organi-

zation founded as a spinoff of the community spirit generated by mobilizing around health care. The Commission sponsors programs, for example, housing rehabilitation and surplus food distribution, that address social and environmental problems which affect the health status of the population. Following the introductory material, data on the demographics of the county in the early 1970s demonstrate the twin problems of poverty and inadequate health services. At this point, a brief history of the area is also given.

Although Clinch River Health Services demonstrates features unique to its communities' demographics, needs, and leadership, it does not vary greatly from any of the common characteristics of a rural community health center. While its location in the southern mountains is a consideration in the analysis, it is not an overwhelming one; its problems are common to most community health centers in low-income rural areas.

Chapter Four, 1975 - 1978, documents the community leaders' efforts to bring health services to their area. Fort Blackmore and Dungannon residents succeeded in their efforts in 1975, when, in cooperation with Vanderbilt University's Rural Student Health Coalition, the two towns co-sponsored a health fair. In the aftermath of the successful health fair, the communities organized a non-profit

corporation to construct a community health center building. This chapter is an analysis of the dynamics of community organizing -- especially the fundraising efforts that evoked community spirit, the role of outside agencies, such as TVA, and the process of applying for federal funding and recruiting health care and administrative personnel. The chapter concludes with the center's opening in Fall 1978. The factors that have been instrumental in the success of the rural community health center program were in place: federal funding and technical support from bureaucrats in the Public Health Service; physicians (and a dentist) to provide comprehensive primary care; a health educator to stress preventive care; and a board of directors to insure community representation and participation in governance.

Chapter Five, 1979 - 1985, begins with a study of the board of directors, discussing the degree to which it represented the health center users, especially the lowest-income patients, and its method of operation in relation to the goals of the center as expressed in the Articles of Incorporation. The chapter then details the center's history from 1979, its first year of operation, through 1985, years of great contrasts, with a period of growth and stability when the center enjoyed physician services, and years of decline and instability when the center was left without a physician and had to rely on a nurse practitioner supervised

by visiting physicians. Utilization rates, third party reimbursements, physician recruitment and retention efforts, and the communities' acute and chronic health problems and the center's programs to treat them are analyzed. Especially important to the 1990s debate on national health insurance, the difficulties encountered by uninsured and underinsured patients are discussed at length.

Despite major problems with physician recruitment and retention and some weaknesses in governance, throughout these years Clinch River Health Services provided comprehensive primary health care to the communities. The continued cooperation of the Public Health Service bureaucrats assured consistent funding even during the years of crisis when utilization rates declined. Two main factors necessary for success, therefore, remained constant, federal funding and the cooperation and assistance of the Public Health Service.

Chapter Six, 1986 - 1990, examines Clinch River Health Services in its maturity during the services of two different physicians, both of whom enhanced the center's visibility in the area. Relying on the dramatic increase in the amount of information demanded in the Rural Health Initiative application, an in-depth examination of the health status of the community, the medical programs, and the referral network is possible for these years. For example, one major and complex health issue, the high percentage of

smokers among the population and the high rate of illnesses attributed to tobacco smoke, is discussed. Also, the arrangements with area hospitals to admit and care for patients from the center are examined, as are the difficulties those arrangements presented for both the center physicians and the patients. A review of these years reenforces the fact that physician-centered services increase center utilization. The period ended with a downturn as the center lost its physician and had difficulty recruiting another. To keep from closing, the center operated with a nurse practitioner under the supervision of a group of physicians affiliated with East Tennessee State University College of Medicine's family practice department.

The socioeconomic circumstances of the surrounding area, affected by a major coal strike, an increase in the poverty rate, and the continued departure of physicians from the region's small towns, demonstrated the great need for Clinch River Health Services' continued operation. The importance of continued federal funding is emphasized, as well as the Public Health Service's continued support.

Chapter Seven is a detailed examination of the period 1991 to 1994, a time of gradual recovery after Clinch River Health Services again secured the services of a physician and retained the services of the nurse practitioner, giving the center a medical team. Based on an increase in utili-

zation and revenues in the early 1990s, the Public Health Service permitted the center to recruit a second physician who began practicing in summer 1994. During this time, under the direction of the Public Health Service, the center's administrative and medical staffs initiated a new system of clinical performance measures designed to improve assessment of health problems and the delivery of care. Again, with the increased volume of data available, a detailed look at health status and medical procedures is possible. Based on interviews with physicians and Public Health Service officials, a critique of the clinical performance measures at the local, state, and regional level is offered. These measures allow a more systematic and realistic appraisal of the quality and quantity of health care being delivered by community health centers.

During this period, the Public Health Service also directed the center's board of directors to revise its bylaws to include term limits, in an effort to correct stagnation and introduce new participants in the process of community governance. A concluding section of this seventh chapter evaluates the center's sixteen years of performance in meeting its own objectives and the recommendations of the National Rural Health Association in its 1992 report on successful rural health care delivery systems, a report contracted under the Public Health Services Act.

This study has provided an opportunity to place the historical account of legislation and bureaucratic policy in a working context. Throughout the study of Clinch River Health Services from 1978 through 1994, relevant executive and legislative decisions made in Washington D.C. are included. Decisions made at the federal level by the president, Congress, and the Public Health Service bureaucrats determined the operation of community health center program at the local level. Thus, the legislative and administrative processes and the local operation are connected.

However, conditions and decisions made at the local level to a substantial degree affected the performance of Clinch River Health Services and its success or failure in delivering health care to its local community. Therefore, the study is concerned with the people -- both outsiders and local residents -- who played a role in the founding and operation of Clinch River Health Services, and with local events and decisions that shaped the center's structure and performance.

Due to the limited archival resources for Clinch River Health Services in its beginning years, a history of its early operation is gleaned from the few available grant applications and from interviews with health care providers, the administrator, and board members. For the middle and later years of this study as the reporting procedure for

grants became more complex, more information was recorded. Due to differences in reporting requirements over the years, the availability of information was not consistent for each grant period. Changes in health status, center utilization, reimbursement, and services offered are examined within the chronological narration, rather than as separate topics.

From all accounts, written and oral, the conclusion was overwhelming. At the end of the study period, 1994, with sixteen years of operation to its credit, Clinch River Health Services was successfully delivering comprehensive primary and preventive health care to the community. Above all else, over the years this rural community health center succeeded because federal funding covered the persistent gap between its operating costs and reimbursements, and the Public Health Department bureaucrats offered continued support and guidance.

CHAPTER 1

U.S. PUBLIC HEALTH SERVICE'S INVOLVEMENT
IN RURAL COMMUNITY HEALTH CARE, 1900 - 1960

In 1900 no one could have predicted that starting in the late 1960s the federal government and the U.S. Public Health Service would be the major funding source and administrator (respectively) for rural community health services, in particular, for the rural community health center program. Throughout the nineteenth century, public health programs had been the province of city governments and philanthropic agencies, with some organization being achieved at the state level. The major public health impetus for much of the century focused on control of the deadly epidemics, such as yellow fever and cholera, that periodically visited the major port cities and spread inland. Quarantine regulations and sanitary campaigns generated enormous enthusiasm and some funding while the threat was present but funds and fervor dwindled after the threat passed.

Ongoing public health measures to protect the health and welfare of the community were mostly urban activities to correct urban problems, for example, unsanitary conditions

caused by rapid population growth, generated by the influx of poor European immigrants and blacks and whites from rural areas. The United States was still basically a rural society, clinging to its belief that the countryside was a clean and wholesome environment.¹

The federal government's role in public health, while extremely limited, was initiated in the late 1700s. Acting upon European and colonial precedents, in 1798 Congress established the U.S. Marine Hospital Service to be responsible for directing hospital services for merchant seamen, whose health was vital to our nation's commerce. Exposed to hazardous working conditions and foreign epidemics and moving constantly between our ports, these seamen needed a central authority to administer the hospital services to which they contributed through compulsory deductions from their pay.²

During the nineteenth century, the federal government acquired other medical responsibilities, but always in a restricted capacity so as not to interfere or compete with the police powers of the states. A definite pattern emerges in analyzing the groups for whom the federal government

¹For the preeminent public health history, see John Duffy, The Sanitarians: A History of American Public Health (Urbana and Chicago: University of Illinois Press, 1990).

²Duffy, pp. 159-160.

provided medical services. The groups are either vital to our national interests, such the merchant seamen or members of the armed forces (and in extension, military veterans); threats to our national health and welfare, such as lepers, or arriving immigrants with potentially deadly diseases; or wards of the nation, such as native Americans on reservation lands, felons incarcerated in federal prisons, or, from 1865-1869, freedmen who were treated in 56 hospitals and 48 dispensaries operated by the Freedmen's Bureau.³ These groups tended to be in isolated, underserved, or protected circumstances; and there was little or no competition for their medical care from private practitioners.

Beginning in the 1870s in the trend towards bureaucratic organization, professionalization, and specialization at all levels of business, government, education, medicine, philanthropy, and social welfare, public health emerged as a new medical specialty. In 1872, public health specialists founded the American Public Health Association (hereafter APHA). In 1879 in the aftermath of the 1878 yellow fever epidemic that swept through all the lower Mississippi and Gulf Coast ports and up the Mississippi Valley, the APHA leadership persuaded Congress to authorize a National Board of Health. With limited powers and funding, this first

³Ibid, p. 116.

federal health agency developed a national quarantine system and assisted cities, counties, and states in establishing or improving their health boards.

However, the Surgeon General of the Marine Hospital Service successfully blocked the reauthorization of the National Board and it terminated in 1893. The Marine Hospital Service, which had already assumed responsibility for examining arriving immigrants for contagious diseases, assumed all the national quarantine and public health responsibilities. Thus, in 1900 the Marine Hospital Service was the dominant federal health agency with expanding responsibilities, powers, and funding. In 1902 Congress reorganized and renamed the agency the United States Public Health and Marine Hospital Service, and in 1912 adjusted the title to the United States Public Health Service (hereafter PHS). In addition to its sanitation, quarantine, and research responsibilities, the PHS continued its support for state and local public health departments, increasing its focus on rural problems.⁴

With the majority of local public health efforts in the late nineteenth century occurring in the cities, for example, in engineering water and sewer systems, in legislating pure milk standards and in establishing well-baby

⁴Ibid., pp. 164, 168, 170-72, 240, 242.

clinics and school medical examination programs, the health of urban populations had steadily improved. Slowly the country realized that the health of its rural population was lagging. On February 9, 1909, President Theodore Roosevelt presented to Congress the report of the Commission on Country Life. Among its recommendations for cooperative efforts to improve rural living, the Commission urged "better sanitation, for easy preventable diseases hold several million country people in the slavery of continuous ill health." The preventable diseases included dysentery, typhoid, gastroenteritis, and, especially in the South, hookworm infestation, pellagra, and malaria. The Commission criticized the "lack of adequate supervision of public health," and recommended "[i]ncreasing the powers of the federal government in respect to the supervision and control of the public health."⁵

In 1916, William J. Bray of the American School Hygiene Association called the rural community "the most unhealthful

-----⁵U.S. Congress, Senate, "The Roosevelt Commission Report," Senate Document 705, 60th Congress, 2nd sess., 9 February 1909, and L. H. Bailey et al, "Report of Commission on Country Life -- A Summary," (Washington, D.C.: 23, January, 1909), reprinted in Rural America 7 (January 1929): 4-6; for a discussion of health problems among rural children in the South, see D. Clayton Brown, "Health of Farm Children in the South, 1900 - 1950," Agricultural History 53 (January 1979): 170-187.

place in which to live." For example, while the public health agencies of Kansas City and St. Louis, Missouri, could rightly claimed great improvements in city children's health, a survey of six rural Missouri counties showed that "country children [were] distinctly worse off than city children." When the Missouri governor's office and voluntary associations called upon the PHS to assist the state in organizing rural public health programs, the federal agency eagerly agreed and sent field workers to the state.⁶

The PHS adroitly used its child hygiene campaign as a "wedge" to establish public health programs and promote a host of public health activities: birth registration campaigns, maternal and infant hygiene programs, well-baby clinics, school health examinations, and nutrition demonstrations. According to Peter Romanofsky who studied the PHS effort in Missouri, the PHS's goal was "permanent local health projects which local citizens would maintain and develop further, especially baby, children's and community health centers." Romanofsky quoted a PHS officer as saying, "The more [community] people ... become actively involved

⁶Peter Romanofsky, "To One Common End': The United States Public Health Service and the Missouri Child Hygiene Movement, 1919-1921," Bulletin of the History of Medicine 52 (Summer 1978): 251, 252, 254.

with the health center work, the more likely it is to be [successful].'"⁷

Public health organization in New Mexico, which was admitted to statehood in 1912, is a good example of the levels of PHS assistance to state governments in establishing health departments. This new state with a widely scattered, rural population had essentially no public health services and one of the nation's highest rates in infant mortality. Upon a request from the governor, in 1918 the PHS assigned a medical officer to survey New Mexico's public health needs and, in 1919, to supervise the organizing and staffing of the new health department. Further assistance to the developing public health system came from the PHS, the federal Children's Bureau, the Rockefeller Foundation, and The Commonwealth Fund.⁸

While health was acknowledged to be poor across much of rural America, public health officials recognized that health problems were worst in the South. Besides the common rural illnesses, such as dysentery and gastroenteritis, the South was tormented by its distinctive diseases, malaria,

⁷Ibid., pp. 254, 255.

⁸Duffy, p. 231; The Commonwealth Fund, "The Anglos Go Nursing," The Commonwealth Fund: Eighteenth Annual Report of the General Director for the Year Ending September 30, 1936 (New York: Commonwealth Fund, 1937), pp. 71, 77.

hookworm, and pellagra. The South's poor health was worsened by the region's widespread poverty and inadequate public health services. In cooperation with the Rockefeller Foundation and The Commonwealth Fund, the PHS increased its efforts to establish and improve county health departments throughout the region. Some of the most dramatic improvements came as a result of the work of two PHS Hygienic Laboratory scientists. Charles W. Stiles's work on hookworm infestation and Joseph Goldberger's research on pellagra led to the control and treatment of those problems.⁹

Whether considering the community health centers the PHS was promoting in Missouri, well-baby stations in Georgia, pre-natal clinics in New Mexico, or rural school medical inspections in Maine, in all instances, the PHS and the local government agencies were offering only preventive services: health education, examination, diagnosis, and referral to private physicians for actual treatment. The PHS, local public health agencies, and private institutions

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 For an excellent discussion of the interaction between poverty, culture, and disease in the South, see James O. Breeden, "Disease as a Factor in Southern Distinctiveness," in Disease and Distinctiveness in the American South, eds. Todd L. Savitt and James Harvey Young (Knoxville, University of Tennessee Press, 1988), pp. 1-23; for a comprehensive study of the health of poor whites and blacks in the South, see Edward H. Beardsley, A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South (Knoxville: University of Tennessee Press, 1987); Duffy, pp. 232, 233, 241, 229.

sponsoring public health programs, for example, The Commonwealth Fund, all carefully distinguished between preventive and curative care. Strictly avoiding competition with private medicine, they offered preventive care but left treatment in the hands of fee-for-service physicians. The roots and continuance of this rigid dichotomy are complex. Briefly, private practice physicians, dedicated to protecting their incomes and professional freedom, controlled the American Medical Association (hereafter AMA) and exerted enormous influence through local medical societies. The AMA at the national and local level influenced politics and, in turn, policy. Because public health officials received their training in medical schools that condemned state medicine and held fee-for-service, private medicine sacred, they accepted the arrangement. And in the aftermath of the Bolshevik Revolution, there was widespread fear of Soviet inroads into our government and institutions. Any usurpation of the private practitioner's role was seen as socialism, the establishment of state medicine.

However, while limited to offering only preventive care, the number of public health endeavors and sponsors grew. Besides the PHS, other federal government agencies undertook programs, especially in child hygiene. The Children's Bureau, established in 1912 in the U.S. Depart-

ment of Labor, designated 1918 as "Child Health Year."¹⁰

One of the most substantial public health efforts resulting from the focus on child health was the Maternity and Infancy Act of 1921, better known as the Sheppard-Towner Act.

The Act was a logical outgrowth of the development of national child welfare agencies and a demonstration of the power of the recently enfranchised women. Rosemary Stevens pointed out that the Sheppard-Towner Act "emphasized the growing social implications of modern medicine." Like the Children's Bureau, its administrative agency, the Act developed from the "social work movement," rather than from the pediatric and/or public health specialties. In their efforts to reduce maternal and infant mortality and preventable childhood diseases, the program administrators recognized the "correlation between poverty and the mortality rate."¹¹ However, the Sheppard-Towner pre-natal and infant

¹⁰ In 1917, in light of the fact that "38 per cent of farms boys [were] found physically unfit for military duty" in World War I, the Farmers Educational and Cooperative Union (the National Farmers Union) called for "an improved child health program in rural areas." Frederick D. Mott and Milton I. Roemer, Rural Health and Medical Care (New York: McGraw-Hill Book Company, 1948), p. 467.

¹¹ Duffy, p. 248; Rosemary Stevens, American Medicine and the Public Interest (New Haven: Yale University Press, 1971), p. 144; J. Stanley Lemons, "The Sheppard-Towner: Act: Progressivism in the 1920s," Journal of American History 55 (March 1969): 776; Sheila M. Rothman, Woman's Proper Place, A History of Changing Ideals and Practices, 1870 to the Present (New York: Basic Books, 1978), pp. 140-141.

health centers were stuck in the rigid categorical framework of the period: the "public health nurses and female physicians" preached prevention, offered advice on personal hygiene and infant care, but avoided any treatment that would create competition with private medicine.¹² Unfortunately, that distinction was not enough to save it from the AMA's wrath.

Since Sheppard-Towner was not a PHS program -- and in a sense competed with the Service for funding and prestige -- its main relevancy here is its demonstration of the impact and importance of substantial federal funding. An initial grant went to each state that applied to the program, with additional grants based on a state's population and its ability to provide matching funds. To appreciate its impact, it is compared here with a philanthropic program in child hygiene operating in the same period. From 1922 to 1929, The Commonwealth Fund, a New York City-headquartered philanthropy concerned with promoting rural health and child health, sponsored four Child Health Demonstrations as exemplary models of public health and child welfare. During the same time, the administrators of the Sheppard-Towner Act implemented 2,978 permanent centers of prenatal care,

¹²Rothman, Woman's Proper Place, pp. 140-41.

183,252 health conferences, and 3,131,996 home visits by public health nurses.¹³ The major difference here is the source and size of the funding: the generous but limited philanthropic contribution of The Commonwealth Fund compared to the federal grants with state matching funds of Sheppard-Towner. The federal appropriation amounted to \$1,480,000 for fiscal 1921-22 and \$1,240,000 for fiscal year 1922-23 through June 10, 1927, scarcely enough for the need and work envisioned, but a portion of this money was matched by state funds, so the final expenditure was well over the \$2,720,000 federal appropriation. From 1922-29, The Commonwealth Fund recorded appropriations of \$1,100,445 for "Community Health." The four Child Health Demonstrations undoubtedly received the major portion of this money; the line item began in 1922 with the establishment of the program. The four sites also contributed to the maintenance of the Demonstrations through city and county public health appropriations.¹⁴

¹³Lemons, pp. 781, 785. Between 1922 and 1929, The Commonwealth Fund sponsored four Child Health Demonstrations: two urban projects, Fargo, N.D., and Athens, Ga.; two rural projects, Rutherford County, Tenn., and Marion County, Ore. For a history of the Demonstrations, see, A. McGehee Harvey and Susan L. Abrams, "For The Welfare of Mankind: The Commonwealth Fund and American Medicine" (Baltimore: Johns Hopkins University Press, 1986), pp. 91-107.

¹⁴Lemons, p. 781; The Commonwealth Fund, Historical Sketch, 1918-1962 (New York: 1963), p. 104.

According to John Duffy, Sheppard-Towner was not the first federal use of matching grants, but he noted that the Act "firmly established the principle of using matching grants for social purposes." Consequently, Duffy said, it served to enforce the "idea that medicine could not be divorced from society." Likewise, Stevens noted that thereafter physicians, especially pediatricians and obstetricians, had to recognize the social aspects of their practices in the wake of the attention generated by Sheppard-Towner.¹⁵

In her analysis of Sheppard-Towner services, Sheila Rothman explained that the Act's administrators focused the services "first on families living in rural areas and second on those in small towns." Recognizing the warning signs -- the number of physicians was decreasing in rural areas and poor, isolated populations suffered higher infant and maternal mortality rates, they established services among these high-risk rural populations. In this first experiment in federally-funded clinics, only a community which had specifically requested a clinic received one, signalling to the Bureau that at least "some influential citizens were

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¹⁵The Chamberlain-Kahn Act of 1918 established a program to treat venereal disease and employed this funding strategy. Duffy, p. 249; Stevens, p. 144.

committed to preventive health care." As hoped for by the Children's Bureau officials and clinic administrators, the local women rallied around community health reform, waging campaigns, for example, for improved sanitation, pure milk standards, and compulsory school attendance laws.¹⁶

The end of this social experiment came on June 30, 1929. The Sheppard-Towner Act's demise was engineered mainly by the AMA, with an assist from some right-wing "patriotic" women's groups lobbying charges of bolshevism and from the Catholic Church. Duffy pointed out an additional problem that weakened the campaign to renew Sheppard-Towner and continued to plague legislation for the poor; that is, "[t]he act's chief beneficiaries, poor women and children, were not an effective political force...."¹⁷ Ironically, if the Sheppard-Towner program had been administered by the PHS it may have fared better. Throughout the campaign for renewal and the struggle against the AMA, the Sheppard-Towner program did not receive endorsement or support from the PHS, a federal agency known for its tenacity in protecting its territory from all invaders, especially other

¹⁶ Sheila M. Rothman, "Women's Clinics or Doctors' Offices: The Sheppard-Towner Act and The Promotion of Preventive Health Care," in Social History and Social Policy, eds. David J. Rothman and Stanton Wheeler (New York: Academic Press, 1981), pp. 184-85.

¹⁷ Duffy, p. 249.

federal agencies -- no matter how worthy their programs and good their intentions.

In summer 1929 as the Sheppard-Towner program expired, ending federal funding for the maternal and infant health care centers -- many of which served rural communities, President Herbert Hoover announced the first meeting of the White House Conference on Child Health and Protection. In the October 1930 issue of Rural America, Ray Lyman Wilbur, M.D., Secretary of the Interior and Chairman of the White House Conference, reported the White House Conference's special sub-committee's preliminary findings:

Motherhood and infancy are more hazardous in rural districts than in the city. The limited supply of doctors, longer distances to be traversed and poorer roads contribute to this hazard.¹⁸

He also reported that the "investigation of public health service and administration" drew attention to the dangers of typhoid and other diseases resulting from inadequate sanitary measures.¹⁹ Obviously, a great need for public health programs at all levels of rural government existed at a time when the Depression was worsening the already depressed farm economy.

¹⁸Ray Lyman Wilbur, M.D., "The White House Conference and the Rural Child," in Rural America 8 (October 1930): 6.

¹⁹Ibid., p. 7.

State health boards, crippled by budget cuts, staff reductions and program cancellations, appealed to the PHS for special emergency grants. From 1930 to mid-1933, with dwindling resources to draw on, the PHS resorted to a funding selection process that hurt the poorest counties, many of which were in rural areas, especially in the South. Edward H. Beardsley reported that "[small] county health units ... and units lacking assurance of continuing local or state support were automatically excluded from assistance." In its efforts to protect the best public health operations, the PHS used a short-sighted selection method that insured that "only those departments which did not really need help could get it."²⁰ This funding policy would slowly change in favor of the disadvantaged communities.

The election of Franklin D. Roosevelt and the commencement of the New Deal brought about the greatest shift in public health responsibility in U.S. history, as funding and control passed from the states to the federal government. As Beardsley explained, previously the PHS had acted in an "advisory capacity" to the states. With the federal government becoming the major funding source and with the PHS serving as chief conduit and administrator, Washington set

²⁰Beardsley, p. 154.

"overall direction." As the PHS director of the southern region remarked, "The Service should accept without question the fact that it is the leader of the public health movement in the U.S." With the imposition of federal guidelines and regulations, regional and state differences in public health program content and quality lessened.²¹

Within the New Deal's plethora of relief, recovery, and reform agencies, several are especially relevant to this review of the federal government's delivery of health care to rural communities: the Federal Emergency Relief Administration and the Works Progress Administration (hereafter FERA and WPA respectively), the Farm Security Administration, and the Social Security Administration. The federal programs offered by these agencies fell into three categories: large-scale projects, community programs, and health care delivery services.

The PHS grabbed at the opportunity to administer the medical piece of Harry Hopkins's enormous FERA/WPA pie, enabling it to protect and expand its authority in public health. FERA, and later the WPA, funded the construction of sanitary privies, the establishment of anti-malaria projects, and the employment of public health nurses. In the

²¹Ibid., pp. 156, 165.

rural communities, the WPA funded medical and dental examinations in schools; health services for crippled children; and nutrition, prenatal and postnatal programs. Still mindful of the need for proper relations with both the state public health agencies and the private medical establishment, the federal government required local public health programs to be approved by the state board and avoid services that would compete with private physicians.²²

Of all the pieces of New Deal legislation, the Social Security Act had the greatest impact for long-term delivery of services to rural populations. Title V of the 1935 Act allowed matching categorical grants to states for maternal and child welfare programs, the funding to be administered by the Children's Bureau; Title VI allowed the PHS to assist state and local governments "in establishing and maintaining adequate public health services." Duffy commended the Act as greatly assisting in the growth and improvement of state public health services. For example, in Wisconsin, under Social Security Act financing, the state board of health expanded "rural health activities."²³

This expansion of public health services throughout rural America was only possible because of federal funding.

²²Ibid., pp. 157-159.

²³Duffy, pp. 258-59.

At the start of the Depression, philanthropic foundations, including the Rockefeller Fund, had severely reduced or even ended their contributions to rural public health programs. And the level of federal funding was critical to the proliferation and success of services. Beardsley compared Social Security funding to Sheppard-Towner's appropriations. All of Sheppard-Towner's state programs shared an annual appropriation of about \$1.25 million. In contrast, the Social Security program allocated \$3.8 million for maternal and infant care, and \$8 million for state and local health services.²⁴

However, to receive a share of this money, the federal government required states and local governments (combined) to provide "dollar-for-dollar" matching funds, a stipulation that would eliminate the most medically needy but fiscally impoverished communities. Fortunately, one mechanism in the funding process allocated special funds "solely on the basis of financial need," thus allowing totally impoverished areas, especially in the rural South, to acquire greatly needed services. Equally important as state/local funding responsibilities demanded by the federal government, the PHS demanded that state boards receiving Social Security monies

²⁴Beardsley, pp. 153-54, 163.

meet high standards for operating public health programs. Thus, more uniformity came to public health services across rural America.²⁵

The New Deal program that is most relevant to this review of federal delivery of rural community health services is the health clinic system of the Farm Security Administration (hereafter FSA), created by the Bankhead-Jones Farm Tenancy Act of 1937. In order to relieve the devastating sharecropper and tenancy problems, especially in the South, the FSA made available low-interest, long-term loans so that tenant farmers and sharecroppers could purchase their own family-size farms. While boasting of the high rate at which its farmers were repaying their loans, the agency noticed that when defaults did occur they were often caused by illness suffered by the farmer or his family. FSA director Will Alexander concluded, "...a family in good health is a better credit risk than a family in bad health."²⁶

The FSA tried to protect the farm families' health through two approaches: government-sponsored health insur-

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²⁵Ibid., pp. 163, 165.

²⁶Richard A. Couto, Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South (Philadelphia: Temple University Press, 1991), p. 264.

ance, utilizing local, rural physicians contracted to serve the FSA-sponsored farm families; and FSA-established health centers at its larger resettlement sites. The Taos County [N.M.] Cooperative Health Association, a premier operation, offers a relevant model for this study of rural community health centers. As described by sociologist Richard Couto, the center's staff provided "a complete array of therapeutic and diagnostic services with preventive medicine." Although the various sites were staffed differently, the Taos staff included health professionals, clinic aides, a non-medical executive director, and an elected board of local residents. In an area of poor roads and widely scattered dwellings, the Taos program also included transportation for its clientele.²⁷

Athough infrequently considered, the FSA clinics -- featuring federal funding, treatment and preventive care, a team approach, supplemental services, and community representation -- may serve as close precedents for the 1960s/70s community health center model. Here the federal government demonstrated its traditional responsibility for providing medical service to special groups (those in isolated, totally dependent, at-risk, and/or medically underserved

²⁷Ibid., p. 265.

categories). In this case, impoverished transients whose poor health and wretched living conditions threatened the public health were generally neglected by or rejected by local community service agencies and the medical establishment, out of prejudice and/or already constrained resources.

Mobilization for World War II stripped the FSA of funding for its farm family health centers. However, in a scenario reminiscent of the Children's Bureau's struggle to promote Sheppard-Towner clinics, all along the FSA had been competing against powerful interests. As William E. Leuchtenburg pointed out,

The FSA had no political constituency -- croppers and migrants were often voteless or inarticulate -- while its enemies, especially large farm corporations that wanted cheap labor and southern landlords who objected to FSA aid to tenants, had powerful representation in Congress.²⁸

Unlike the Children's Bureau and the FSA, the PHS was a more politically astute and entrenched federal agency with a record of protecting itself and its programs, and accommodating the established powers, especially the AMA and the APHA. That political and bureaucratic savvy would serve it well in promoting and protecting its community health center program

²⁸Couto, p. 266; William E. Leuchtenburg, Franklin D. Roosevelt and the New Deal, 1932-1940 (New York: Harper & Row, 1963), p. 141.

from political competition or opposition in the 1970s and 1980s. Under the PHS the rural community health center program would also serve middle-income people in underserved communities, gaining valuable support from these active and articulate voters.

In 1937 the Interdepartmental Committee to Coordinate Health and Welfare Activities, created in 1935 by presidential order, set up a Technical Committee on Medical Care to evaluate the nation's health needs and recommend a national health program. Among the agencies represented on the five member taskforce, the PHS had three representatives.²⁹ While much of the report, delivered to the President in 1938, dealt with the correlation between income levels, health needs, and medical service utilization, several recommendations are relevant here. Recognizing the unmet health needs of all age groups, the committee called for "more comprehensive public health services" and addressed the inadequate distribution of physicians, dentists, nurses, and hospitals in rural areas and small communities. The committee also noted:

...[H]ealth and diagnostic centers are greatly needed in rural areas where they may serve as centers for the local health department staff,

²⁹Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Harper Collins, 1982), p. 275; Duffy, p. 261.

local physicians, visiting nurse services, maternal and child welfare staff, basic laboratory and other diagnostic services, emergency beds, etc.³⁰

While these centers were to be limited to diagnostic and preventive services, the committee "conservatively estimated" that the construction of "about 500 such centers" could serve communities without local hospitals," but "adjacent to areas which have local hospitals" where acute care could be delivered.³¹ Although these centers were not full-service community health centers -- the barrier between preventive and curative care still in place -- they represent a move in that direction.

One of the initial goals of the Interdepartmental Committee was to coordinate the various health and welfare programs created by the New Deal. As demonstrated here, various federal agencies funded or administered New Deal programs delivering health services. For example, the Children's Bureau in the Labor Department administered Title V programs of the Social Security Act; the PHS in the Treasury Department shouldered responsibility for Title VI

³⁰ Josephine Roche, "Special Report: A National Health Program and Some Proposals Toward Its Design," Journal of the American Medical Association 110 (26 February 1983): 656-665, especially 665.

³¹ Ibid., p. 665.

programs and FERA/WPA health projects, as well as its traditional responsibilities; and the FSA operated medical services. These are but a few of the many examples of fragmented responsibility, often resulting in duplication of services. In 1939, the Reorganization Act -- supported by the Committee -- attempted to "consolidate federal health, education, and welfare services" by creating the Federal Security Agency. In the process, the Public Health Service, the Children's Bureau, and other agencies, such as the Food and Drug Administration, came under its administration.³² While these transfers improved coordination to some degree, the federal government was far from achieving an organized health service system.

During World War II, the federal government gained responsibility for the medical care of new groups isolated and/or underserved due to the wartime emergency. During the Depression, another important undertaking of the FSA had been its "operation of sanitary, well-run migratory labor camps" that also offered medical services. During World War II, the migrant farm worker clinics were transferred to the Office of Labor under the War Food Administration. The Office operated "health centers or clinics in about 250

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³²Duffy, p. 261.

areas where agricultural labor was concentrated." According to Milton I. Romemer, the migratory farm worker clinics were staffed by "[d]octors on part-time salary and full-time nurses with rather broad 'standing orders' (shades of the nurse practitioner of the 1970s)...."³³ Here again, the federal government assumed its responsibility to deliver medical care to an at-risk, transient group whose labor was essential to the interests of the nation, that is, food production in time of war.

In a rage of wartime hysteria, abetted by longstanding racism among the civilian white population, early in 1942 the federal government incarcerated 115,000 Japanese Americans, whose only crimes were their Japanese ethnicity and residence on the West Coast. For the duration of the war, at isolated relocation camps in the Midwest and West, the federal government provided medical services for the internees, and it assigned the task to the PHS.³⁴

The federal government had always assumed responsibility for the health care of military personnel. But in

-----³³Stevens, p. 268; Leuchtenburg, p. 141; Milton I. Roemer, M.D., "Historical Perspective of Health Services in Rural America," in Rural Health Services: Organization, Delivery, and Use, eds. Edward W. Hassinger and Larry R. Whiting (Ames, Ia.: Iowa State University Press, 1976), p. 13.

³⁴Duffy, p. 269.

the wake of the largest military callup in U.S. history, it was faced with a new responsibility in treating the civilian dependents of members of the armed forces, in particular, the wives and children who lived in the vicinity of its military bases. For this group, the greatest need was for obstetrical and pediatric care and hospital facilities for childbirth. Around southern bases, this was a major problem as such services were inadequate or did not exist. In order to provide medical, hospital, and nursing care for dependents of servicemen in the lowest four pay grades, Congress enacted the Emergency Maternity and Infant Care Act (hereafter EMIC) in March 1943. One result of the act was the upgrading of participating hospital and health department standards.³⁵

Despite its great service to address a health care crisis in wartime, this program -- administered by the Children's Bureau -- incurred the fury of the AMA. In a replay of its old quarrel over Sheppard-Towner, the AMA was suspicious that the Bureau was trying to use the EMIC to impose "the socialization of medicine in this country." Beardsley explained that the AMA's fears were so great that it "tried, unsuccessfully, to get EMIC shifted to the more

³⁵Ibid., p. 270; Beardsley, pp. 174-75.

manageable PHS," a responsibility the PHS would have undoubtedly welcomed.³⁶

The crisis addressed by the EMIC highlighted the shortage of adequate hospital facilities, especially in rural areas. During the Depression and World War II, many of the nation's hospital facilities had deteriorated and especially during the war new construction and renovations had ceased. In the immediate postwar years, the federal government invested its attention and resources in bricks and mortar projects and research. Therefore, in assigning an overall health care theme for the years 1945-60, William L. Kissick chose the "Federal investment in health care resource development," a decided change from the program and service funding of the previous decades.³⁷ But even in this new emphasis, rural health care was a consideration and the PHS had a role to play.

That investment got underway on August 13, 1946, when President Truman signed the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act. Initially, the act funded only public and community hospital construction, much of it in rural areas, but beginning in 1954, the

³⁶Beardsley, p. 175.

³⁷William L. Kissick, "The Evolution of American Health Policy," Transactions & Studies of the College of Physicians of Philadelphia Set. 5. 11 (1989): 191.

"[p]rogram broadened to include nursing homes, diagnostic and treatment centers, rehabilitation facilities, and chronic disease facilities." However, Hill-Burton's major emphasis remained hospital construction.³⁸

In this review of federal funding and delivery of rural health care, Hill-Burton's relevancy rests in an analysis of its funding process and an identification of the weaknesses therein. In order to insure that the greatest benefit would go to the poorest states, Hill-Burton allocated matching grants based on a formula which considered a state's total population and per capita income. After a federally-funded survey of needs, federal funds were distributed through appropriate channels to agencies or communities that would raise one-half (later one-third) of the construction costs and guarantee continued economic maintenance. In the survey and approval process, after state board of health approval, the PHS delivered the final authorization.³⁹

³⁸The act received bipartisan sponsorship from Senator Harold Burton (R-Oh.) and Senator Lister Hill (D-Al.) and was administered through the PHS. Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (New York: Basic Books, 1989), p. 217; U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Hospital and Medical Facilities, 2 Decades of Partnership: Hill-Burton Program, 1946-1966, Public Health Service Publication Number 930-F-9 (Washington, D.C.: U.S. Government Printing Office, 1966) p. 1.

³⁹Duffy, p. 278; Beardsley, p. 177.

Unfortunately, Hill-Burton's policy operated to the detriment of poor communities. Only economically secure towns could successfully compete for funds, communities which would probably have secured hospitals through their own means. During the congressional debate in 1946, Senator Robert Wagner (D-N.Y.) criticized the financial criterion for awarding grants, stating "...the poorest communities -- the very ones that need help the most; these are the ones that will have to be turned down."⁴⁰ Also, besides raising one-half or one-third of the construction costs of hospitals or other health care facilities, communities had to demonstrate ability to continue economic support. Health care analysts Frederick Mott and Milton Roemer understood that the presence of a large number of prepayment hospital plan subscribers in a community insured the hospital's economic viability; but poor rural areas, especially in the South, had the fewest prepayment plan subscribers.⁴¹ Until an innovative funding mechanism was devised and federal health

⁴⁰U.S. Congress, Senate, Congressional Record, 79th Cong., 1st sess., 11 December 1945, vol. 91, part 1, p. 11,794. For an analysis of Hill-Burton financing, see Dan Feshbach, "What's Inside the Black Box: A Case Study of Allocative Politics in the Hill-Burton Program," International Journal of Health Services 9 (1979): 313-339.

⁴¹Frederick D. Mott and Milton I. Roemer Rural Health and Medical Care (New York: McGraw-Hill, 1948), p. 498.

care coverage for the poor was legislated, poor, rural communities were often unable to compete for federal (and private) grants for health facilities.

As more and more rural communities suffered from the absence of general practitioners and hospital facilities, there was a surge of activity to organize rural health cooperatives. In 1948 the Farm Credit Administration in the U. S. Department of Agriculture and the PHS conducted a study of 48 of the 93 known groups involved in "various stages of development" of rural health cooperatives.⁴²

The communities -- the majority of which were west of the Mississippi -- had considerable experience with cooperative associations, for example, "[c]ooperatives to market farm products, purchase farm supplies, insure property, or secure credit, electricity, and other services...." The federal study found -- as with all cooperatives -- "[t]he members set the goals and determine general policies." However, in the case of health cooperatives, the members and elected board of directors "confine[d] their interests to business aspects of the associations," relying on the physicians to conduct "all professional affairs." The cooperatives offered preventive health care, such as "regu-

⁴²Helen L. Johnston, "Rural Health Cooperatives,"
Public Health Reports 65 (27 October 1950): 1384-85.

lar physical check-ups," besides the curative care, but did not undertake outreach services.⁴³

Economics dictated a large measure of the communities' planning and, consequently, the study's findings. Besides organizing a local health center, the cooperative board had to develop a prepayment plan "to help local families budget the cost of health services" and "to provide regular support" for the center's services. While all the communities studied were rural and medically underserved, very few (only seven) were poor; most "were organized in counties with a rural level of living approximating, or above, the average for the country as a whole." After all, the members had to afford the initial investment, usually between \$50 to \$100, to the building program and the annual dues to the prepayment plan.

Non-members could also receive services by paying "the fees ... customarily charged in the community," but there were no provisions for indigent care. If residents could not afford the membership fee, annual dues, or the customarily charge, they lacked access to care, despite the presence of the health cooperative in their midst. Also, if the area suffered an economic downturn affecting the

⁴³Ibid., pp. 1384, 1395, 1383, 1389.

members, the health service center's existence was threatened. The prospects for keeping the physicians dimmed when the community could not offer them a guaranteed income.⁴⁴

Recruiting and retaining a physician "in an isolated rural community" was a major problem for the surveyed centers. And the local medical societies' opposition to the health cooperatives added to the problem. According to the report, the AMA affiliates often objected to "lay development and control of prepayment systems," and the cooperatives' common practice of "salaried payment to doctors." The medical societies only approved of the traditional fee-for-service arrangement. Where hostility existed, the cooperative's physicians were refused admittance to the local medical societies and denied privileges at the area hospitals.⁴⁵

Through this study, the PHS learned of the potentiality and problems of community-organized rural health centers offering curative and preventive care. To be successful, such centers had to have secure funding, the cooperation of the local medical societies, a plan for recruiting and retaining physicians, and a strong community board with

⁴⁴Ibid., pp. 1384, 1386, 1387, 1390-91.

⁴⁵Ibid., pp. 1391-92.

management skills. The PHS also noted the limits of the cooperative model, that is, the lack of provision for indigent care and outreach services. Most important, the PHS and the Farm Credit Administration concluded:

Although the achievements of rural health cooperatives thus far appear small measured in terms of total rural health needs, the organizations demonstrate interest and willingness on the part of rural people to work for their own health security.⁴⁶

Prior to assuming responsibility for the community health centers in the early 1970s, the PHS's most important experience in providing comprehensive, primary health care to rural communities was its involvement in the Manyfarms Clinic on the Navajo reservation in the 1950s. The Manyfarms Clinic was established as a "community health demonstration project" by the Department of Public Health and Preventive Medicine of New York Hospital-Cornell University Medical Center for the Public Health Service-Indian Health Service (PHS-IHS) and the Navajo Tribal Government.⁴⁷ Although the project operated for only five years, approximately 1955-60, the Manyfarms Clinic had a lasting impact, as explained by several rural health care analysts.

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⁴⁷ Walsh McDermott et al, "Introducing Modern Medicine in a Navajo Community, Science 131 (22 January 1960): 197.

In their history of The Commonwealth Fund and its support of rural health programs, A. McGehee Harvey and Susan L. Abrams stated that the Manyfarms Clinic "was the prototype of [the 1970s] neighborhood health centers." And activist physician H. Jack Geiger, M.D., who with a colleague brought the neighborhood health center concept to the Office of Economic Opportunity, acknowledged the influence of the Manyfarms Clinic as one which "joined curative and preventive medicine in local centers serving defined populations." Kurt W. Deuschle, director of the Manyfarms Clinic, wrote in 1982 that "there are critical lessons learned from that experience that are applicable to the COPC movement today. (COPCs, community-oriented primary care centers, are similar to community health centers.)"⁴⁸

The Cornell team and the PHS physician and project director Kurt W. Deuschle had realized, that given the strong presence of traditional Indian customs, it was important to understand "cultural differences when treating patients." As Deuschle recalled, from the very beginning,

⁴⁸ Harvey and Abrams, p. 299; H. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in Reforming Medicine: Lessons of the Last Quarter Century, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon Books, 1984), p. 17; and Kurt W. Deuschle, "Community-Oriented Primary Care: Lessons Learned in Three Decades," Journal of Community Health 8 (Fall 1982): 14.

the Manyfarms medical staff understood that it was "essential to have community participation and active involvement, thus insuring a close communication between the health providers and the community served." For example, a "health committee" with "district-wide representation," included "several medicine men as members," and consulted regularly with the professional staff. In order to reach the people, the health care professionals also placed "great reliance" on community health workers, who were "bilingual Navajo men and women, trained to the level of a field nurse assistant -- a kind of public health Licensed Practical Nurse."⁴⁹

Besides bridging the cultural gap, an important contribution in itself, the community health workers also extended the services usually provided by the public health nurses. With the Navajo population thinly scattered over rough terrain, the project's public health nurses could only make a few home visits per day and they each had to be accompanied by a "driver-interpreter." The Manyfarms staff created the position of Health Visitor, "a single all-purpose subprofessional worker -- that is, an auxiliary to the field nurse, a driver-interpreter, a sanitarian, and a community

⁴⁹ Navajo Medicine Men blessed the Manyfarms clinic building before it opened for service. Deuschle, pp. 15-16; McDermott, p. 200.

worker all in one."[authors' italics] In contact with the nurses or physicians "by radio-telephone" installed in their vehicles, the trained Health Visitors were able to administer injections and "immunization procedures," record "the patient's basic history" and details of the current problems, and "perform many of the tasks that so frequently consume the time of more highly trained personnel."⁵⁰

While excited about studying the interaction of culture and medicine, Deuschle put the greatest emphasis on studying demographic and epidemiological factors, being able to record fertility and mortality rates, and to describe disease patterns within the strictly defined population. His studies revealed another aspect of community health work. Based on "careful documentation of health and disease problems of the community," Deuschle acknowledged:

[i]t was soon documented that the primary care problems seen in the clinic were, for the most part, preventable, and that overall improvement in the health picture would require major work in health education and health promotion,⁵¹ as well as improvement in socioeconomic levels.

Besides proving what could be done with sufficient federal funding, the Manyfarms Clinic offered valuable

-----⁵⁰Walsh McDermott et al, "Introducing Modern Medicine in a Navajo Community," Part Two, Science 131 (29 January 1960): 282.

⁵¹McDermott et al, 22 January 1960, pp. 200-203; Deuschle, p. 15.

lessons on the importance of cultural sensitivity and communication, community participation, and the utilization of health care teams and community lay workers. Deuschle had also promoted the concept that improving community health required improving socioeconomic conditions as well as health care delivery. By closely preceding the 1960s reforms and by involving so many professionals in public health and community medicine, the Manyfarms Clinic deserved to be cited as "the prototype of today's neighborhood health centers."⁵²

However, as a joint venture of a major university medical center, the PHS-IHS, and the Navajo Tribal Government, Manyfarms demonstration was adequately funded by these sources and by private foundations; but this was only a demonstration, not an ongoing commitment.⁵³ But an ongoing federal program does exist, through the Indian Health Service (IHS) under the administration of the PHS. Through

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⁵²In 1960, Kurt W. Deuschle, M.D. developed a department of community medicine at the University of Kentucky College of Medicine, incorporating the lessons he had learned in the Manyfarms project. In 1968, he moved on to head the Department of Community Medicine at the Mount Sinai School of Medicine in East Harlem, New York City, and there he adapted his rural model to an urban setting. Harvey and Abrams, pp. 299-303.

⁵³McDermott et al, 22 January 1960, p. 198.

a series of treaties dating back to the 1800s it has a "comprehensive federal health program for Native Americans" living on or near reservations. Most of the PHS-IHS budget is allocated for primary medical services delivered through health centers and hospitals, but there are outreach programs as well to address environmental and social problems. This is an excellent example of the federal government's responsibility for delivering health care to special underserved populations, a responsibility carried out in conjunction with the PHS.⁵⁴

But even with federal funding, the PHS-IHS has difficulty in recruiting and retaining medical professionals in isolated posts. Cecil G. Sheps of the School of Medicine and Health Services Research Center at the University of North Carolina at Chapel Hill understood difficulties such those encountered by the PHS-IHS. Even in nations with national health insurance and national health services -- and the United States has neither -- he reported "that special arrangements must be made to provide adequate

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 Sixten S. R. Haraldson, "Health and Health Services Among the Navajo Indians," Journal of Community Health 13 (Fall 1988): 134-35. From 1849 to 1955, the U.S. Department of Interior operated the Indian Health Services; in 1955, the Department turned it over to the PHS. Roemer, p. 14.

medical care resources in an accessible form in rural areas."⁵⁵

Efforts to provide adequate health care in rural America would steadily increase in the 1960s, and the PHS would continue its entrepreneurial drive to enlarge its responsibilities for rural health programs.

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⁵⁵Sixten S. R. Haraldson, pp. 134-35; Roger A. Rosenblatt and Ira S. Moscovice, Rural Health Care (New York: John Wiley & Sons, 1982), p. vii.

CHAPTER 2

LEGISLATIVE HISTORY OF THE COMMUNITY HEALTH CENTER PROGRAM

1960 - 1977

From 1900 through 1960 the federal government had steadily increased its role in funding and/or delivering health services, especially to rural America. With the exception of some categorical and public health programs funded through the Social Security Act, the federal government's ever-expanding role in delivering medical care followed its traditional responsibilities: limiting treatment to groups in isolated or dependent circumstances and/or vital to the national defense or interest. In several cases PHS administration of these projects increased program acceptance by the medical and political establishment and improved the standards, coordination of services, and enforcement of regulations.

Beginning in the 1960s the federal government extensively broadened the population groups it medically assisted and the range of programs it supported, for example, serving poor, underserved urban and rural communities through the community health center program. The literature on the community health centers emphasizes the program's origins in

the Office of Economic Opportunity in 1965. The authors of the studies neglected developments in the national public health community and forces in the PHS that readied that agency to administer the community health center program in the 1970s. This analysis hopes to redress this omission, without ignoring vital contributions of the Office of Economic Opportunity. Thus, this review starts in the early 1960s.

Paul Starr identified several terms as central to health policy during the 1960s: "community," "coordination" "comprehensive services," and "center."¹ They were incorporated in studies, legislation, and bureaucratic policy throughout the decade; beginning in 1962 with the inauguration of a major, joint public and private, community health study. In August 1962, the American Public Health Association (hereafter APHA) and the National Health Council created the National Commission on Community Health Services to undertake a major study of community health needs. The APHA applied to several foundations and the PHS for funding for the Commission's study. Of the \$920,000 raised, the PHS provided "a grant of \$400,000 over a four-year period," and

¹Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Harper Collins, 1982), p. 365.

the Assistant Surgeon General served on the twenty-three member Board of Commissioners.²

Under the chairmanship of Marion Folson, former secretary of the Department of Health, Education, and Welfare (hereafter DHEW), the Commission worked through its board of commissioners, advisory committees, task forces, regional forums, and community research teams. So ambitious was the undertaking that the study took four years to complete, during which time major political and social changes occurred that influenced the final report, published in 1966.³ The Commission's recommendations -- relevant to this study -- are discussed later. However, it is important to note here that its work was not motivated by the anti-poverty movement -- which it preceded -- but by health professionals and civic leaders concerned with the lack of coordination in health services and facilities and the shortage of comprehensive services in cities, small towns and rural communities. The Commission and its Report entitled Health Is a Community Affair represented mainstream America.

²National Commission on Community Health Services, Health Is a Community Affair: Report of the National Commission on Community Health Services (Cambridge: Harvard University Press, 1967), pp. 226-27, 236. (Hereafter, NCCHS)

³Rosemary Stevens, American Medicine and the Public Interest (New Haven: Yale University Press, 1971), p. 515, fn 33.

Although President John F. Kennedy's proposals for mental health and mental retardation programs are outside the scope of this study, several observations are relevant here. Starr pointed out that the "rediscovery of community" found a willing audience in these mental health fields. "Community-based" mental health services were offered --- not at clinics -- but at community health "centers," a careful semantic change to indicate that these units "would go beyond traditional medical functions," as would community health centers.⁴

In March 1961 in introducing the "Health Services Facilities Act (S. 1158), Senator Hubert H. Humphrey (D-Minn.) commented that a physician required a modern office and equipment to do his job and, not often finding these in "the more sparsely populated areas," settled in an urban center where modern facilities were available. Humphrey proposed that an underserved rural community should form "a voluntary health plan organization" and be able to apply for "low-interest, long term loans from the Federal Government" to finance "the group practice facilities" which the community required. He positioned his argument well within the rhetoric of American medical services debates,

⁴Starr, pp. 365-66.

stressing that "no one" wanted "to see the government at the Federal, State, or local level control medicine." Therefore, as an "alternative to Government control or a program of socialized medicine," he proposed that the government encourage the "formation of voluntary groups to meet the medical needs of the people." However, because the proposed legislation concerned "loans -- not grants," the poorest and most medically-needy rural communities were still unable to take advantage of the program. Although Humphrey's legislation was stalled, it did bring needed attention to the medical needs of small communities, encouraged "nonprofit or cooperative" associations, and fostered "comprehensive health services."⁵

President Kennedy's health proposal that is most relevant to this study appeared in his February 27, 1962 Message to Congress. He proposed legislation to improve the health of "domestic agricultural migrant workers."⁶ Passed in 1962, the Migrant Health Act (P.L. 87-692) became "the first piece of migratory labor legislation to be enacted in

⁵U.S. Congress, Senate, "Health Services Facilities Act," 87th Cong., 1st sess., 2 March 1961, Congressional Record, vol. 107, pp. 3024-25.

⁶U.S. Congress, House, "Health and Medical Care -- Message from the President of the United States," H. Doc. 347, 87th Cong., 2nd sess., 27 February 1962, Congressional Record, vol. 108, p. 2993.

more than 30 years." The Act offered assistance, in the form of grants and expansion of PHS activities, for diverse programs initiated by government and community groups. Programs included health centers, usually offering evening hours, and mobile units. Most projects included a strong health education component, and many involved lay health workers, for example, "young bilingual Mexican men and women." Prenatal care and sanitation services were frequently included.⁷

The migrant health bill, labelled "noncontroversial" by a Californian congressman, won general congressional acceptance, in part because of the composition of its clientele and its guarantee of local control. The recipients of its health care and social welfare activities were poor Mexicans, blacks, remnants of "Oakies and Arkies" who had crashed California's border fleeing the Dust Bowl of The Thirties, and some Japanese, Chinese, and Filipinos. These were not people who availed themselves of the services of private practitioners. Most often they waited until their

⁷U.S. Congress, House, "Success of Migrant Health Act," including reprints of Robert J. Anderson, Assistant Surgeon General, Chief, Bureau of State Services, "Migrant Health Act -- Progress Report;" "Medical Plight of Coast Migrants -- I: Health Prospects of 250,000 Brightened by Federal Grant," Medical Tribune (4 October 1963); and "Three Md's and Pilot Projects Offer Health Hope to Coast Migrants," Medical Tribune (7 October 1963), 88th Cong., 1st sess., 18 December 1963, Congressional Record, vol. 109, pp. 25077-79.

illness forced them to use the local hospital emergency rooms, or they utilized the usually underfunded public health department services. As one congressman reported, the migrant workers' "health problems ... throw quite a burden on the local communities, doctors, and taxpayers." The federal assistance was readily accepted. One of the most important factors in the success of the migrant worker health services program was this federal funding, available to communities all along migrant farm workers' routes.⁸

Another important factor in explaining the acceptance of the migrant health care bill was its guarantee of local control. As another Representative from California explained, "Responsibility for planning and conducting the individual programs would remain in the States and local communities where these particular health problems exist."⁹ Local control was deemed important for federally-funded programs, acknowledging states' prerogatives and allowing community flexibility in planning; but consequently, pro-

⁸U.S. Congress, House, "Health Clinic for Domestic Migratory Farmworkers," H. R. 781, 87th Congress, 2nd sess., 10 September 1962, Congressional Record, vol. 108, p. 18894; U.S. Congress. Senate. "Success of Migrant Health Act," Congressional Record, vol. 109, p. 25079.

⁹U.S. Congress, House, "Health Clinic for Domestic Migratory Farmworkers," Congressional Record, vol. 108, p. 18894.

grams depended not only on presidential policy and congressional climate, but also on local political forces.

While concern for the poor is evident in the implementation of the Migrant Health Act, most of the other pieces of Kennedy administration health care legislation do not specifically address the interlocking problems of poverty and poor health services. However, the theories on poverty that later influenced the War on Poverty and subsequently the community health center program became popular among the Kennedy administration's social program planners. In the spring of 1963, "poverty" became a major theme with the New Frontier staff as they discussed Michael Harrington's book, The Other America. Of particular importance here is Harrington's recommendation that "[o]nly the larger society, with its help and resources, can really make it possible for these people [the "invisible poor" among our prosperous majority] to help themselves." Harrington was building on John Kenneth Galbraith's landmark work, The Affluent Society.¹⁰

Galbraith warned that our prospering majority was ignoring the needs of the significant minority of insular

¹⁰ Michael Harrington, The Other America: Poverty in the United States (New York: Macmillan Company, 1962), p. 15; John Kenneth Galbraith, The Affluent Society, 4th ed. (Boston: Houghton Mifflin Co., 1984).

and inarticulate poor, while also neglecting the public services on which those poor depended. According to Galbraith, "Poverty is self-perpetuating partly because the poorest communities are poorest in the services which would eliminate it." "To eliminate poverty efficiently," he called for major investment in improving the public sector, the public services on which the poor -- especially poor children -- depended, including schools and health services. Both Galbraith and Harrington pointed out that the poor also suffered the most illness and had the least medical care.¹¹

Added to Harrington's and Galbraith's national assessment of poverty, Harry M. Caudill's stark portrait of the Kentucky coal lands, Night Comes to the Cumberland, A Biography of a Depressed Area, published in 1963, addressed poverty at the regional level. In the case of the Cumberland, isolation, poverty, and injuries and diseases resulting from work in the mines stressed people's health and burdened already inadequate health care services. He reenforced the case made by Galbraith and Harrington for investment in public services and the infrastructure.¹²

¹¹Galbraith, pp. 252-53; Harrington, p. 15.

¹²Harry M. Caudill, Night Comes to the Cumberland: A Biography of A Depressed Area (Boston: Little, Brown & Co., 1963), pp. 364-92, especially pp. 379, 392.

While Caudill's concerns were centered on the southern mountains, some of the problems he addressed -- poverty, isolation, occupational injuries -- were common throughout rural America.

Although some of Kennedy's advisers and planners may have been motivated to plan programs influenced by the poverty theories they read and discussed, the President was slow to call for comprehensive antipoverty legislation. For the time being, he ordered studies; in September 1963, he created the Task Force on Manpower Conservation and instructed it to submit a report before the end of year.¹³

When Lyndon B. Johnson took office upon President Kennedy's assassination on November 22, 1963, he inherited much unfinished business. As he worked on his first Message to Congress, he had before him the grim Manpower Conservation Task Force report that detailed the crippling results of poverty. In his message delivered January 8, 1964 before Congress, Johnson issued a bold challenge, "This administration today here and now declares unconditional war on poverty in America." He declared, "Poverty is a national problem...." and enlisted federal, state, and local efforts. Very little was left uncovered, from calling for "better

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¹³Richard Reeves, President Kennedy: Profile of Power (New York: Simon and Schuster, 1993), p. 656.

schools, and better health, and better homes, and better training, and better job opportunities."¹⁴

To turn his speech into action, Johnson pushed through Congress the Economic Opportunity Act of 1964, which established the Office of Economic Opportunity (hereafter OEO) to administer programs authorized under this act. The section of the Economic Opportunity Act most pertinent to this study is Title II, entitled Urban and Rural Community Action Programs. Embedded in this Title were the concepts of community action and maximum feasible participation, concepts that manifested themselves in the mandate for community governance of the community health centers.

Historian Arthur M. Schlesinger Jr. and political scientist John C. Donovan recognized that maximum feasible participation and community action programs had their roots in Kennedy administration programs to combat juvenile delinquency. Youth programs sponsored by the Committee on Juvenile Delinquency and Youth Crime in the Office of the Attorney General emphasized maximum feasible participation of the poor. According to Schlesinger, the Attorney General and brother of the President, Robert Kennedy, worked to

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¹⁴U.S. Congress, House, "The State of the Union -- Address of the President of the United States," H. Doc. 251, 88th Cong., 2nd sess., 8 January 1964, Congressional Record, vol. 110, pp. 114-15.

insure that the youth programs "would not just be schemes benevolently imposed by social workers and welfare agencies." He and his staff brought "the poor into planning and execution" of the projects, introducing the concept of "community action." When the House examined Title II, Robert Kennedy testified on its behalf, speaking as follows:

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. ...

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.¹⁵

As explained in the Economic Opportunity Act's "Declaration of Purpose," the Community Action Program would "provide stimulation and incentive for urban and rural communities to mobilize their resources -- to combat poverty." Seen in this light, maximum feasible participation and community action overcame the lethargy of

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¹⁵ Arthur M. Schlesinger, Jr., A Thousand Days: John F. Kennedy in the White House (Boston: Houghton Mifflin Co., 1965), pp. 701, 1008; John D. Donovan, The Politics of Poverty (New York: Pegasus, 1967), pp. 30-35, 40-43, 124-25 U.S. Congress, House, Subcommittee on the War on Poverty Program of the Committee on Education and Labor, "Statement of Hon. Robert F. Kennedy, Attorney General," 88th Cong., 7 April 1964, Committee Hearings, Vol. 2083, p. 305.

poverty and fostered initiative on the individual and community level.¹⁶

In considering Clinch River Health Services, a community health center in a poor, rural county, the founding members employed this rhetoric of selfhelp and incorporated it into the center's constitution. They declared that one of the purposes of the clinic would be

... to lessen the burdens of government, to promote the social welfare of the area, and to encourage local initiative in solving health problems and relieving the poor and distressed and underprivileged residents of these communities.¹⁷

Although the Economic Opportunity Act of 1964 did not specify health care programs for the poor, all the major poverty studies had made the link between poverty and poor health. As H. Jack Geiger cogently explained, "...the land of the poor was also a land of pain, suffering, needless disability, and early death."¹⁸ The initial stimuli to create health care programs came from several areas. The

¹⁶Gareth Davies, "War on Dependency: Liberal Individualism and the Economic Opportunity Act of 1964," Journal of American Studies 26 (August 1992): 210-11.

¹⁷Clinch River Health Services, Inc., "Articles of Incorporation," Article 2(c), 12 March 1976, Clinch River Health Services, Inc. Collection, Dungannon, Va.

¹⁸H. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in Reforming Medicine: Lessons of the Last Quarter Century, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), p. 11.

Task Force on Manpower Conservation's paper, entitled "One Third of a Nation," reported that "one-third of the nation's youth would, on examination, be found unqualified for military service," due in large measure to their suffering the effects of poverty. While some would be rejected because of educational deficiencies, mental retardation, and emotional illness, others would be rejected for poor health, including many ailments which could have been easily corrected with timely and proper health care.¹⁹

Administrators of the earliest OEO programs, the Neighborhood Youth Corps, the Job Corps and Head Start, reported serious health deficiencies within their target groups. For example, administrators and teachers found that many of the children enrolled in Project Head Start had never seen a physician; twenty five percent had "serious untreated health problems;" and many suffered from malnutrition and dental problems. The OEO officials realized that poor health was adversely affecting the performance and

¹⁹ Donovan, p. 26. This same startling revelation occurred after examining World Wars I and II draftees. During World War I, the military rejected over one-third of the draftees as physically unfit for service and discovered that a high percentage of this group was from rural areas. A. McGehee Harvey and Susan L. Abrams, "For the Welfare of Mankind:" The Commonwealth Fund and American Medicine (Baltimore: Johns Hopkins University Press, 1986), p. 84; Frederick D. Mott and Milton I. Roemer, Rural Health and Medical Care (New York: McGraw-Hill Book Co., 1948), p. 467.

potential of persons enrolled in "OEO programs which were designated as the vehicles to move people out of poverty." The federal government would have to get involved.²⁰

Dissatisfied with a few early attempts to incorporate health care in community action projects, the OEO staff sought a comprehensive solution that would offer a new way of delivering health care to the poor. In June 1965 they funded two experimental projects proposed by H. Jack Geiger, M.D. and Count Gibson, M.D., the projects being the Columbia Point Health Center, Boston, and the Tufts-Delta Health Center in Mound Bayou, Mississippi. The Columbia Point center was the first to open, beginning operation in December 1965. On July 13, 1965, the OEO organized an Office of Health Affairs and funded five additional health centers as demonstration projects.²¹ In 1966, Senator Edward Kennedy

²⁰ Elizabeth J. Anderson et al, The Neighborhood Health Center Program, Its Growth and Problems: An Introduction (Washington, D.C.: National Association of Neighborhood Health Centers, 1976), p. 11; Richard A. Couto, Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South (Philadelphia: Temple University Press, 1991), p. 267; Geiger, p. 15; and Isabel Marcus, Dollars for Reform: The OEO Neighborhood Health Centers (Lexington, Mass.: D.C. Heath & Co., 1981), p. 3.

²¹ Anderson, pp. 11-12. Other OEO centers were: Martin Luther King, Jr. Health Center, South Bronx; Lower East Side Center, New York City; Watts Health Center, Los Angeles; Mile Square Health Center and North Lawndale Health Center, Chicago; and the Denver Community Health Center. Geiger, p. 18; Marcus, p. 131.

sponsored and Congress enacted an amendment to the Economic Opportunity Act, appropriating fifty million dollars and authorizing the OEO to "make grants ... 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."²²

In her definitive study of the legislative and bureaucratic history of the community health center program, Alice Sardell identified the three main "elements" of these OEO projects: "(1) community health services, (2) community economic development, and (3) community participation."²³ Community health services designated a full range of curative treatment and preventive services to constitute comprehensive, primary care. Community economic development was a more ambiguous feature. The OEO hoped that community health services and non-medical outreach services would employ local people, promote health and welfare service careers

-----²² Karen Davis and Cathy Schoen, Health and the War on Poverty: A Ten-Year Appraisal (Washington, D.C.: Brookings Institution, 1978), p. 163; Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986 (Pittsburgh: University of Pittsburgh Press, 1988), p. 52. U.S. Congress, United States Statutes at Large, 1966, Vol. 80, Part 1 (Washington, D.C.: U. S. Government Printing Office, 1967), p. 1463

²³Sardell, pp. 52-53.

among local people, and thus create economic development. Community participation in governance, through the board of directors, became a cornerstone of the community health center program.²⁴

A sixth community health center was co-sponsored by the OEO and DHEW.²⁵ This joint sponsorship occurred at a crucial time, coinciding with heightened private and PHS interest in and knowledge of community health care needs and services, as expressed in two reports. On April 22, 1966, Marion B. Folsom, Chairman of the National Commission on Community Health Services, presented the Commission's report, Health Is a Community Affair, to President Johnson. In accepting the report, Johnson said:

Our age, which is an age of miracles, is still an age where too many families must travel too far and pay too much to receive treatment, where health services are not organized to get the full benefit of our health manpower.²⁶

The PHS in DHEW had supported the Commission's four-year study which included the work of six task forces, twenty-one community self-study projects, consultants, and

²⁴Richard A. Couto, "Toward a Human Service Economy," in Communities in Economic Crisis: Appalachia and the South, eds. John Gaventa; Barbara Ellen Smith; and Alex Willingham (Philadelphia: Temple University Press, 1990), pp. 251-62.

²⁵Anderson, p. 12.

²⁶NCCHS, p. 234.

regional and national forums. The final fourteen positions and accompanying recommendations, therefore, represented a broad overview of the concerns of health professionals and concerned civic leaders across mainstream America. Most of the research had been undertaken before the OEO's demonstrations in community health services were widely known. Because the Commission concentrated heavily on state and regional planning of "health service resources," only positions and recommendations relevant to this history of the delivery of community health services are summarized here.²⁷

Central to the highly readable report was the concept of a "community of solution," that is, planning units would be based on "environmental health problem-sheds and health service marketing areas -- rather than primarily on political jurisdictions." This new approach allowed "interrelated communities" to address common health problems and combine resources. The community of solution was responsible for "assuring that personal and environmental health services [were] available to all residents." The health services were to be comprehensive, that is "from detection of disease to rehabilitation, and including environmental control, accident prevention, family planning, and health service

²⁷Stevens, p. 515; NCCHS, p. ix.

information." Because "local needs, preferences, customs, and capacities" differ, variations in the range of health services offered were acceptable, as long as standards were maintained, for example, that "all age groups" were adequately served.²⁸

In order to improve "integration and continuity of all medical and medically related services" the Commission insisted that each person should have a personal physician. That physician needed "to be aware of the many and varied social, emotional, and environmental factors that influence[d] the health of his patient and his patient's family;" and all the available health resources that could be coordinated and mobilized to assist the patient. At the same time, to assist in delivering comprehensive care, the Commission encouraged group practices and health teams including "all those [health care providers, social workers, and lay health workers] who work together to improve the health of people."²⁹

Preventive care and health education were to be integrated, on-going activities, geared to all age groups served. And the location of the health services (for example, all under one roof) and the scheduling (for

²⁸NCCHS, pp. 4, 6, 19, 18; Stevens, p. 515.

²⁹NCCHS, pp. 21, 13, 23, 86.

example, some evening hours) needed to benefit both the providers and the consumers, thus increasing utilization.³⁰

The Commission had not conducted an antipoverty study, nor had it closely examined health care problems of rural communities (the twenty one, intensive "community action studies" involved populations of 30,00 to 3,500,000). But the Commission was not working in a vacuum and had reviewed recent federal studies, research papers, and legislation. Thus, the report acknowledged:

Realistically, health cannot be considered apart from environmental, social, and economic influences. ... The opportunity to work and job security are as essential to man as access to a hospital. Poverty in all its insidious complexities acts like a virus³¹ affecting the health of the total community.

For example, the Commission urged the "community health team," including "indigenous nonprofessionals drawn from the lower socioeconomic groups, to "coordinate its work with efforts aimed at the eradication of poverty."³²

Similarly, its community analysis revealed that group relationships (ethnic, racial, or class) affected a

³⁰Ibid., pp. 62, 25, 29.

³¹Ibid., pp. v, 6-7. Lisbeth Bamberger [Schorr], the member of the OEO team who first recognized the value of Geiger and Gibson's proposal for a community health center, served on the "Task Force on Financing Community Health Services and Facilities." p. 239.

³²Ibid., pp. 28, 86.

community's ability to solve its health problems and "the rights of individuals and groups and their acceptance of each other" needed to be considered in designing solutions. At the same time, the report's authors recognized the need to involve "the interest of the power leadership within the community" in the planning and implementation.³³

Devoting an entire chapter of the report to "Partners in Progress: The Volunteers," the Commission emphasized the "vital role of voluntary participation." Volunteerism was critical to solving community health problems, in both the planning and operation of services. However, the voluntary health agencies needed to include representatives from "all social strata and occupational groups" and work to attract new leaders to avoid stagnation and to assure generational continuity.³⁴

Health Is A Community Affair concluded with a review of "Federal Grants for Public Health," acknowledging:

Federal grants-in-aid have proven a very effective method for providing assistance to bring some underdeveloped health activities up to national standards and to aid communities in maintaining their facilities at satisfactory levels.³⁵

³³Ibid., pp. 8, 9.

³⁴Ibid., pp. 151-166, especially pp. 151-52, 160, 154, and 161.

³⁵Ibid., p. 146.

Even while recommending "special grants to stimulate new health programs," the Commission confessed that the present "federal grant system [was] enormous and complex." It called for "periodic review" and "a consistent policy" to insure an efficient and effective "distribution and utilization" of federal funds.³⁶

In the report, the Commission endorsed all the major components of a community health center: comprehensive, primary, curative and preventive care; delivered by a health team including professionals and lay health workers; offering services at convenient hours and at a central place; with sensitivity to community dynamics, such as ethnicity and class; and concerned with socioeconomic and environmental factors that influence health.

Although Stevens reported that Health Is a Community Affair was "widely distributed," it is ignored in the literature on the development of community health centers.³⁷ Possibly because the health care commentators were themselves emotionally and politically committed to the War on Poverty's mission, they preferred to concentrate on the activities of the OEO, which also had the advantage of being

³⁶Ibid., pp. 146-47.

³⁷Stevens, p. 151. Sardell, Marcus, Starr, Couto, Geiger, Anderson and her colleagues, and co-authors Karen Davis and Cathy Schoen do not mention it.

the first federal agency to put health care centers into operation.

However, the National Commission on Community Health Services's report had an immediate and long lasting effect on the delivery of community health services. Stevens attributed the report to being the impetus behind the Partnership for Health legislation which was signed into law in November 1966 as the Comprehensive Health Planning and Public Health Services Act, P.L. 89-749. While principally concerned with the mechanisms of planning at the federal, state, and local levels, the object of the planning was local "comprehensive health services."³⁸

In December 1967, DHEW -- of which the PHS is a part -- published its own report, Delivery of Health Services for the Poor, which focused on the "personal health care needs of the poor."(italics in original). In proposing health service, the DHEW Analysis Group stated:

The physical and social environment of the poor, including housing, sanitation, education, and recreation, must be given simultaneous attention, and programs in these areas must be³⁹ linked to personal health services programs.

³⁸ Stevens, p. 516

³⁹ U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary (Planning and Evaluation, Delivery of Health Services for the Poor (Washington, D.C.: Government Printing Office, 1967), p. 1. (hereafter DHEW, Delivery)

In its attention to "social injustice and inequities of poverty," the report read more like a War on Poverty document. It confirmed the overwhelming evidence that there was "an undisputable association of increased morbidity and mortality with poverty." The report catalogued the "barriers to receipt of medical services by the poor," including: inability to pay; fragmentation of care, especially at outpatient clinics; lack of facilities and manpower, especially in rural areas and urban ghettos; depersonalized services and difficulties in communication between patients and health professionals; as well as poorly organized delivery features, for example, inconvenient hours of operation, travel distance for the patient population, and long waits for service.⁴⁰

In its design for health care delivery, it reads like Health Is a Community Affair. As its first recommendation to deliver improved health care services for the poor, DHEW proposed "Comprehensive Health Centers" featuring family-centered comprehensive care (preventive, diagnostic, therapeutic, advisory, and rehabilitative services); health care teams (medical professionals, physicians assistants and neighborhood health workers); and participation by the community served. Likewise, the centers were to be well

⁴⁰Ibid., pp. 1, 3, 31-35.

situated for the patient population; offer convenient hours of service; strive to protect the dignity of the patient; arrange and supervise referrals for specialists and hospitalization in order to maintain continuity of care; and operate by integrating all possible funding sources. Understanding that certain rural areas could not support comprehensive programs, the DHEW urged flexible arrangements, such as mobile van clinics for widely scattered rural populations.⁴¹

Of course, these DHEW-proposed centers also closely matched the design of the neighborhood/community health centers being demonstrated by the OEO. Now, either DHEW did a very quick study of the OEO operation -- only thirteen were operational "as of fall 1967;" or it drew on its own studies and experiences, the PHS's 1948 study of rural health cooperatives, most recently the Health Is a Community Affair report which the PHS had supported, and the late 1950s Manyfarms PHS/IHS project. The Manyfarms project had demonstrated the workability of many features of the comprehensive health center, and the Community Affair report had promoted the basic design of such a center -- for mainstream American communities. Throughout the poverty report, DHEW

⁴¹Ibid., pp. 5, 53-55.

noted that "the comprehensive health center concept may also be applicable to non-low-income areas as well."⁴²

While the DHEW report dutifully acknowledged the OEO's demonstration of neighborhood health centers as an innovative means of delivering health services to low-income populations, it was also quick to note that of the forty one centers the OEO funded, "the great majority [had just been funded] in the spring of 1967" and only thirteen were fully operational "as of fall of 1967." And the DHEW pointed out that most of the OEO centers were operated by a "health department, medical school, hospital, [or] group practice," and only "occasionally" by a "newly informed corporation," that is, an incorporated community group.⁴³

Publishing its report in December 1967, DHEW predicted the need for 400 comprehensive health centers to serve "the 10.0 million concentrated low-income metropolitan population," and 220 comprehensive health centers to serve the "5.5 million non-metropolitan low-income population."⁴⁴ That these ambitious figures were never met has been the fault of presidential and congressional politics more than the failure of DHEW/PHS's entrepreneurship and commitment.

⁴²Ibid., p. 52.

⁴³Ibid., p. 39.

⁴⁴Ibid., p. 52.

In 1968 an enormous shift in PHS policy quietly shattered a longstanding tradition. Through its own community health center program, the PHS began directly funding treatment as well as prevention for "poor citizens not covered by a special separate beneficiary authority," such as a categorical disease program. Much as PHS administrators had been opportunistic during the New Deal, "health care reformers" and "policy entrepreneurs" -- aware of the great opportunities presented by the War on Poverty -- broke with their careful distinction between private and public sector responsibilities. Consequently, the PHS received funding authorization for community health centers through section 314(e) of P.L. 89-749, the Comprehensive Health Planning and Public Health Services Act mentioned above, which was amended by the "Partnership for Health Amendments of 1967" (PL 90-174).⁴⁵

Sardell offers the most in-depth analysis of this major transformation within the DHEW and the PHS, crediting a reform "coalition" that included Dr. John Gardner, the secretary of DHEW who had ordered the study, Delivery of Health Services for the Poor, and other DHEW officials. The coalition also counted in its ranks a cadre of "socially

⁴⁵Anderson, p. 14; and Sardell, p. 69; U.S. Congress, United States Statutes at Large, 1967, Vol. 81 (Washington, D.C.: U.S. Government Printing Office, 1968), p. 533.

concerned" physicians and administrators who were serving a "two-year commitment in the PHS" rather than in the military, and even some "career" bureaucrats who supported the agency's direct involvement in providing comprehensive, community health services. The hard-won reforms were solidified in 1968 when the newly-appointed DHEW secretary Wilbur Cohen, a veteran of the New Deal, reorganized the PHS bureaucracy. Community Health Services, a newly created unit, administered 314(e) grants.⁴⁶

As mentioned in the DHEW poverty report, and according to Sardell's informants, community health center advocates in the PHS shared the OEO vision that the new model would not only serve the poor but -- once its innovations had been successfully demonstrated across the nation -- would be adopted by the middle class and allowed to "reform the health care delivery system in general."⁴⁷

⁴⁶Sardell, pp. 68-72. James T. Patterson referred to Cohen as a "welfare expert." During the New Deal, Cohen had served as an aide to the cabinet-level Committee on Economic Security, and had advanced to an advisory position on the Social Security Board. James T. Patterson, America's Struggle Against Poverty, 1900-1980 (Cambridge: Harvard University Press, 1981), pp. 59, 75, 130.

⁴⁷Sardell, pp. 72-73. The model was to incorporate "prepaid practice, the employment of salaried physicians, and the organization of health profession[al]s into multidisciplinary teams." Ibid., p. 72.

In 1969, the community health centers enjoyed a brief period of stability under the Nixon administration, and, as reported by the National Association of Neighborhood Health Centers, "financial support for programs actually increased that year." With two federal agencies operating centers, by 1971 there were 100 OEO- and 50 PHS-sponsored centers.⁴⁸ However, once Nixon was well settled into office, he worked to terminate the OEO itself and either tame or destroy its programs. Fortunately, he permitted the transfer of OEO-sponsored community health centers to the PHS, a process that was completed by 1974.

Although the PHS centers focused more on medical services than outreach -- a sign of the times and presidential influence as much as DHEW dictates -- the PHS policy still incorporated community participation and, as Richard A. Couto noted, promoted the "formation of new nonprofit corporations of community residents to direct the health centers." (As DHEW had been quick to note, the majority of the early centers sponsored by the OEO were located in urban areas and the grantees were medical schools, hospitals, or health departments.)⁴⁹

⁴⁸Anderson, pp. 15-16, 18

⁴⁹Davis and Schoen, p. 171; Couto, Ain't Gonna Let Nobody, p. 284; Marcus, p. 15; Sardell, pp. 77-78.

The transfer also satisfied Nixon's desire for "regionalization of administrative functions," shifting the control from Washington where the OEO had maintained it to the PHS's regional offices. In 1967, in a memorandum to the agency and to regional health directors, the Surgeon General "urged his field staff .. to emphasize the need for delivering comprehensive health services to the poor." Health care analysts criticized this takeover in general and the regionalization in particular. Despite the Surgeon General's message, they feared that the regional bureaucrats did not share OEO's mission or DHEW/PHS headquarter's new philosophy. The record has proved them wrong as the PHS regional bureaucrats became advocates of the program and assisted the local centers with funding and technical guidance.⁵⁰

Reflecting the Nixon administration's priorities, the PHS emphasized "a more efficient management system in the programs" and stressed "financial self-sufficiency." To meet the new economics, the community health centers were permitted to serve "patients who were not poor" and to adopt a "sliding fee schedule based on patients' incomes" for the

⁵⁰ Anderson, pp. 16, 18; Sar A. Levitan, "Healing the Poor in Their Back Yard," in Neighborhood Health Centers, eds. Robert M. Hollister, Bernard M. Kramer, and Seymour S. Bellin (Lexington, Ma.: D.C. Heath and Company, 1974), pp. 62-66. Marcus, pp. 23-24; Sardell, pp. 77-79; Davis and Schoen, pp. 170-71.

near poor. They were instructed to recover, whenever possible, third party reimbursements, for example, private insurance, union, Medicaid or Medicare payments.⁵¹

Suddenly, the centers were no longer simply delivering "poor people's medicine." Former Secretary of DHEW Wilbur Cohen had warned that "Programs for the poor become poor programs."⁵² This change to servicing a broader segment of the community removed some of that onus. While some middle class residents continued to avoid the centers in their community, opting to travel considerable distances for their medical care, others utilized the centers and participated in their governance. Middle class users frequently were more readily available for service as board members, again insuring that the centers were not dubbed "poor people's clinics." Generally, they were more politically active and let their opinions be known to their congressional representatives -- all advantages for the community health center program when it needed their support.

Even with its more streamlined operation, focusing on medical care over non-medical services and on efficient

⁵¹Anderson, pp. 16-17.

⁵²Lisbeth B. Schorr with Daniel Schorr, Within Our Reach: Breaking the Cycle of Disadvantage (New York: Doubleday, 1989), p. 287.

management, the community health center program did not gain Nixon's support. When Donald Rumsfeld, presidential advisor, sent the president a proposal "to establish 800 neighborhood health centers," Nixon rejected it because the idea "looked too much like a revival of the Great Society." Despite rising operating costs and increased utilization, funding for centers was not increased; and between 1971 and 1973, DHEW did not fund any new centers.⁵³

A major factor in the success of the community health center program had been its consistent federal funding. Beginning in 1970, Nixon not only failed to support increased funding, he worked to change the centers' funding mechanism, through his promotion of New Federalism. Had New Federalism succeeded with regards to the community health centers, it might have seriously altered the operation -- and the success -- of the centers. New Federalism would have terminated the centers' federal funding through the categorical grant system and replaced it with a revenue sharing plan, carried out through a block grant system to the states.

Block grants, formulated on a population and income basis, would have allowed the states to implement the funds as they saw fit, throwing the community health center

⁵³Starr, p. 396; Sardell, pp. 78-79.

program onto the rocks of state and local politics and prejudices. In an extensive examination of the financing of health care programs for the poor and underserved, Karen Davis concluded that "programs with considerable state discretion have not had a past record of high performance" in making health care accessible to the poor. The community health center program survived only through continued and forceful congressional opposition to Nixon's proposed cancellation of the program's categorical grant status and to his "substantial cutbacks" in funding.⁵⁴

A bipartisan coalition of congressmen "from rural states and states that contained urban ghettos" supported the community health center program, seeing it as a "noncontroversial" program which served their "unserved" or "underserved" disadvantaged populations. In 1974, Congress initiated and passed legislation specifically describing "community health centers" and authorizing their separate funding. When the President pocket-vetoed the legislation, Congress passed identical legislation in 1975. When President Ford vetoed it, Congress overrode his veto. The

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⁵⁴Sardell, p. 111; Karen Davis, "A Decade of Policy Developments in Providing Health Care for Low-Income Families," in A Decade of Federal Antipoverty Programs: Achievements, Failures, and Lessons, ed. Robert H. Haveman (New York: Academic Press, 1977), p. 230; Davis and Schoen, p. 170.

legislation became the Special Health Revenue Sharing Act (P.L. 94-63) on July 29, 1975, giving the community health center program "its own separate legislative authority."⁵⁵

The labeling of a health care delivery program as "noncontroversial" had also occurred in the bipartisan support of the Migrant Health Act of 1962. When federal programs are not redistributive but rather alleviate severe problems that stress local resources, federal action may be acceptable to conservative parties. Also, when benefits programs include measures for local control, conservative congressmen are generally more comfortable. Despite the taint of Community Action Program activities in urban health centers, most rural centers, especially under the PHS, did not threaten local authorities.

Interestingly, the AMA did not actively oppose the federal funding and administration of community health centers. Sar A. Levitan suggested that one of the reasons for their acquiescence was that "in the past [the AMA had] been tolerant of legislation on behalf of the poor who could not pay 'standard' fees." The centers did not compete, but rather freed physicians and dentists from serving "unpaying

-----⁵⁵ Sardell, pp. 89, 104, 109. Also, in 1976, DHEW assigned the classification "community health centers" to "neighborhood health centers, family health centers (smaller medical centers), and networks of various health providers." Davis and Schoen, p. 170/fn.24.

patients." Even after the centers admitted non-poor, paying patients, they were still serving communities that could not attract physicians without a federal incentive or subsidy program.⁵⁶ However, in the mid 1980s, the AMA, perhaps encouraged by the conservative administration, began to object to the growth of the centers.

The 1975 legislation, P.L. 94-63, gave community health centers a distinct identity but limited their activities. As explained by Sardell, under P.L. 94-63, center services were divided into "primary," that is "required" services and "supplemental" services that were optional. Health and nutrition education, social services, and outreach became "supplemental" to the "required" services, such as medical and dental care, X-ray and lab work. Preventive services and transportation remained in the primary category.⁵⁷

While this law diminished the standing of services addressing social and environmental problems affecting the health of individuals and the community, it protected vital curative and preventive services from Nixon and Ford [or Reagan] hatchets. The two-tier system also reflected Medicare and Medicaid policies that reimbursed traditional

⁵⁶Levitan, pp. 60-61.

⁵⁷Sardell, p. 100.

medical services, but not community non-medical services.⁵⁸ This policy discontinued funding for "supplemental" outreach services in existing centers and discouraged their incorporation in new centers. However, some of these supplemental services later regained improved status. Also, as will be demonstrated in the study of Clinch River Health Services, these auxiliary functions were not always lost but sometimes were carried out by grassroots associations that owed their existence to the creative impulses generated by health care organizing.

The 1975 law built on the OEO's original stress on community action and maximum feasible participation, and on the DHEW's original policy to promote community sponsorship of the centers. Thus, it "mandated" that each community health center would be governed by a "consumer-dominated" board that would serve as "the recipient of all federal funds to the center." The majority of board members had to be "consumers who used the center" and "who, as a group, represent[ed] the individuals being served by the center."⁵⁹ Thus, one of the factors in the success of the program -- community representation and participation -- was preserved and strengthened by the PHS.

⁵⁸ Davis and Schoen, p. 171.

⁵⁹ Sardell, p. 101.

At this time, the majority of community health centers, inherited from OEO or originated within the PHS, served urban populations. However, beginning in 1973, the PHS addressed a need it had long recognized, the "deficiency of health resources in rural areas," for example in the southern highlands.⁶⁰ As contrasted to urban areas, rural areas suffered from higher accident and occupational injury rates; an older and poorer population; and inadequate health services due to fewer physicians and dentists, less access to emergency and primary care, and limited public health services. However, to meet rural needs the predominant model, the comprehensive neighborhood health center, had to be modified to deal with the realities of rural areas: isolation and low population density, fewer social and health service resources, great difficulty in recruiting and retaining health professionals, especially physicians, and limited community experience in technical and management areas needed to apply for and implement federal health service grants.

Therefore, "to improve accessibility, availability, and quality of primary health care services in rural areas," the PHS created the Rural Health Initiative Program in July 1975. This administrative policy, implemented through the

⁶⁰DHEW, Delivery, p. 35; Sardell, p. 112.

Bureau of Community Health Services (hereafter BCHS), urged the establishment of "programs on a much smaller scale," and their coordination with other federal grant programs, specifically the National Health Service Corps (hereafter NHSC). Roger A. Rosenblatt and Ira S. Moscovice placed the impetus for formulating the RHI on the need to integrate PHS resources. Thus, according to these researchers, "resource integration meant that a single site could receive funds from several federal programs at the same time."⁶¹

However, even under the Rural Health Initiative (hereafter RHI) communities were still responsible for "initiating and developing grant applications," and the PHS was concerned that the rural communities with the greatest need but with "little or no capability to develop a grant application" would lose out in the competition for limited federal resources. As experience with many government and

⁶¹Bureau of Community Health Services, "The PHS Rural Health Initiative (Public Health Service, Health Services Administration, USDHEW, 1975), p. 1; quoted in Lois C. Steinfeldt, Gerald E. Sussman, and Michael Decker, "Federal Primary Health Care Projects in Texas," Journal of Community Health 8 (Winter 1982): 111; Sardell, pp. 112-113; Roger A. Rosenblatt and Ira S. Moscovice, Rural Health Care (New York: John Wiley & Sons, 1982), p. 45. The NHSC was authorized by the Emergency Health Personnel Act (P.L. 91-623) in 1970, providing for "the recruitment and placement of physicians and other health professionals in areas that lacked primary care providers." See, Eric Redman, The Dance of Legislation (New York: Simon and Schuster), 1973, for an analysis of its congressional history.

philanthropic programs had shown, community organizers who possessed grant writing skills had the advantage in gaining funds and programs, what analysts refer to as the "principle of cumulative community advantage." In order to overcome the inexperienced communities' handicap, the PHS developed the principle of positive programming, an innovation Sardell called "a form of outreach by the federal government."⁶²

Besides establishing criteria for identifying "priority" areas (usually counties) with the greatest needs, the PHS ordered "the responsible program staff in the regional offices ... to take an active role in the initiation and development of grant applications in needy communities." The BCHS gave a county "priority" status for receiving RHI funding if its statistical data demonstrated its inclusion in several of following critical areas: "High Infant Mortality (HIM) area; Medically Underserved Area (MUA); Critical Health Manpower Shortage Area (CHMSA); and/or High Migrant Impact Area (HMIA). Of particular importance to the study of the Dungannon-Fort Blackmore area of southwest Virginia is the Medically Underserved definition. This designation is calculated on "an index comprised of

⁶²Maxine L. Rockoff, Louis Gorin, and Joel C. Kleinman, "Positive Programming': The Use of Data in Planning for the Rural Health Initiative," Journal of Community Health 4 (Spring 1979): 208, 204, 205; Sardell, p. 114.

physician-to-population ratio, infant mortality rate, the percent of the population below the poverty level, and the percent of the population over age 65."⁶³

Under the RHI, as throughout the history of the community health center program, there was no demand for matching funds, although the centers were increasingly pushed towards financial self-sufficiency, especially by serving the non-poor, and urged to seek all possible third-party reimbursements. By exempting communities from providing matching funds, and incorporating positive programming, the BCHS in the PHS was able to do what no previous rural health reform institution -- philanthropic or federal government -- had succeeded in doing; that is, helping the communities most in need and least able to compete with administrative expertise or matching dollars.⁶⁴

⁶³Rockoff: pp. 205-07; Steinfeldt: p. 112.

⁶⁴For example, the Hill-Burton Act had authorized hospital and medical facility construction in communities that presented persuasive arguments for authorization and backed them up with matching funds. The Area Redevelopment Administration, signed into law by Kennedy, required "local matching contributions," and elaborate plans for projects it funded to develop depressed areas. Many of the counties it was designed to serve -- for example, those in Appalachia -- had neither the matching funds nor the local expertise to draw up the required plans. The Appalachian Regional Commission, a stepchild of the ARA, only funded its health centers for five years. When funding ceased, the centers were left with "huge deficits to meet on their own...." Michael Bradshaw, The Appalachian Regional Commission: Twenty-Five Years of (continued on next page)

Therefore, entering the presidency of Democrat Jimmy Carter in 1977, the rural community health center program was well-positioned to take advantage of the administration's liberal agenda and to expand -- which it did. For example, in fiscal year 1977, the PHS/BCHS almost doubled the number of RHI projects funded, from 138 projects in fiscal year 1976 to 262.⁶⁵ In 1977, Clinch River Health Services serving the Dungannon-Fort Blackmore area of southwest Virginia received its initial RHI funding.

The next chapters are an analysis of Clinch River Health Services: the area served, the community organizing, the center's RHI funding and relations with PHS Region III, the health problems and services, periods of growth and decline, utilization rates, and problems -- especially in recruiting and retaining physicians. PHS policy changes and Congressional legislation affecting the community health center program are addressed throughout.

 (continued) Government Policy (Lexington, University Press of Kentucky, 1992), p. 31. Karen Davis and Ray Marshall, "New Developments in the Market for Rural Health Care," Research in Health Economics 1 (1979): 78.

⁶⁵Sardell, pp. 120, 114.

CHAPTER 3

INTRODUCTION TO
CLINCH RIVER HEALTH SERVICES, INC.

Clinch River Health Services (hereafter CRHS) is a rural community health center serving the Dungannon-Fort Blackmore area of Scott County in southwest Virginia. Since its beginnings in 1977, CRHS has been funded and administered through the Rural Health Initiative Program (hereafter RHI) of the PHS. CRHS incorporates the characteristics common to a rural community health center. It is a facility that provides affordable, comprehensive, primary health care, including both curative and preventive services, delivered by a health team, to a predominately poor, medically underserved rural population.

In delivering primary, curative care, the center's health professionals offer the first line of treatment that is needed for the majority of common ailments afflicting the general population, for example, treatment for an upper respiratory infection, as well as on going treatment for common chronic illnesses, such as hypertension. The availability of convenient, affordable primary services at the community level reduces the inappropriate use of the area's hospital emergency departments for such treatment.

Provision of timely, competent primary treatment often stops an illness from advancing to a more serious -- even life threatening -- level, when specialists may need to become involved and hospitalization (tertiary care) may be necessary. Since both medical specialist services and tertiary care are also more expensive, immediate and appropriate primary care may save unnecessary expense, as well as unnecessary pain and medical risk caused by postponing treatment. At this entry level at the center, medical providers immediately make assessments and, if necessary, refer patients to specialists or arrange for hospitalization. The staff strives for continuity in care by arranging and monitoring patients' care from the primary through the specialist and tertiary levels.

The center tries to provide consistency in care so that a patient may build a relationship with its health professional team. The center's program is structured to overcome the fragmented care traditionally encountered by the poor and underserved, for example, in their use of hospital or public health department clinics. At its most efficient operation, the center's health care team includes a physician and nurse practitioner, as well as other nursing and health education personnel. This team is an extended version of our traditional promotion of a "personal physician" for each person. Several times over its sixteen year

history, CRHS experienced difficulty recruiting and retaining health professionals, especially physicians; but its goal of a physician-directed health team never faltered.

In its effort to provide comprehensive care, the community health center also offers preventive services, such as blood pressure tests, immunizations, prenatal supervision, and health education, such as nutritional guidance and weight loss and smoking cessation assistance. Patients may receive referrals to social agencies if their problems require such intervention. For all services, the staff keeps records so a medical history is locally available.

The individual is cared for with the recognition that he or she is a member of a family and the entire family's health is considered important. The health care team is equipped to deal with the needs of the entire family, from prenatal, to pediatric, to adolescent and adult, to geriatrics. Ideally, the center offers general or family practice at its best, with the added benefits of health education, and if possible, outreach services. This holistic approach to health care emerged from both the National Commission on Community Health Services' report and from the innovations of the demonstration centers sponsored by the Office of Economic Opportunity (hereafter OEO), and has been continued by the PHS.

As representative of a rural community health center, CRHS delivers its family-oriented services from a single, convenient location, operating at hours suitable to the community's needs. CRHS has on-site laboratory equipment for simple tests; for more complex testing, it uses lab services in Kingsport, Tenn. It has also arranged for affordable pharmaceutical services. Although it has dental equipment and had a dentist for several years, it currently does not have a dentist and must refer patients elsewhere. Thus, as much as possible, given local resources, CRHS offers comprehensive primary services.

Ideally, a community health center provides supplemental, non-medical outreach services that may range from transportation and housing rehabilitation to welfare advocacy. CRHS has rarely offered outreach services, due to limitation in federal funding and lack of initiative by its board of directors. However, a grassroots community development organization created in the aftermath of organizing around health care, the Dungannon Development Commission, does offer a variety of outreach services, especially in education, food programs, and housing rehabilitation. The Dungannon Development Commission is discussed at length further on in this chapter.

Since its opening in 1978, CRHS has made comprehensive primary health care (both curative and preventive) available

to its communities. And most important, the services offered by CRHS are affordable. Because CRHS receives federal funding through the RHI, it is expected to assure access to its services "without regard for a person's ability to pay."¹ Technically, it cannot turn anyone away; however, federal policy has pressured it to maximize payments. It accepts Medicaid and Medicare (as well as other third-party) reimbursements and provides a sliding fee schedule for low-income persons not covered by third-party payers and unable to afford its standard fees.

From its beginnings in March 1976, it has operated as a nonprofit corporation with a board of directors composed of community members and center users, representing -- to some degree -- the majority of its users. As pointed out by the PHS, this health delivery program with its community governance requirement is "unique among health service programs and [is] the basis of ensuring that each center is responsive to the needs of its community."²

CRHS has throughout its history delivered comprehensive primary (curative and preventive) health care; utilized a

¹U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Program Expectations of Community and Migrant Health Centers, Attachment A., 1 May 1991, p. 14.

²Ibid., p. 6.

team approach, including mid-level health care providers; governed through community representation, and received consistent federal funding. (Its failure to provide non-medical outreach services detracts from but does not invalidate its operation.) Therefore, it is an appropriate choice for a study of a rural community health center within the RHI Program. However, what makes it a distinctive choice?

Timing is the first factor in its favor. CRHS joined the community health center program in its maturity; long after the program had passed through its experimental stage under the direction of the OEO; well after its transfer to the PHS; and soon after the inauguration of the RHI, the PHS's bureaucratic policy that coordinated federal funding and included the concept of positive programming which awarded grants to communities based on need rather than expertise in grantsmanship. During the Carter administration, the PHS had increased the number of centers it funded; and CRHS had joined the program in 1977 during this window of opportunity. Therefore, CRHS provides an opportunity to observe the PHS process of funding a center through the innovative RHI policy during a period of expansion.

Several years later, during the Reagan administration, funding for new centers had virtually ceased; and it is unlikely CRHS would have received initial funding if it had first applied at this time. Under this hostile adminis-

tration, weak and troubled (and troublesome) centers lost funding, usually leading to their swift demise. For part of this period CRHS endured serious problems in retaining a physician, resulting in lowered utilization and revenues. However, through the cooperation of the PHS Region III bureaucrats, the population's demonstrated need, and the center's conscientious attempts to improve, it remained funded. For most (twelve) of its sixteen years of operation, CRHS labored in a nonsupportive, federal environment. Since 1991, CRHS has experienced growth and stability. It has retained its physician, recruited a second physician, and increased its utilization and revenue rates. Thus, it is poised to take advantage of any increase in funding under supportive administrations and of any expansion in patient coverage resulting from any health insurance reform that might be legislated in the mid-1990s.

CRHS was not, however, chosen as a representative community health center on the basis of its success in improving the health status of the population it serves. Its success in delivering health care will be demonstrated through user/encounter figures. However, its success in improving the health status of the community is much more difficult to demonstrate and is actually outside the scope of this dissertation. Researchers repeatedly commented on the problem of evaluating the centers in general. For

example, Karen Davis and Cathy Schoen, who conducted a ten-year appraisal of the national program, offered the following caveat: "Sample sizes inadequate for detecting changes in the incidence of some types of health problems among the people served by the centers constitute a particularly troublesome obstacle."³

Notwithstanding the cautionary note, Davis and Schoen, as well as H. Jack Geiger, reported a variety of studies. A lowering of infant mortality had long been one of the most sought-after results of public health department and philanthropic foundation endeavors. In predominately black Bolivar County, Miss., the site of one of the first two centers, "the infant mortality rate dropped from 48.5 per 1,000 to 31.0 in the four years" after the center was founded. In Lowndes County, Ala., between 1967 and 1971, during the period when a center was established and operating, the infant mortality rate was reduced from 46.9 deaths per 1,000 to 28.3.⁴ Geiger mentioned substantial reductions in infant mortality in Dade County, Fla., and in Denver. In a New York study reported by him, there was a "41 percent decrease in the perinatal mortality rate over four years, a

³Karen Davis and Cathy Schoen, Health and the War on Poverty: A Ten-Year Appraisal (Washington, D.C.: Brookings Institution, 1978), p. 184.

⁴Ibid., pp. 184-85.

19 per cent decrease in the prematurity rate, and an accompanying decrease in neonatal mortality." He added:

...[A] survey of low-income census tracts in Baltimore over a ten-year period showed a 60 percent reduction in the incidence of rheumatic fever -- a change attributed to the early detection and treatment of streptococcal infection -- in those tracts served by health centers; it showed no similar reduction in comparable areas without health centers.⁵

Community health centers have also been shown to reduce hospitalization and emergency room use. Davis and Schoen as well as Milvoy S. Seacat have reported studies showing that among children using a center in Rochester, N.Y., there was a 50 percent reduction of hospital days, and a 38 percent reduction in pediatric emergency department visits. For 1,000 users at the Mile Square Health Center in Chicago, there was a reduction from a total of 1,000 hospital days to 750 days over the three-year study period.⁶

It is also especially difficult to pinpoint the exact components of the design that improve the health status.

Geiger, one of the designers of the model, admitted:

What we do not know, so far at least, is the relative contribution of the different elements of

⁵H. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in Reforming Medicine: Lessons of the Last Quarter Century, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon Books, 1984), p. 29.

⁶Davis and Schoen, p. 182; Milvoy Seacat, "Neighborhood Health Centers: A Decade of Experience," Journal of Community Health 3 (Winter 1977): 161.

the health center model to these achievements. How much is due to easier geographical access, and how much to the partial removal of fiscal barriers? What is the impact of health care teams, of outreach workers, of community boards, of the target population's sense that they have a community-responsive institution that "belongs" more or less to them?

In line with Geiger's comments, it is important to note other influences and institutions in the community that affected health services. CRHS was also a good choice to study because of its interaction with four other institutions. The presence of Holston Valley Hospital and Medical Center in Kingsport, Tenn., the nearest large city, provided an opportunity to examine the relationship between a tertiary, medical institution and its rural service area, and to analyze its relationship to the center itself, providing specialists for referrals, hospitalization for center patients, and the possibility of staff privileges for center physicians. Two outside institutions played a role in the Dungannon-Fort Blackmore community organizing efforts around health care. Beginning in the 1970s, the Rural Student Health Coalition conducted health fairs in underserved rural communities in Tennessee, Kentucky, and Virginia. The Coalition hoped that the community people's efforts in supporting the health fair would motivate them to solve

 7 Geiger, p. 30.

their long-term health care delivery problems, principally through organizing a community health center and taking advantage of federal funding. The Coalition's efforts in conducting a health fair and a campaign for a health center permit an examination of how young, motivated outsiders worked in a conservative community. Similarly, TVA, in its long-term commitment to the people of the region, sent a community organizer to assist the local leaders, and their interaction provides another area of study.

The fourth institution is the Dungannon Development Commission, a textbook perfect model of grassroots mobilization for community development in the wake of organizing for health care. With the PHS's retrenchment on supporting supplemental, non-medical outreach programs and the CRHS board's reluctance to engage in outreach activities, the Dungannon Development Commission performed a much-needed service. Through its nutrition and housing rehabilitation projects, it tackled socioeconomic problems that affected the health status of the community.

Finally, of prime importance in choosing CRHS, Dungannon's and Fort Blackmore's needs and resources are representative of many rural communities, making these two communities a fair example for study. The history of how the Dungannon-Fort Blackmore area fell into economic decline and lost its physicians is fairly typical. It is the history of small

rural communities that suffered economic decline brought on by external forces and was left with a deteriorated socio-economic infrastructure, including inadequate health services and no resources with which to improve them.

Prior to the 1950s, Dungannon (and to some extent Fort Blackmore) enjoyed a strong economy as an important freight exchange point and terminal for the Norfolk and Western Railway. From 1913 to 1925, it served as a center for lumber shipping for the area's timber industry. Although the communities are not in coal mining country, they are adjacent to the coal fields and their economy depended in part on the health of the coal industry. Thus, the important rail business -- Dungannon had its own switchyard -- depended on the extractive industries of coal and timber.

Two different factors on the national scene hurt the local economy: the slump in the coal industry and the federal commitment to expand the highway system. With the general decline, business people and professionals fled the communities. Some of the remaining better educated or more highly skilled residents found employment in the factories in Kingsport, Tenn, a long commute away. The rest of the population relied on a "combined economy of subsistence farming and intermittent employment" in low-skill, low-wage jobs outside the community. Small-scale agriculture and underemployment provided insufficient income; for many

there was no employment at all. As was typical of other southern mountain communities, there was high outmigration.⁸

When the local physicians died, no one replaced them, and the communities were left without medical care. With most of the population trapped in low-wage jobs, intermittent employment or dependent on welfare, the community could not recruit a physician with any hope of offering him or her a prosperous medical practice. As one resident explained,

Used to be two doctors in this little village here and then there was none. And we kept trying to get doctors but never had any success. Course, we really didn't have anything to offer them.

These communities needed consistent, substantial funding to subsidize a medical practice. While the community lacked local primary care services, residents could travel to the nearest large city for outpatient, specialist, and tertiary care. Since its opening in 1935, Holston Valley Community Hospital (hereafter HVCH and later Holston Valley Hospital & Medical Center) served the residents of the New South industrial city of Kingsport where it was located, and the rural population within a twenty-five

⁸Dungannon Historical Society, "Dungannon, A Place in History" (Dungannon, Va.: Dungannon Historical Society) n.d., n.p.; Nelda Knelson Daley and Sue Ella Kobak, "The Paradox of the 'Familiar Outsider'," Appalachian Journal (Spring 1990): 249-50.

⁹Interview with Curtis Mays, Dungannon, Va., January 7, 1993.

mile radius, including Scott County, Va., and the communities of Dungannon and Fort Blackmore. (See maps, pages xviii, xix, and xx.)

As one of the fifteen community hospitals built with financial and technical assistance of The Commonwealth Fund, through its Rural Hospital Division, the hospital had agreed to meet The Fund's requirements concerning indigent care. Besides providing free inpatient care for the indigent sick, HVCH also conducted free, specialty and general outpatient (ambulatory) clinics for indigent clients within the hospital service area. However, HVCH never established clinics or outreach services in the rural communities, expecting people to come into the hospital for services.¹⁰

Over the years, residents from the Dungannon-Fort Blackmore area have consistently used the hospital and outpatient clinics. For example, in 1947, in "a detailed analysis indicating County, State and City of patients admitted to the [hospital] during the period July 1 to December 31, 1946," Scott County, Va., with 639 patients

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¹⁰"Agreement Entered Into Between The Commonwealth Fund of New York and the Holston Valley Community Hospital (A Tennessee Corporation) ... signed on behalf of the Holston Valley Community Hospital ... on August 15, 1993, and on behalf of The Commonwealth Fund ... on August 22, 1933," Rural Hospital files of The Commonwealth Fund Collection, Box 66, Folder RH897, Rockefeller Archive Center, North Tarrytown, N.Y. (hereafter RAC).

ranked second to only Sullivan County, Tenn., where the hospital is located. Of that Scott County total, thirty one came from Fort Blackmore, five from Dungannon, and at least 164 came from surrounding hamlets.¹¹

Even for those who traveled to HVCH and took advantage of the outpatient departments, the service was far from ideal. In a critique of outpatient departments as compared to neighborhood health centers, Seacat explained that outpatient clinics never adequately substituted for a primary health care center due to the fragmented, "episodic" and "crisis-oriented" nature of their services. He commented, "Personalized continuous care is seldom achieved in such a setting, simply because the outpatient departments are not designed to function as comprehensive care units providing family-oriented care...."¹² A patient does not have a "personal physician" in this type of delivery model.

And if one was unable to travel to the hospital and its outpatient departments, and if one lacked access to affordable care in the community, one still did without medical care; many people in the Dungannon-Fort Blackmore area were in that predicament. How the people of these poor, under-

¹¹"Estimated Population of the Area Served ... as of January 30, 1947," p. 2, Rural Hospital files of The Commonwealth Fund Collection, Box 66, Folder RH893, RAC.

¹²Seacat, p. 159.

served communities found out about the federal funding program for community health centers and organized CRHS is distinctive of an activist period in health center organizing. While CRHS's beginnings may be justly attributed to local community spirit, support, and leadership, an outside organization introduced the health center concept to the community. In summer 1975 the Rural Student Health Coalition (hereafter RSHC) of Vanderbilt University conducted a community health fair and urged the community to organize a community health center as a long-term solution to its health service needs. Also in summer 1975 the PHS had just instituted the RHI, a boon for communities such as Dungannon and Fort Blackmore.

In spring 1976 the communities organized the nonprofit corporation, Clinch River Health Services, Inc., for the purpose of building and operating the center. TVA, a dominant presence in the Tennessee Valley and its highlands since 1935, maintained its traditional interest in improving socioeconomic conditions. To help facilitate organizing, funding and implementation of the center, TVA sent a representative to work with CRHS's board. The actions of the RSHC and TVA are examined further in the narration of CRHS.

The RSHC also hoped that after organizing a center, the community would go on to address other socioeconomic conditions that affected health. This is exactly the scenario

that unfolded in Dungannon and Fort Blackmore with the organization of the Dungannon Development Commission.

At several points in the narrative of CRHS, the Dungannon Development Commission offers a strong counterpoint, a contrast in operation, for example, in addressing socioeconomic problems that affect health status, in fundraising, and in community participation. Therefore, it is helpful here to understand the origins and operation of this grassroots organization. In the Dungannon Development Commission (hereafter DDC), one finds a near textbook-perfect example of subsequent organizing for community development, including health-related programs, such as nutrition and housing rehabilitation.

The community organizing process, such as the one that resulted in the DDC, is explained in the manual The Best Medicine: Organizing Local Health Care. After mobilizing for health care services, a concerned constituency may be ready to work on other issues -- "be it Medicare assignment, food stamps, toxic waste, neighborhood development," or any other local concern. Likewise, Richard Couto noted that community health care efforts may "spill over" into campaigns for better housing, potable water, sewerage treatment, and education. As he phrased it, "The stream of voluntary action for health services may serve as the headwaters for voluntary action for other services." Karen

Davis and Ray Marshall explained that citizens "who have learned to unravel the secrets of Federal grantsmanship to obtain funding for a health project become sophisticated in seeking support" for other projects, for example, "from paving a road to improving local water supplies and sewage disposal," to housing rehabilitation.¹³

But was this activism in community development relevant to health status? Just as community health centers' direct impact on health status is often difficult to measure, so too is the influence of these social and environmental services difficult to evaluate. However, social activist and physician Raymond Wheeler, M.D., offered a strong argument in his statement, "In the modern world, housing, nutrition, accident prevention, sanitation -- clean water, food, streets, and homes -- have improved health conditions more than all the hospitals and doctors combined."¹⁴

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 Geraldine Dallek, Will Collette and Jeff Kirsch, eds, The Best Medicine: Organizing Local Health Care Campaigns (Washington, D.C.: Villers Foundation, 1984), p. 1-7; Richard Couto, "Toward A Human Service Economy," in Communities in Economic Crisis: Appalachia and the South, eds. John Gaventa; Barbara Ellen Smith, and Alex Willingham (Philadelphia: Temple University Press, 1990), p. 254; Richard Couto, Streams of Idealism and Health Care Innovation: An Assessment of Service-Learning and Community Mobilization (New York: Teachers College Press, Columbia University, 1982), p. 76; Karen Davis and Ray Marshall, quoted in Couto, Streams, pp. 75-76.

¹⁴Raymond Wheeler, "Health and Human Resources," New South 26 (Fall 1971): 15.

The OEO staff understood this and included non-medical outreach programs in the first centers. Under Nixon's constraints, the PHS was forced to demote these non-medical services to supplemental status and reduce or eliminate funding. But the need for these services remained, and some centers with aggressive, activist boards managed to find funding to tackle the problems. In CRHS's target population, there was need for improvement in all these areas but the board showed little or no inclination to develop outreach programs. However, others in the community responded.

In 1979, community activist Nancy Robinson and other concerned citizens organized the Dungannon Development Commission, Inc., an "independent, nonprofit corporation," to address community development. In subsequent years, DDC ambitiously attacked problems through its diverse activities, including rehabilitating and building houses; organizing a fire department; constructing a town hall and fire station; operating SHARE, a food program, and a crisis fund; and sponsoring parent advocacy and literacy tutoring.¹⁵

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¹⁵Interviews with Anne Leibig and Nancy Robinson, Dungannon, Va., November 14, 1990 (hereafter Leibig Interview; Robinson Interview); DDC, "We have faced the fact ... we'll have to do it for ourselves," and "The Dungannon Development Commission and Our Community: 10 Years of Service, DDC Programs 1979-1989" (Dungannon, Va.: DDC, n.d.), n.p., Dungannon Development Commission Collection, Dungannon, Va.

Whether considering the problems addressed by CRHS or the DDC, they are typical of problems encountered by many rural communities regardless of where they are located. CRHS's location in a designated Appalachian county was not a significant factor in choosing it for study. Poor housing and sanitation and nutritional problems afflict many rural areas. CRHS's major problem, the recruitment and retention of physicians, is encountered throughout rural America. Like most rural centers, CRHS had to cope with a multitude of small, mundane problems. In its survival of tedious times are lessons for the community health center program as a whole.

In order to understand the PHS's decision to fund CRHS based on its needs, the next section of this introduction to the center analyzes the socioeconomic conditions in Scott County in the early 1970s. Under the RHI policy with its concept of positive programming, "areas with the greatest need were to be selected on the basis of demographic and health status data."¹⁶ Communities had to demonstrate that they suffered high poverty levels, poor health, and were medically underserved. To better understand the socio-

¹⁶ Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986 (Pittsburgh: University of Pittsburgh Press, 1988), p. 114.

economic conditions of Scott County and the communities of Dungannon and Fort Blackmore and the cluster of hamlets surrounding them in the context of southwest Virginia, statistics are given in the footnotes for the neighboring southwest Virginia counties, Lee and Wise. In order to understand this data in the context of rural America and, particularly, the rural South, comments from researchers on general rural conditions and problems and especially those in the South are included.

In a 1979 report, health care economists and officials in the Carter administration Karen Davis and Ray Marshall cited conditions frequently found in rural areas: "Low incomes, poor diets, unsafe or deteriorated housing, impure water supplies (and lack of indoor plumbing), poor transportation and communication, and limited medical resources." Several of these general conditions, such as poor nutrition, substandard housing, or poor sanitation, were especially prevalent or more severe in the rural South.¹⁷

In 1971, in an article similar in tone and content to Harrington's The Other America, Raymond Wheeler, M.D., who had served as President of the Southern Regional Council,

¹⁷ Karen Davis and Ray Marshall, "New Developments in the Market for Rural Health Care," Research in Health Economics (1979): 58, 66-67.

also cited "[p]oor housing [and] poor sanitation," but emphasized poor nutrition as a major problem in the rural South, stating: "The people of the South are among the most malnourished in the nation." He linked poverty and malnutrition and disease in a vicious pattern.¹⁸

Did Scott County fit the description of a poor rural county suffering from these problems? In many ways, yes. It is definitely a rural county, despite its inclusion in the Johnson City-Kingsport-Bristol (Tenn.-Va.) Metropolitan Statistical Area. This inclusion contradicted the county's rural profile but confirmed longtime patterns, for its rural residents did look to northeast Tennessee's tri-city area for employment and services, as illustrated by their utilization of HVCH. Scott County has 539 square miles, with 24,376 persons, giving it a population density of 47 persons per square mile.¹⁹

According to federal census figures, Scott County's "median family income in 1969" was \$5,957, and in 1970, it

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¹⁸Wheeler, pp. 2, 9, 10, 11.

¹⁹U.S. Department of Commerce, Bureau of the Census, County and City Data Book, 1977, A Statistical Abstract Supplement (Washington, D.C.: U.S. Government Printing Office, 1978), p. 498. (hereafter CCDB, 1977) Russell County: 483 square miles, 24,533 persons, 54 persons per square mile; Lee County: 438 square miles, 20,321 persons, 55 persons per square mile. CCDB, 1977, pp. 498, 486.

reported 27.0 per cent of its families below the poverty level. According to the Central Virginia Health Planning Council, in 1973, 30 percent (2,014) of Scott County's (6,712) families lived in poverty. If one considers Davis and Marshall's figure of "23 percent of rural Southern families [having] below-poverty incomes," Scott County is in poorer shape.²⁰ Aid to Families with Dependent Children (hereafter AFDC) recipients numbered 439 (309 children) and the average payment per family per month was \$175.²¹

This AFDC figure is a very misleading indicator of actual need, as it is a low representation, and its under-representation has serious repercussions for health care services. AFDC discriminates against rural populations, because many states, especially in the South, limit

²⁰CCDB, 1977, pp. 500-501; Davis and Marshall, p. 69. Lee and Russell, reported a low of \$3,901; and a high of \$6,155, respectively. Russell County's higher figures might reflect the coal mining base of its economy. Scott County's poverty level was worse than Russell's 25.4 per cent and much better than Lee County's 39.7 percent of its families below the poverty level. CCDB, 1977, pp. 488-89, 500-501. U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 28 December 1976, 6 January 1977 letter from Central Virginia Health Planning Council, Inc., p. 6., Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 28 December 1976, CRHS).

²¹CCDB, 1977, p. 501. Lee County: 1,144 AFDC recipients (833 children), average payment per family per month, \$191; Russell County: 861 AFDC recipients (602 children), average monthly payment of \$176 per family. CCDB:1977, pp. 489, 501.

eligibility to single-parent households. Most rural families, including southern families, are "two-parent families with low incomes from agriculture, small manufacturing, or public service jobs." These are the working poor. Because recipients of AFDC are "automatically entitled" to Medicaid, this further discriminates against the working poor or unemployed two-parent families. This policy contributes to the large number of uninsured and medically-indigent people in rural America, especially in the South.²²

As pointed out by researcher Sophie M. Korczyk, many rural residents "whose income might qualify them for [AFDC and] Medicaid" were "disqualified by farm or business assets." Also, given the poor communications in rural areas, many lacked "information about eligibility," and some, Korczyk suggested, might be "reluctant to apply for a means-tested program," which AFDC/Medicaid is.²³

One concise description of the Dungannon-Fort Blackmore area agricultural base read, "The communities consist of small farms raising tobacco, cattle, sheep, hay, and small

²²Sam M. Cordes, "The Changing Rural Environment and the Relationship between Health Services and Rural Development," Health Services Research 23 (February 1989): 779-80; Davis and Marshall, p. 69.

²³Sophie M. Korczyk, Health Care Needs, Resources, and Access in Rural America (Washington, D.C.: National Rural Electric Cooperative Association and Prudential Insurance Company, n.d.), p. 28.

vegetable crops." These farm assets may have disqualified the heads of households from AFDC/Medicaid coverage, without providing sufficient income to insure medical care.²⁴

A major factor in poverty considerations and health care needs is the percentage of elderly persons in a population. As reported by local leaders, Scott County's low income population included a "large percentage ... of elderly people on fixed incomes." In a state with 8.5 per cent of its population "65 years and over," Scott County recorded 12.1 per cent. In population studies of age distribution, researchers noted that an "unusually high median age" is one striking characteristic of rural counties

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 U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 31 January 1990, Project Description, p. 21., Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 31 January 1990, CRHS). As reported in the 1974 agricultural census, Scott County farms were small in acreage, averaging 85 acres, as compared to 93 acres in Lee and 146 acres in Russell. It had more farms under 180 acres than the surrounding counties. The average value of land and buildings per Scott County farm was \$29,000 (\$337 per acre), compared to \$38,000 (\$404 per acre) in Lee and \$48,000 (\$330 per acre) in Russell. Across all fields, Scott County's agricultural values were lower. The "Value of farm products sold by farms with sales of \$2,500 and over" were \$3.7 million for Scott; \$5.4 million for Lee; and \$7.8 million for Russell. Lee and Russell counties' higher values may be attributed to a larger percentage of the value derived from dairy and livestock than in Scott County, which had more of its product value derived from "crops, including hay and nursery products." CCDB, 1977, pp. 497, 509.

and a major factor in providing health services, both medical care and outreach services.²⁵

In a 1993 journal article, Jean Goeppinger reported that traditionally, rural elderly "are cared for by their families to a degree far exceeding that of their urban counterparts;" but she acknowledged that outmigration of "young and middle-aged people" had weakened the support systems. She observed that "an aging population [was left] who not only have no doctors nearby but no children, young relatives, or neighbors to look after their health or even to do their shopping if they are sick."²⁶ While the media reported the most recent outmigration of young people as coming from the Midwest, the southern mountains had long experienced such a loss, with serious repercussions for the declining communities.

-----²⁵ CCDB, 1977, pp. 486, 498; Edward W. Hassinger, "Pathways of Rural People to Health Services," in Rural Health Services: Organization, Delivery, and Use, eds., Edward W. Hassinger and Larry R. Whiting (Ames: Iowa State University Press, 1976), pp. 165-66. Lee County reported an even higher percentage (13.6) of elderly, while Russell County's "65 and over" were only 9.7 per cent of population. Approximately three fourths of the counties had lower percentages than Scott; but the counties with higher percentages often showed figures as high as 16, 18, and 19 per cent. CCDB, 1977, pp. 486, 498.

²⁶ Jean Goeppinger, "Health promotion for rural populations: Partnership interventions," Family & Community Health 16 (April 1993): 5-6.

A high percentage of elderly in the community affects transportation needs as these residents are no longer able to drive; housing rehabilitation as older people, especially women, are unable to repair their homes; and the need for outreach services to allow these people to remain living independently in their homes. Recent studies confirm that older people, especially older women, prefer to remain in their homes but need community assistance to do so. Helping them remain healthy and independent tremendously reduces the cost of hospitalization and nursing home services.²⁷

The ability to make routine housing repairs is often a problem for the elderly, but substandard housing and lack of water and indoor plumbing can cause or contribute to ill health for anyone, young or old. In the 1970s, rural areas accounted for sixty percent of the nation's substandard housing. In poor, rural southern counties, one-third of the houses lacked plumbing. In Scott County, 40.7 per cent of

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 Tony Lawson, "Innovations in Health Services for the Elderly: Stone Mountain Health Services' Geriatric Programs," Appalachian Health Care: New Ways of Doing Business, Johnson City, Tenn: 20 April 1993; Sonya Hardin, "Let the Circle Be Unbroken: Health of Elderly Southern Appalachian Widows," Appalachian Studies Conference, Asheville, N.C.: 21 March 1992; Janet M. Collins, "Functional Health, Social Support, and Morale of Older Women Living Along in Appalachia," Appalachian Studies Conference, Johnson City, Tenn.: 20 March 1993. Copies of presentations in my possession.

all housing was "lacking some or all plumbing."²⁸

Bruce Behringer, 1993 president of the National Rural Health Association, recalled an incident when he was working in eastern North Carolina. At a health center that operated a kidney rehabilitation unit, a physician ordered a woman he was treating to drink a large quantity of water each day. She went home with his instructions but came back the following week worse than before. He asked what happened. She explained that she hadn't been feeling well enough to walk the mile to get the necessary quantity of water to drink. There was no water in her house.²⁹

Nancy Robinson, Housing Director of DDC, explained the Dungannon-Fort Blackmore area's housing needs and DDC's response very simply:

We rehab homes. There's a lot of substandard homes and in addition we ... build new homes. ... I concluded a survey and I can't believe the people that live in substandard houses still. Even in this day and time, with all our modern technology ... we still got people who have to walk to outhouses. I mean some of these are

-----²⁸ Davis and Marshall, p. 67; CCDB, 1977, pp. 490, 502. In Lee County, 46.9 per cent and in Russell County, 47.9 per cent lacked some or all plumbing. CCDB, 1977, pp. 490, 502.

²⁹ Interview with Bruce Behringer, Summer 1986. At the time, Behringer was Executive Director of Virginia Primary Care Association, Richmond, Va. Interview was conducted for article: Caro, Edythe Quinn, "Patterns of Tradition, Elements of Need: Appalachian Health Care, Appalachian Focus 2 (Winter 1986): 5-9, 25-26.

elderly people. ... And I think that relates to health. And it's really sad.³⁰

Conditions in Scott County reflected problems common in rural America and especially in the South. And the communities to be served by CRHS were a microcosm of the county, of the rural South, and of rural America. Out of the county's total population of 24,376, the population in the proposed center's service area of 110 square miles was 4,432. Their statistics mirrored the county's depressed image. For example, in describing this catchment area the community leaders emphasized the "low socioeconomic status," with forty percent of the families earning "an annual income" below \$4,000. Using data from the 1970 federal census, the community leaders reported the "per capita income" as \$1,847.00. They repeated the county figure of "26.9" as the "percent of all families with income less than poverty level."³¹

In 1976, the Dungannon-Fort Blackmore community leaders described their community as follows:

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Robinson Interview.

³¹U.S. Department of Health and Human Services, Public Health Service, Region III, National Health Service Corps Application for Placement of Personnel, Clinch River Health Services, Inc., 1976, I, Description of the Community; III, Estimate of User Population....; letter from LENOWISCO Planning District Commission, 15 July 1976, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter NHSC, Application, 1976, CRHS).

Jobs available in the community are farming, saw milling, mining, and employment at the local garment factory. This garment factory employs approximately 50 persons [mostly women]. Several citizens work in Kingsport at various plants. The community has no banks, theaters, or restaurants. Several small grocery stores and filling stations are spread throughout the community.³²

The long history of outmigration of young people from the area may be easily understood considering the limited opportunities. And the limited opportunities for making a decent living -- never mind prospering -- not only drove people away, but also prevented the communities from attracting professionals, for example, physicians.

Scott County as a whole was seriously underserved in health care facilities, programs, and providers. In 1975, the county had only five active non-federal physicians, giving it a rating of 19.8 per 100,000 population. Some of the county's shortages may be attributed to its location, immediately adjacent to Sullivan and Washington counties in Tennessee, with their medical centers and specialists.³³ Unfortunately, due to economic and transportation barriers, the availability of facilities within Scott County's orb did

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³²NHSC, Application, 1976, CRHS, I, Description of Community.

³³CCDB, 1977, pp. 488, 500. Smaller Russell County had six active non-federal physicians and a rating of 23 per 100,000 population, and Lee County had ten physicians, rated at 41.5 per 100,000. CCDB, 1977, pp. 488, 500.

not guarantee accessibility to all its residents.

The lack of available and accessible health services especially troubled the area residents. Availability refers to "the existence of ... necessary personnel to provide essential services."³⁴ No health personnel were located within the 110 square mile area. The 4,432 people depended on three full-time physicians and one part-time physician located outside the area, in Nickelsville, Weber City and Gate City, all at least a half-hour's drive away, over mountain roads. Because these physicians were so over-worked, they were not accepting any new patients. For their regular patients there were long waits for routine care and physicals. People were often forced to resort to hospital emergency rooms in Kingsport for treatment of illnesses that should have been treated in a physician's office.³⁵

For pre-school and school children, lack of health services made it difficult for them to obtain immunization

³⁴Angeline Bushy, Editorial, Family & Community Health, 16 (April 1993): viii.

³⁵The closest physician was 12 miles away; two others were 22 miles away; and in all cases these were country road miles, slowing travel time. The "resident per physician ratio" was stated as 6800 to 1 for Scott County and 4400 to 1 for the CRHS service area; compared to a "national average" of 800 to 1. NHSC, Application, 1976, CRHS, I, Description of the Community, II, Health Resources; RHI, Application, 28 December 1976, CRHS, Letter, ARCHA to CRHS, 4 October 1976.

shots and physicals. After reviewing school health records, the Division Superintendent of Scott County Schools noted the level of poverty and lack of health services; the two elementary schools in the Dungannon-Fort Blackmore area reported the "highest number of health deficiencies among pre-school children as compared to the rest of the county."³⁶

Along with a physician shortage, dental service was inadequate. Five dentists -- two of them over age 65 -- served the region from their practices in Nickelsville, Weber City and Gate City, the nearest being twelve miles from Dungannon.³⁷ Davis and Marshall considered poor dental health as a "major problem" in their appraisal of southern health. They enumerated some of the causes, for example, "individualized, unfluoridated water sources," lack of education in "good dental habits," dentist shortages; even when dentists are available, many people were too poor to gain access to care. As pointed out by the researchers and also very evident in any field trip to the Dungannon-Fort Blackmore area, "[l]oss of permanent teeth even among young adults is a shocking fact...." More threatening to

³⁶NHSC, Application, CRHS, Letter, Division Superintendent, Scott County Schools to NHSC, 18 August 1976.

³⁷Ibid., I, II.

health than the cosmetic problems, tooth infections and pain "affect the whole body." Toothaches impair "school and work performance; "tooth loss and poorly fitted dentures compound nutritional and digestive problems."³⁸

Scott County had no hospital and tertiary facilities were situated at a distance; for Dungannon-Fort Blackmore residents, it was at least thirty miles to the most utilized hospital, HVCH in Kingsport, Tenn. Three other hospitals, also between twenty-five and thirty miles away, were located in the cities of Wise and Norton, Va.³⁹ If a life-threatening situation arose, there was "no qualified person in the community to handle an emergency." The communities had to rely on the county's volunteer rescue squad headquartered in Gate City, "approximately 20 miles on mountain roads." With only two vehicles to cover the entire county of 535 square miles, the squad could not guarantee quick response.⁴⁰

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³⁸ Davis and Marshall, p. 65.

³⁹ Russell County had one hospital with 50 beds; Lee County had one hospital with 74 beds. St. Mary's Hospital and Norton Community Hospital were in Norton, and Wise Appalachian Regional Hospital, previously a UMWA Miners Memorial Hospital, was located in Wise, Va. CCDB, 1977, pp. 500, 488.

⁴⁰ NHSC, Application, CRHS, IV, Description of Health Care Problems.

Emergency rescue service is vitally important in rural America. Despite the common image of the countryside as a healthy environment and farming as a safe occupation, the reality is much more threatening. Agriculture is high on the list of the "nation's most dangerous occupations." Most of the injuries and fatalities result from tractor-related accidents. Nature too can be deadly or cause serious injuries by lightning, exposure, and natural disasters. Rural roads, poorly planned, maintained, and with little speed enforcement, are the scenes of many accidents.⁴¹

Considering all the indicators, Scott County in general and the communities of the Dungannon-Fort Blackmore area were deficient in health services and providers, especially physicians and dentists. But even if the shortage of medical personnel was remedied, problems of accessibility remained. Due to the high poverty rate, many suffered from poor accessibility to the services that existed, even at a distance. Accessibility refers to the "logistical access to, as well as the ability to purchase, needed services." As explained in an editorial in the Journal of Family

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⁴¹The National Safety Council estimated that in 1993, nationwide, "2,400 people died as the result of farm accidents, and 400,000 received disabling injuries." Amy Smith, "Tractor rollovers leading cause of farm deaths in state, nation," Knoxville News-Sentinel, 24 October 1994, A1, A 3; Korczyk, p. 9; Davis and Marshall, p. 66.

& Community Health, barriers to accessibility include:

great distances that must be traveled to obtain services, lack of public transportation, lack of telephone services, ... [and] inability of clients to pay for or procure⁴² entitlements to obtain necessary services.

Access to services, whether provided by overworked county physicians or Kingsport's specialists, required transportation to reach the services and money to pay for them, two things in short supply for all but the most well off residents of these economically depressed communities. And the problem would not be remedied by simply setting up a physician or dentist in the rural communities. Unless some kind of a financial assistance program was in place, many of the residents would not be able to afford the physician's or dentist's services. And unless the medical professional's salary was guaranteed, the communities would not be able to attract anyone. A guaranteed salary would need to be subsidized and that would require outside funding. The statistics clarified the need, but they did not provide the answers.

The statistics presented here are cold and dry, the faces of the people they enumerate are lost behind the numbers. From community narratives and interviews, the

⁴²Bushy, p. viii.

people reappear with their problems and their resources. One such interviewee offered a good introduction to the community and its health problems. In June 1972, upon graduation from the seminary, Vance Sherwood moved into the Methodist parsonage in Dungannon to minister to a "three point circuit" made up of Dungannon, Fort Blackmore and the neighboring community of Slant. He found in those communities a combination of factors -- a lack of money, a large number of elderly, and a heavy incidence of illness -- that all pointed in one direction -- to serious health care problems. He explained:

My churches were top heavy with old people; ... the children had left at this point. Their [the elderly] health was pretty bad. They had a lot of chronic health problems. ... But what I remember that made me feel so bad for a lot of them were the old people who had to drive to Kingsport, get somebody to drive them, then sit in the doctor's office for three hours, and get a blood test and come back. And they'd be worn⁴³ out and exhausted, and a whole day would be shot.

Although the older people's health especially concerned Sherwood, he admitted, "Everybody was sick up there. ... Health was just iffy up there in general. Everybody had kidney problems or urinary problems."⁴⁴ This prevalence of

⁴³ Interview with Vance Sherwood, Knoxville, Tenn., March 22, 1993.

⁴⁴ Ibid.

chronic conditions, especially among the elderly, is a characteristic of rural health status nationwide, with hypertensive and cerebrovascular heart diseases, ulcers, emphysema, arthritis, and rheumatism among the major ailments.⁴⁵ According to 1974 figures, the leading causes of deaths in Scott County were: "cardiovascular diseases," especially "ischemic heart disease;" "cerebrovascular disease;" several forms of "malignant neoplasms [tumors]," especially those of the "digestive organs and peritoneum," of the "respiratory system" and of the "genital organs;" and "pneumonia."⁴⁶

This overwhelming lack of health care made an immediate impression on Robin Feierabend, M.D. when he first arrived in the community in 1977. He explained:

There was a significant portion of the population that was receiving essentially no health care, largely because of transportation and to some extent economic barriers. There were a lot of people who simply just never went to a doctor because they couldn't get over the ridge to Nickelsville, or get down to Kingsport, or up to St. Paul. There was also a need -- a less critical need for folks who had regular physicians elsewhere but found it very inconvenient. They were getting their basic health care needs met, but they had to go some distance to get them....⁴⁷

⁴⁵ Davis and Marshall, p. 67; Korczyk, p. 9.

⁴⁶ RHI, Application, 28 December 1976, CRHS, Table 36.

⁴⁷ Interview with Raymond [Robin] Feierabend, M.D., Bristol, Va, November 14, 1990.

These county and local statistics and the newcomers' impressions were summed up succinctly by the local leaders:

The Dungannon-Ft. Blackmore area is virtually cut-off from medical assistance due to the following problems; transportation difficulties, heavy workloads of area physicians, the amount of time necessary to receive an appointment for care, and the lack of trained manpower to cover an emergency situation.[sic]⁴⁸

The history of how the people of the Dungannon-Fort Blackmore area overcame their lack of health care is the history of Clinch River Health Services, their community health center. It is a successful story because from the beginning the communities mobilized local resources, exploited outside experts -- including PHS regional officials, established a health care delivery system, and took advantage of federal funding through the RHI Program. However, CRHS's success is vulnerable since it depends on forces at the national level that it cannot control, and on socio-economic circumstances, community relations and support, and leadership at the local level that it can only control to varying degrees.

Chapter Four analyzes the history of CRHS: beginning in 1975 with the plan to bring a health fair to the area; continuing with the establishment of a nonprofit corporation

⁴⁸NHSC, Application, CRHS, IV, Description of Health Care Problems.

to build and operate the community health center; proceeding with the fundraising and building efforts, to the application to the PHS for federal funding through the RHI; ending with the recruitment of medical personnel, and the opening of the center in Fall 1978.

The importance of the PHS's RHI policy with its concept of positive programming will be emphasized. Without PHS support and federal funding, CRHS could not have started operating.

CHAPTER 4

ORGANIZATION AND OPENING, 1975 - 1978

In the introductory chapter to the history of Clinch River Health Services, data from census records and from oral and written accounts demonstrated the high incidence of poverty, low level of health services, and the poor health status in the Dungannon-Fort Blackmore area. These factors made it possible for the communities to qualify for federal grants to operate a community health center. How the communities learned of the community health center program and its funding through the Rural Health Initiative policy of the PHS is one of the subjects of this chapter. CRHS is a very strong example of the RHI's concept of positive programming in action.

Townsfolk often credit Vance Sherwood, who was ministering to the Methodist congregations in the area, with being instrumental in bringing medical care to these communities. He remembered it differently, assigning the real credit to the community members themselves. Sherwood's own attempts to improve the health care in the communities had decidedly mixed results. Recognizing the great need for medical services, he contacted Vanderbilt University of which he was an alumnus. He arranged for "two student

doctors" from Vanderbilt's Medical School to work with a physician in Nickelsville, about twelve miles from Dungan-non. With more assistance, perhaps the physician could see more patients, including folks from the Dungannon-Fort Blackmore area. Two medical students arrived in the summer of 1974, but, according to Sherwood, their presence proved very disappointing and any improvement was negligible. He also remembered the community offering "little miniature health fairs," with public health nurses teaching good hygiene to the children.

Disappointed with his student doctor scheme but determined to improve health care services and "make a difference," Sherwood next promoted a plan to hire a nurse practitioner. He and several community members investigated that possibility, but it soon "died on the vine."¹ It was competing with another new idea that generated real interest among more people -- a health fair.

¹Interview with Vance Sherwood, Knoxville, Tenn, March 22, 1993 (hereafter Sherwood Interview). A Vanderbilt University chapter of the Student American Medical Association sponsored summer apprenticeships for medical students to work with physicians in the Appalachian region, hoping to encourage rural practices. The "two student doctors" may have been part of that program. Richard A. Couto, Streams of Idealism and Health Care Innovation: An Assessment of Service-Learning and Community Mobilization (New York: Teachers College Press, Columbia University, 1982), p. 2.

Sherwood's inquiries to locate a health provider had alerted Vanderbilt University's Center for Health Services of the communities' needs and efforts. In the fall of 1974, he got a call from a representative of the Rural Student Health Coalition at the Vanderbilt Center, asking if the communities "wanted to be put on their list" for a health fair in summer 1975. Despite his reputation for bringing the health fair to town, Sherwood claimed, "all I did was serve as the contact for the first phone call that came in, and maybe I referred some people to some other people to get something going." As he recalled, the idea of a health fair "kind of snowballed" over the winter of 1974-5.

For a community to sponsor a large health fair, considerable planning was required, and Sherwood recalled, "a community committee formed. ... Charlotte Nickels [a matriarch in the community] was real involved. Some people in our church were real involved. ... There was pretty good enthusiasm and response at that time." Sherwood left the area in June 1975, before he could see the positive results of the communities' organizing efforts.² Instead of following Sherwood's modest plan for recruiting a nurse practitioner, the two communities sponsored a health fair and

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²Sherwood Interview.

organized a community health center, and got their nurse practitioner -- and more.

Dungannon-Fort Blackmore's health fair, and the resulting health council, community health center, and spill-over programs, such as the Dungannon Women's Club and Development Commission, perfectly fit the design promoted by the Rural Student Health Coalition to improve health care in underserved rural areas. Beginning in 1970 at Vanderbilt University, concerned students from diverse disciplines, such as medicine, nursing, law, education, and liberal arts, organized the Rural Student Health Coalition (hereafter RSHC) to respond to the problems of rural communities, especially to the lack of adequate health services. Although they offered assistance that ranged from legal aid to marketing agricultural products, they centered their efforts on conducting summer health fairs, first in Tennessee, later in Virginia and Kentucky. However, their goals were more ambitious than simply providing physical examinations and treating minor ailments. The health fairs were to serve as catalysts to activate the communities to focus on their health care problems and to organize around health care issues for long-term solutions.³

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³Couto, pp. 6-11. The Coalition's two major units emerged in 1970, the Urban Student Health Coalition and the Rural Student Health Coalition. (continued on next page)

The students defined health care in its broadest sense, as freedom from disease and also as the general well-being of an individual and community in social, political, economic, environmental, education, and psychological terms. Health care was described as "the basis on which to better all aspects of community life."⁴ Therefore, in addition to curative and preventive health services, the students encouraged communities to include in their planning

 (continued) Although the RSHC itself divided into two working units, the Appalachian Student Health Coalition and the West Tennessee Student Health Coalition, throughout this study, the program is referred to simply as the RSHC. Dungannon was only the third health fair that the RSHC conducted outside of Tennessee. In summer 1973, the RSHC traveled into southwest Virginia to conduct a health fair in St. Charles, a depressed coal mining community in mountainous Lee County. The fair resulted in St. Charles Community Health Center which started operating in January 1976. As a result of a 1974 RSHC health fair, Western Lee County Health Center was founded and started operating in 1977. In 1985, St. Charles and Western Lee formally joined together as a health care consortium. In 1993, a third center in Castlewood in Russell County joined the consortium, which now operates under the name, Stone Mountain Health Services. Couto, Streams of Idealism, pp. 1-2., 7-8; Rural Student Health Coalition, "Final Report: Community Outreach V, June 1, 1973 - December 31, 1973," pp. 1-4, 17-19, Center for Health Services Collection, Vanderbilt University, Nashville, Tenn. (hereafter RSHC, "Final Report," CHS); Interviews with Tony Lawson, Executive Director, Stone Mountain Health Services and Western Lee County Health Center, Summer 1986 and February 15, 1993. (Lawson had been administrator of St. Charles Community Health Center.) Summer 1986 Interview for Article: Edythe Quinn Caro, "Patterns of Tradition, Elements of Need: Appalachian Health Care," Appalachian Focus 2 (Winter 1986): 5-9, 25-26.

⁴RSHC, "Final Report," CHS, p. 3.

non-medical activities to address socioeconomic problems. Likewise, they stressed community control of the programs they introduced. As explained in the 1973 RSHC Program:

By far the most important aspect of the RSHC work is with the communities. As students, we are transient; the community will always be there. If something permanent is to exist, the local people must be the deciding factor.⁵

However, in his analysis of Dungannon-Fort Blackmore community mobilization, the RSHC leader made provocative and often contradictory statements regarding the social structure and dynamics in the community. Kevin McDonald, director of the RSHC in 1976, worked on the 1975 projects, including the Dungannon-Fort Blackmore health fair and follow-up planning. In his final evaluation he remarked:

...[M]ost of the area's people have been dependent upon some extra force to carry them along, be it the tenant farming system, a kind leader in the community, or welfare. ... Thus, asserting the self among peers was contrary to habit. Furthermore, though almost every person we met was an incredibly warm and generous individual, giving as a group, acting as a community - was rare for them. Apathy and passivity indeed were great. Yet a cluster of lively and idealistic people lay scattered about the valley. All they needed was a rallying point and a push. They got both.⁶

⁵RSHC, "Final Report," CHS, p. 95.

⁶Kevin McDonald, "SHC Final Evaluation," 18 August 1975, p. A., Center for Health Services Collection, Vanderbilt University, Nashville, Tenn., (hereafter McDonald, "Evaluation," CHS).

This RSHC leader's recollections sound very much like descriptions found in the period's dominant writings on Appalachia, which were heavy on "otherness" and identifying character traits, such as fatalism, to explain poverty and underdevelopment. McDonald explained that before venturing forth for summer work, he and a fellow worker had "read a bit about community organizing, and ... on the history of the Appalachian people." He said, "We thought a lot about being guests and strangers, and about intervention into another culture."⁷

Reading "the history of the Appalachian people" in the mid-1970s could be quite misleading. For example, Jack Weller, a minister who based his 1965 study on one coal town in West Virginia, concluded that Appalachian people had an "inadequate" culture that ill-prepared them for assimilation into modern, industrial society. Weller dwelt on cultural traits -- rather than on economic, political, or environmental conditions -- to explain the mountain people's poverty. His book Yesterday's People, Life in Contemporary Appalachia influenced many researchers and policymakers, including David H. Loeff, whose 1971 book Appalachia's Children, The Challenge of Mental Health described the children's "mental disorders" as consequences of the

⁷Ibid.

region's "social matrix."⁸ This mode of thinking was not challenged until the late 1970s and early 1980s when such authors as Helen Lewis, Henry D. Shapiro, David E. Whisnant, John Gaventa, and Ronald D. Eller critically examined the various concepts of Appalachia and the economic and political influences on the southern highlands.⁹

The RSHC worker's recollections foster a stereotype that is contradicted by the history of the communities' organizing efforts found in oral and archival record. At the same time, McDonald's observations provide important

⁸ Jack Weller, Yesterday's People: Life in Contemporary Appalachia (Lexington: University of Kentucky Press, 1965). pp. 6, 30-37, 46, 49, 51, 116-29; David H. Looff, Appalachia's Children, The Challenge of Mental Health (Lexington: University Press of Kentucky, 1971), pp. ix, xiv, 122.

⁹ Helen Lewis, "Fatalism or the Coal Industry?" Mountain Life and Work (December 1970): 4-15; Henry David Shapiro, Appalachia On Our Mind: The Southern Mountains and Mountaineers in the American Consciousness, 1870-1920 (Chapel Hill: University of North Carolina Press, 1978); John Gaventa, Power and Powerless: Quiescence and Rebellion in an Appalachian Valley, (Urbana: University of Illinois Press, 1980); David E. Whisnant, Modernizing the Mountaineer: People, Power, and Planning (Boone, N.C.: Appalachian Consortium Press, 1981) and All That Is Native and Fine, Politics of Culture in an American Region (Chapel Hill: University of North Carolina Press, 1983); and Ronald D. Eller, Miners, Millhands, and Mountaineers, Industrialization of the Appalachian South, 1880-1930 (Knoxville: University of Tennessee Press, 1982). For an excellent discussion of the cultural theories, see Stephen L. Fisher, "Victim-blaming in Appalachia: Cultural Theories and the Southern Mountaineer," Appalachia: Social Context Past and Present, 2nd ed., eds. Bruce Ergood and Bruce E. Kuhre (Dubuque, Ia.: Kendall/Hunt Publishing Co., 1983), pp. 154-163.

clues to class relations, useful in a later analysis of the class structure of the board of directors and the degree to which it represented the community. One of the factors in the success of the rural community health centers is community mobilization and organization, representation and participation. This study will attempt to evaluate the level and success of community action over time, from the initial impulse to organize a center and gain the support of the whole community to the later efforts to govern the center through cycles of growth and decline.

Contrary to McDonald's perception of the community's "apathy and passivity," the residents had already exhibited the ability to work together -- in the planning for the health fair. Once the community decided on the health fair, mobilization started immediately, with committees organized to plan for the students' arrival. Forty or more students were scheduled to be there for several weeks and homes had to be found for them. The students arrived in June. As planned, they stayed with local families, a practice which contributed to the success of the program as it broke down barriers and provided a learning experience for all involved. Commenting on the students' and residents' interaction, McDonald wrote: "They [the students] lived with them, held jamborees with them, and became their friends. ...[T]he students looked to the local people for answers,

and the local residents shared their way of living with pride." One student summed it up best, "We learned to listen and believe what we heard on porches." One Dungannon resident reported:

The students from Vanderbilt really made a hit with the people. They didn't come in and just sit up here like they knew it all. They got acquainted with the people before they went to work. They got on the first floor with them and got their affection. When they left, they cried,¹⁰ and I'll have to admit, I shed a little tear too.

Before the medics arrived, the RSHC and the community workers promoted the event, sending notes home with school children, advertising by radio, newspaper, and posters. Residents participated as paid and volunteer workers in the fairs; some cooked for the students and community workers.

At the health fair, held in the Dungannon Elementary School, the medical students offered free comprehensive physical examinations to all area residents. They took medical histories; gave immunization shots where necessary; provided blood and urine tests and chest X-rays. (The RSHC enlisted the aid of pharmaceutical companies who contributed valuable drugs, such as antibiotics and antiparasitics, to the health fairs.) Under supervision, the medics treated minor problems and referred serious problems to the health

¹⁰ Kevin McDonald, "Outreach and Outrage: The Student Health Coalition," Southern Exposure 6 (Summer 1978): 20. Couto: Streams of Idealism, pp. 102, 59.

department or the patient's own physician. As one resident recalled: "They started eight in the morning and closed at eight at night. They were exhausted."¹¹

Over the course of the five-day health fair, 1,186 persons were examined; many of them had never had a physical before nor had seen a doctor in years. The very volume of people responding to the opportunity for medical attention "attested to the lack of ordinary access to health care, particularly screening and preventive services" in the area. Besides receiving a thorough examination and some health education, the people gained an understanding of just how critical were their community's health needs. As one resident remarked, "Wouldn't it be nice if we could go to see a doctor right here all the time."¹²

If the communities were at first dismayed by the

¹¹ McDonald, "Evaluation," CHS, A; Clinch River Health Services, Inc., Press Release, 10 June 1976, Clinch River Health Services Inc. Collection, Dungannon, Va.; RSHC, "Final Report," CHS, pp. 2, 25-26, 64-65; Interview with Curtis Mays, Dungannon, Va., January 7, 1993 (hereafter Mays Interview).

¹² The first and main phase of the health fair ended abruptly a day early, due to poor scheduling by the RSHC, and "only 60 patients [were examined] on the last day." A second, follow-up phase resumed a few weeks later, operating more smoothly. McDonald, "Evaluation," CHS, pp. A-B; "Community Acts Bring Medical Care to Scott," Kingsport Times 26 August 1976, p. 4D, Clinch River Health Services Inc. Collection, Dungannon, Va. (hereafter Times, 26 August 1976, CRHS).

enormity of their health care needs, the possibilities for a permanent solution encouraged them. The students eagerly told stories of "how other communities as small as Dungannon had developed medical clinics and attracted doctors to staff them."¹³ The students were able to offer these examples as a solution for Dungannon and Fort Blackmore because of the existence of the PHS's RHI program offering funding and technical assistance. Utilizing the concept of positive programming, the PHS bureaucrats at the regional level administered the RHI so that a poor, medically underserved community with little experience in grant writing could successfully apply for and receive funding and assistance to operate a community health center.

What followed the health fair attested to its success and closely followed the RSHC design. The students always hoped that once the people's attention was aroused around health care issues generated by the fair, they would focus their attention next on seeking long-term solutions to their problems. The community did just that, setting a community health center as its goal. Even though the medics left, several RSHC workers remained to help with the organizing process. The Fort Blackmore and the Dungannon Ruritans

¹³ McDonald, "Evaluation," CHS, p. A; NHSC Application, 1976, CRHS, p. IV; Couto, Streams of Idealism, p. 10; Times, 26 August 1976, CRHS, p. 4D.

planned a joint meeting. Although the two chapters shared common goals to promote better rural conditions, they infrequently worked together. However, with health care services as an organizing point, the chapters joined together. As described by McDonald, "The joint Ruritan meeting was great," with highly visible signs of "unity, social momentum and community control of the project," what were to McDonald "crucial concepts" for successful organizing.¹⁴

Plans were quickly made for a joint community meeting at which time a health council would be elected. Organizing for health care services is a noncontroversial, nonthreatening activity; the description of the joint town meeting offers an opportunity to observe the diverse support the health center project gathered. According to McDonald,

The community meeting was awark [sic, probably awkward] and choppy, but beautiful. The people were ready for it. A Baptist preacher opened the meeting with an invocation. The Dungannon Ruritan president turned the floor over to the Dungannon mayor, who directed traffic. ... A Catholic priest gave his clinic spiel to the people.¹⁵

At these last meetings the RSHC workers had less and less input, as McDonald said, "My roles at the meetings had

¹⁴McDonald, "Evaluation," CHS, pp. A-B.

¹⁵Ibid, p. C.

grown smaller and smaller." The student workers were surprised when the community -- after watching a videotape on the organization of other rural clinics and engaging in some general discussion -- "quite suddenly ... elected an 18 person board of directors, with at least one board member from each main community in the county." Fund-raising started then and there as the board circulated "a piece of paper, on which participants pledged donations, both open and specified." The board of directors quickly appointed "'proven' fundraising captains from each community in the county ... to lead a door-to-door donations campaign."¹⁶

It is difficult to reconcile the RSHC leader's first impressions of community apathy and the later descriptions of rapid community mobilization. Given a viable project with good prospects for assistance through the PHS funding and guidance, the communities responded quickly and efficiently. For example, these adjoining communities usually pursued their interests separately. However, when the response to the health fair demonstrated the area-wide lack of adequate health care, the communities realized they would have to work together to gather enough support to build a health care facility, apply for federal funding, and bring in a physician. Significantly, the health council repre-

¹⁶ McDonald, "Evaluation," CHS, pp. C-D.

sented both Dungannon and Fort Blackmore, as well as surrounding settlements. In commenting on the Fort Blackmore residents' participation, Charlotte Nickels said,

I just love those people. I never knew them, and I guess they didn't know us. We knew them, you know, but we didn't know anything about them. ... But to be personally acquainted with them and to have a working relationship with them, we didn't have it 'til we started this, and now we work together just¹⁷ as good as any communities can be expected to.

After meeting all winter, on March 22, 1976, the health council incorporated as Clinch River Health Services, a not-for-profit corporation, organized "to improve the health services and health education" of area residents. The service area included Dungannon and Fort Blackmore, as well as the "communities and/or towns [of] Sinking Creek, Nickelsville, Flatwood, Copper Creek, Rye Cove, Clinchport, and Midway," and other neighboring settlements.¹⁸ With incorporation, the real work of building a clinic started.

After conducting a health fair and introducing the communities to a viable solution to their health care needs,

¹⁷ Maura Doherty, "Health Council Survey, Final Report, August 1980," pp. 5-6, Center for Health Services Collection, Vanderbilt University, Nashville, Tenn. (hereafter Doherty, CHS).

¹⁸ Clinch River Health Services, Inc. "Articles of Incorporation," Article 2(a), 12 March 1976, Clinch River Health Services Inc. Collection, Dungannon, Va.

the RSHC students provided followup. They kept in touch, visited, corresponded, and often one or two students would return to live in the community, from several months to a year, assisting as needed with grant writing, legal services, or administration. One such student, a graduate of Vanderbilt's College of Liberal Arts, spent the summer of 1976 in the Dungannon-Fort Blackmore communities helping the CRHS board file for tax exempt status, expedite grant applications, and conduct fundraising.¹⁹

Throughout the spring and summer of 1976, the two communities were heavily engaged in fundraising, choosing and purchasing a site, and "clinic raising." By some accounts, little over a year before there had been little visible evidence of sustainable, formal community organization, certainly no record of inter-community cooperation. Richard Couto observed that after communities had successfully sponsored RSHC health fairs, leadership emerged, organization was achieved and mobilization was sustained. He concluded that "a community's doubts about its ability to achieve something is one of the earliest and most persistent

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 Couto, Streams of Idealism, p. 19; "Student Health Coalition," n.d., n.p. [single page typewritten report], Center for Health Services Collection, Vanderbilt University, Nashville, Tenn.; RSHC, "Final Report," CHS, pp. 16-17.

difficulties in mobilizing local support for new services."²⁰ Anne Leibig, an outsider who gained acceptance as a community leader and became the first administrator of the CRHS, made a similar observation. She too believed that the very success of planning for and conducting a health fair generated the confidence to forge ahead with this major undertaking. She said,

The people really had the energy for the clinic because the people from Vanderbilt came in and did the health fairs in the right way, and people saw that they could do stuff. If they did this, this happened and then that happened.²¹ So there was a lot of energy for doing stuff.

Given the intense level of community activity in such a short period of time, it is very difficult to uncritically accept the judgment that the community had completely lacked indigenous leadership, initiative, and organization before the arrival of the RSHC. After all, twenty to thirty years before, Dungannon had been a thriving town. After its decline, precipitated by outside forces, the town lacked the economic resources and formal mechanisms to reverse the decline and institute improvements, for example, in health care services. Even with indigenous leadership, the means were not available to affect change.

²⁰Couto, Streams of Idealism, p. 61.

²¹Interview with Anne Leibig, Dungannon, Va, November 14, 1990 (hereafter Leibig Interview).

However, beginning in the mid-1960s and continuing in the 1970s, federal support of the community health center program provided a means for health care reforms at the local level. Even so, the community health center program as administered by the Office of Economic Opportunity in the mid 1960s was more conducive to urban areas. Only after the program's transfer to the PHS and further innovations was it conducive to rural operation. The RHI Program, the most relevant innovation, was created by the PHS in 1975, the year of the Dungannon-Fort Blackmore health fair. The RHI allocated more resources to rural areas; authorized small, primary care projects which small rural communities were better able to manage; through positive programming channeled resources to communities with the "greatest need;" and advocated service to poor and non-poor alike.²²

Before the arrival of the RSHC, information about a community health center as a viable option had not reached Dungannon and Fort Blackmore. Along with a lack of services, rural areas traditionally lacked access to information about government policies. Researchers Karen Davis and Ray Marshall noted "the absence of strong rural media and

-----²² Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986. (Pittsburgh: University of Pittsburgh Press, 1988), pp. 111-12, 116.

communications" to spread the news of opportunities and successful strategies in health care. Therefore, government policies and successful programs went "unnoticed or unheralded outside a narrow confine."²³ However, the citizens of Dungannon-Fort Blackmore recognized a good opportunity when one was presented and willingly supported it.

At this point in the collective history of CRHS, the people's willing support acquired mythic overtones. In interviews with the original organizers, the recital of fund raising activities almost becomes a litany: covered dish dinners, cake walks, candy sales, bake sales, shooting matches, country and western musicals, and square dances. Arthur Farmer, the first treasurer, counted the pennies -- not dollars, -- collected after every Saturday night activity. The activities themselves raised community spirit as well as the badly-needed funds. For example, at the second fundraising event on Saturday evening, July 24, 1976, held at the newly-purchased clinic site, folks enjoyed a family supper, country and bluegrass music, and contributed over \$1,000. As the newspaper reported, "The best assess-

-----²³ Karen Davis and Ray Marshall, "New Developments in the Market for Rural Health Care," Research for Health Economics 1 (1979): 74.

ment of the evening was voiced by one of the community participants, "That's the best time I ever had."²⁴

From 1940 to 1970, and especially during the 1950s, one of the greatest outmigrations in American history occurred with the movement of people out of the southern highlands. From 1950 to 1970, the Appalachian region experienced 3.3 million outmigrants, with 2.2 million of that total leaving during the 1950s. Mountain people - especially the young - moved to industrial centers in the Midwest. In a classic pattern of chain migration, the Dungannon-Fort Blackmore folks migrated to Wabash and Fort Wayne, Indiana, to Defiance, Ohio, to the auto cities of Michigan. The fundraising committee solicited contributions from these former residents, urging them to remember those they left behind and contribute to their health care.²⁵ Some of the folks hadn't gone any farther than Kingsport, and press releases to the

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²⁴Interview with Arthur Farmer, Dungannon, Va., November 13, 1990 (hereafter Farmer Interview); Interview with Otis G. Lawson, Gate City, Va., January 6, 1993; "Fund Raising Held at Clinch River Health Center," newspaper article, n.d., Clinch River Health Services, Inc. Collection, Dungannon, Va.

²⁵Farmer Interview; Jerome B. Pickard, "Population Changes and Trends in Appalachia," The Invisible Minority: Urban Appalachians, eds. William W. Philliber and Clyde B. McCoy (Lexington: University Press of Kentucky, 1981), pp. 95-104. Forrest Lang, M.D., Vice Chairman and Director of Medical Education, Department of Family Medicine at East Tennessee State University, (continued on next page)

area newspapers carried this appeal, "All former residents of the Dungannon-Fort Blackmore area are invited to donate to the building of this clinic. ... We urge you to share in the improved medical facilities for the future health of your hometown."²⁶

In these cash-poor farm communities, many people who could not contribute money donated building supplies or the use of their equipment. Curtis Mays, who served as president of the new organization's board of directors, recalled:

And what surprised me, some of the people who really didn't have the money on hand, said they'd write a little note, send up to St. Paul Builders to get ²⁷so many sheets of plywood ... that kind of thing.

Many men -- regardless of whether they had donated money or supplies -- also contributed their labor in the actually building of the clinic. Mays, who labored as hard

(continued) served as a family practitioner in Haysa, in southwestern Virginia. Lang remembered communities raising funds for clinics by appealing to outmigrants. In their new locations, migrants organized benefits and sold raffle tickets, sending the proceeds back home. Interview with Forrest Lang, M.D., Johnson City, Tenn., Summer 1986. Interview was conducted for article: Edythe Quinn Caro, "Patterns of Tradition, Elements of Need: Appalachian Health Care," Appalachian Focus 2 (Winter 1986): 5-9, 25-26.

²⁶ Clinch River Health Services, Inc., Press Release, "June 19 [1976] fundraising," single, typed page, n.d., Clinch River Health Services, Inc. Collection, Dungannon, Va.

²⁷ Mays Interview.

as anyone in constructing the clinic building, recalled,

We would work, have [events] of different types here to try to raise money. We'd build a while, run out, do it again. I don't know how many dances we had in this building before the partitions went up to form the rooms in it.²⁸

After studying communities that had organized community health centers, Couto observed that "mobilization is greatly enhanced by the visible signs of a building's foundation being poured and framing erected." People became believers and supporters when the evidence was right before their eyes. For example, one of the CRHS board members recalled:

A guy who hadn't been here since we had a supper came by. We just had the roof [of the clinic] on, we didn't have [the building] partitioned off or anything. He said, "This is one of the best things that has happened in the community."²⁹

Therefore, the "cornerstone laying," was a momentous event. On June 19, 1976, "several hundred people" attended the day-long event which started with "men from both communities donating their time and skills to lay block." Later in the day, the politicians arrived to help lay the cornerstone. The Hon. Ford C. Quillen and Rep. Bill Wampler demonstrated their support for the clinic by each contributing \$100 and staying for dinner. Proceeds from individual

²⁸ Ibid.

²⁹ Couto, Streams of Idealism, p. 72.

contributions and the covered dish supper which closed the day increased the building fund by close to \$1000.³⁰

As the summer months passed and the CRHS building took shape, the board turned to other duties, less relaxing and social than the dances and covered dish suppers, more tiring than laying brick or raising partitions at the clinic after a day work at one's regular job; that is, they started the long process of applying for federal funding. Even with the support of the PHS bureaucrats, the process was demanding. Commenting on the momentum it took to get CRHS funded and fully operating, Farmer said that building the clinic "kind of boosted us along because we got this job done."³¹

The board undertook the formal business of securing large-scale funding to open and operate the clinic. But even though they had to go to the federal government for financial assistance, they remembered it was their own considerable efforts that created CRHS. Through community efforts, they had raised \$28,000 in cash contributions, the equivalent of \$26,000 in donations of labor and material, and "received \$6,000 in contributions from outside private

³⁰"Clinch River Health Clinic Dedicated," newspaper article, n.d., Clinch River Health Services, Inc. Collection, Dungannon, Va.

³¹Doherty, CHS, p. 11.

sources."³² Farmer, the original treasurer, offered this strong endorsement of the community's achievement; he explained,

In building the clinic, it was the community's effort. The government didn't have anything to do with it until later, after it was built.³³

To facilitate the grant application process, the CRHS board drew on the resources of an institution that had a long history in regional development, the Tennessee Valley Authority (hereafter TVA). TVA believed it had a mission to offer a "coordinated approach to resource problems, physical and human, mobilizing all available technical and social skills to advance the interests and welfare of the Valley people." While concentrating its enormous resources on huge projects, TVA committed itself to less spectacular services as well, for example, promoting education and health. Although this human services component of its regional commitment was never as well-funded -- rarely receiving more than two per cent of its budget -- through a variety of programs, TVA interacted with the communities of the valley. For example, TVA was very familiar with the RSHC health fairs as it loaned its Mobile Medical Van to the Coalition for six weeks each summer, and the health fairs utilized TVA

³²Couto, Streams of Idealism, p. 64.

³³Farmer Interview.

facilities for lab tests. In order to arrange utility hookups for its van, TVA officials visited each of the communities scheduled for a health fair.³⁴

TVA provided resource people to assist rural communities in planning health centers and related projects. Upon learning of this service, the CRHS council requested assistance and the communities gained valuable assistance and a friend when John C. McClellan, Jr. arrived. A Community Specialist with the Community Resource Development unit of TVA, McClellan was, in a sense, coming home. A native of Scott County, Va., he had a special fondness for these people and knew their problems and respected their ability to overcome problems -- with the right opportunities and some resources.³⁵

³⁴Avery Leiserson, "Administrative Management and Political Accountability," and Vernon W. Ruttan, "The TVA and Regional Development," in TVA: Fifty Years of Grass-Roots Bureaucracy, eds. Erwin C. Hargrove and Paul K. Conkin (Urbana: University of Illinois Press, 1983), pp. 139, 157-58; RSHC, "Final Report," CHS, pp. 25-26.

³⁵John C. McClellan, Jr., "Series of Events Involving Establishment of a Primary Health Care Project at Dungannon, Virginia," typed report (JCM:NK:R. Hunigan--8/17/79), p. 1, In possession of John C. McClellan, Jr., Knoxville, Tenn., copy in my possession. (hereafter McClellan, "Series"); As a TVA health service representative, McClellan was experienced in community organizing. From 1971 - 1975, as a TVA health educator, he worked with the Chattanooga-Hamilton County [TN] Health Department, helping communities develop satellite public health centers. See his article, "Decentralizing Urban Health Departments," in Health Education, Nov. - Dec. 1976: 9-10.

In assessing the CRHS plans, McClellan immediately noted that "the most important element of a health care program was missing: participation by medical professionals and agencies." McClellan and "five local leaders" chosen by the board met with "medical societies, hospital administrators, public health officials, the rescue squad, the Health Systems Agency, LENOWISCO Board of Supervisors, and other groups." Forming early and positive relationships with these individuals and agencies was deemed very important for the future success of CRHS.³⁶

In the process of reviewing CRHS's application for a RHI grant, PHS officials from the Region III office in Philadelphia visited the communities. According to McClellan, they "recognized the need for health care services;" they were impressed by "the commitment and involvement of the local people;" and "they were very pleased that TVA was offering assistance to the community and could act as liaison [and] provide the needed organizational structure." The PHS proceeded to "channel instructions" through McClellan, who interpreted the "rules and regulations of [the] Federal programs" to the board.³⁷

³⁶ McClellan, "Series," p. 2. LENOWISCO represents Lee [County] - Norton [City] - Wise [County] - Scott [County] Planning District Commission.

³⁷ Ibid.

With only four weeks before the PHS deadline, the CRHS board, the communities, and McClellan worked together to complete the application and submit the endorsements from various regional agencies. The level of activity was tremendous. McClellan recalled:

I practically lived with the people in Dungannon in order to keep them totally involved in the planning process. We needed letters of support from medical societies, hospital administrators, boards of supervisors, nurses' associations, businesses, public and State health departments, congressmen, and others, and we got these by dividing up the work and utilizing all the committee members. After working diligently for three-and-a-half weeks, we developed a plan that was supported by both the board and the medical community.³⁸

The RHI application required the National Health Service Corps (hereafter NHSC) to designate the communities as a "health scarcity area." To assist CRHS in securing this crucial designation that would allow center physicians to qualify for loan forgiveness, the Scott County Medical Society, the County Board of Supervisors, and LENOWISCO, the local Planning District Commission, among others, issued Certifications of Need.³⁹ What is striking about this

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³⁸Ibid., p. 3.

³⁹NHSC Application, CRHS, "Certification by Local Government of Need...", signed by Clerk, Scott County Board of Supervisors, n.d.; "Recommendation ... Need for Medical/Health Personnel," from LENOWISCO Planning District Commission, 16 August 1976; letter from William P. Grigsby, M.D., President, Scott County Medical Society, 18 August 1976.

cooperation is the "unanimous approval" each agency conveyed, reflecting the nonthreatening character of the community project and its board. On November 29, 1976, the NHSC granted the designation and informed CRHS:

Approval of your community as an NHSC designated health scarcity area may enable health personnel in your area to qualify for loan forgiveness under the provisions of legislation being administered by the Bureau of Health Resources Development, National Institute of Health.⁴⁰

Unfortunately, as the NHSC warned, this approval did not guarantee that the board would find two physicians willing to come to their new clinic. It only allowed them to offer physicians the incentive of working off their medical education indebtedness.

When DHEW/PHS awarded CRHS "approximately \$600,000 over a 3-year a period," the communities were faced with implementation of their long-awaited dream. The board's responsibility for finding funds now shifted to utilizing them. With McClellan's continued stress on full participation of all board members, each committee assumed some portion of the responsibility for implementation. For example:

the personnel committee decided on staff, salaries, and benefits; the equipment committee worked with local physicians in purchasing the proper medical equipment; the building and publicity

⁴⁰ H. McDonald Rimple, M.D., Assistant Surgeon General, Regional Health Administrator, U.S. Department of Health, Education, and Welfare, Public Health Service, Region III, Letter to Curtis Mays, CRHS, 29 November 1976, Clinch River Health Services, Inc. Collection, Dungannon, Va.

committee selected the furniture, and community residents made⁴¹ drapes and painted pictures for the interior....

With authorization and funding in place, the board's next challenge was to recruit two physicians. The recruitment process had its own dynamic as physicians investigated community health centers, sizing up the communities and boards, and the boards interviewed likely candidates, trying to determine their suitability; both sides trying to find the right match. After interviewing several prospective physicians, the CRHS board recruited two physicians, Raymond (Robin) Feierabend, M.D. from Tulane Medical School, and Alice Coblentz, M.D. from the Medical College of Pennsylvania.

Robin Feierabend didn't come to CRHS as a NHSC candidate enrolled in its loan forgiveness program. He and his wife Margaret came because of the mountains and the opportunity to serve an underserved population. Feierabend said that during his three years of residence in Greensboro, N.C., "I really felt like the mountains were calling us." And he knew he wanted "to spend some time practicing in an underserved area." In spring 1978, they began investigating opportunities and "looking at communities in the mountain area of North Carolina and Tennessee." He learned about

⁴¹McClellan, "Series," p. 3.

CRHS from the Virginia Primary Care Association. On their first visit to Dungannon, they met Curtis Mays and were so impressed with his forthright manner and dedication that they chose CRHS.⁴²

Although Feierabend was attracted by the "sense of community spirit," he recognized "[t]here were some down sides," as he explained,

...I knew I would be going to a community where I had no other support from other physicians immediately available, other than my partner; that I wouldn't be seeing physicians on a day-to-day basis. That [isolation] can be sort of stifling. I knew that I wouldn't have a hospital practice. That at the time didn't seem like a big concern. I knew that it was going to be a very different existence for us; we were both city people. ... So we had some fear and trepidation as to how we would adjust to pretty much of a rural setting.⁴³

The fact that CRHS was a NHSC site was not a deciding factor in his decision. He had looked at a number of Corps sites as well as "straight private practice opportunities." He accepted the fact he would be salaried. An advantage he recalled was the "administrative support built into it." During the summer of 1978, he and his wife arrived in Dungannon. Feierabend and his fellow physician and partner at

⁴²Interview with Raymond [Robin] Feierabend, M.D., Bristol, Va., November 14, 1990 (hereafter Feierabend Interview).

⁴³Ibid.

CRHS, Alice Coblentz, worked together "taking care of the details of getting things in order to start practicing." Although Feierabend didn't start his actual practice until November, Coblentz started seeing patients in August.⁴⁴

Alice Coblentz came to Dungannon through the NHSC; as she explained, "they paid for my last two years of medical school" and she would repay the Corps by serving two years at CRHS. With only one week during her internship in which to visit possible sites, she hurriedly visited three, one in eastern Colorado and two in southwest Virginia. She chose CRHS, recalling, "...I was really impressed with the community, that they could work together and build this building." She immediately recognized the communities' need for a health center, remarking later, "People in the county definitely have to travel too far for medical attention."⁴⁵

As a graduate of the University of Pennsylvania and the Medical College of Pennsylvania, some of Coblentz's experiences had centered around small cities in Pennsylvania: Reading, where she was raised; Allentown, where she did her

⁴⁴Ibid; Rita Quillen, "Dr. Alice Modernizes 'Country Doctor' Role," newspaper article, n.d., In possession of Alice Coblentz, Asheville, N.C., and copy in possession of author. (hereafter Quillen/Coblentz).

⁴⁵Quillen/Coblentz; Correspondence with Alice Coblentz, September 22, 1993 (hereafter Coblentz Correspondence).

internship. However, her student medical experiences had included diversified rural practices. In the mid-1970s, she had worked "with a rural health program in New Mexico for 3 months," and had spent another month, "with a GP [general practitioner] in Scotland on the Isle of Harris observing rural care under that system." She described her interests as "more in `alternative medicine,'" involving "preventive medicine, counseling and educating people," especially in nutrition.⁴⁶

The CRHS board received authorization to add a dentist to its initial medical team. Dentists were as scarce as physicians in the county. While the PHS considered a normal service to be 4,000 persons per dentist, five dentists -- two of them over age 65 -- served the entire Scott County population of 24,376. The PHS was willing to support dental facilities in this designated "dental shortage area," and awarded the additional funding. As was its consistent strategy, the board carefully exploited existing services and experts. Using the services of TVA's Architectural Design Branch to provide the building addition plan, the center expanded with two dental treatment rooms, a laboratory, and office space. Learning that some "practically new" NHSC dental equipment was available in a small town

⁴⁶Quillen/Coblentz; Coblentz Correspondence.

some fifty miles away, the board got it by simply agreeing to go pick it up.⁴⁷

A board member located a young dentist, Alan Bagden, who was willing to practice in the area if a facility and equipment were provided. The NHSC agreed to pay his salary for two years and he arrived, starting his practice in October. A registered nurse and a licensed practical nurse completed the medical staff. Beginning in December, CRHS contracted for pharmacy services with the Appalachian Regional Hospital system.⁴⁸

The comprehensive health care package was almost complete, offering primary medical and dental care, but its preventive care program was inadequate, lacking a strong educational service. Although health education had been reduced to supplemental status under the 1975 legislation (P.L. 94-63, Title V, sec. 330), in 1978 legislation created a category of "priority supplementary services," that included "home health services, dental services, health

⁴⁷McClellan, "Series," p.3.

⁴⁸McClellan, "Series," p. 4; U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program, Clinch River Health Services, Inc., Grant Application, signed 21 February 1979, Annual Progress Report, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 21 February 1979, CRHS); NHSC Application, CRHS, p. V.

education, and other social services that would facilitate the use of primary health services."⁴⁹ Thus, health education funding -- though limited -- was more readily available. With some money for programs, CRHS needed to hire a health educator. As McClellan described the situation, "We wanted a person who could relate to the people and who had the expertise and dedication needed to plan and implement a comprehensive program for people who had no knowledge of how to care for their health."⁵⁰

While there is some room for doubt as to the total ignorance of the citizenship in health matters, there was certainly room for improvement. The board learned from McClellan that TVA had a program for assisting the University of Tennessee in placing health education students in rural areas. A good match was made; in December, CRHS gained the services of Susan Hutchinson, M.P.H. McClellan described Hutchinson as a young woman "who was devoted to her profession and who fitted in with the community." CRHS board asked TVA to pay her salary for six months; TVA agreed.⁵¹

⁴⁹Sardell, pp. 147-48.

⁵⁰McClellan, "Series," p. 4.

⁵¹Ibid.; Leibig Interview; Anne Leibig, Correspondence, July 15, 1993; Mays Interview; RHI Application, 1 March 1979, CRHS, Budget Justification.

The non-medical member of the first team was Anne Leibig, ACSW, in the role of administrator. As a community worker with the Appalachia Community Development Corporation, she had been involved with planning the health fair and health council at St. Charles, Va., in 1973. In her social work in the region, she knew well the problems indigenous to southwest Virginia, economic depression and lack of services, especially health care. When she settled in Dungannon, the community was in the midst of organizing their clinic. She attended a community meeting and got involved in fundraising. When it came time to hire an administrator, the board considered her for the position.⁵²

McClellan and members of the board of directors talked to Leibig about the position, but did not immediately hire her. She had to pass their muster and gain the approval of the PHS administrators in Region III in Philadelphia. She recalled:

I think it was kind of a big thing for them [the board members] to ask me because I wasn't part of the community. ... But then they did and I had to go up there [to Philadelphia] and get approval.... I had to go up there and meet them before I could take the job. ... We're in their region. They really wanted the clinic to get started well and they wanted some review and approval of the first administrator.⁵³

-----⁵² RSHC, "Final Report," CHS, p. 23; Leibig Interview.

⁵³ Leibig Interview.

The regional officials -- following PHS policy -- worked closely with communities to assure that centers were well-launched. They were ready to instruct the centers in changes in legislation. For example, besides the creation of "priority supplementary services," the 1978 legislation had "authorized special funds for technical assistance to local community groups to be provided by private nonprofit or state organization," such as the state chapters of the National Association of Community Health Centers.

Also, if centers generated additional income through increased efficiency in the collection of patient fees and third-party reimbursements, they were allowed to retain "at least 50 percent of such income." Centers could use this revenue to increase services and/or extend their catchment area, to improve administration and management, to construct new facilities or modernize existing structures, or to lay the economic foundation for conversion to a prepayment system.⁵⁴ Although it would be a long time before CRHS would generate sufficient income, the incentive was there.

For the present time, CRHS needed to get started on firm medical and administrative footing and if Leibig could help make that possible, she would be hired. She definitely

⁵⁴Sardell, pp. 146-48.

had some things working in her favor. When CRHS was being organized, the community began to tackle other projects as well. The women organized a Women's Club "to do community improvement," and Charlotte Nickels asked Leibig to be its president. As she explained, "Charlotte was real instrumental in saying that I should be the first president of the Dungannon Women's Club. ... So that's the role I got...." With the blessings of the town mother, the bureaucrats in Region III, and finally, with the endorsement of the (mostly male) board members, she became the clinic's first administrator. One additional person -- filling the roles of receptionist, bookkeeper, and office manager -- assisted Leibig and the medical team in running the business end of the center.⁵⁵

In August 1978, CRHS opened for business; by December 1978, it was fully operational. In the red brick building, besides a spacious waiting room and four examining rooms, there were rooms for offices, a laboratory, medical records, and an emergency room "to provide limited emergency services." As mentioned, space for the dentist and a pharmacy

⁵⁵Leibig Interview; RHI Application, 1 March 1979, CRHS, Budget Justification. In order to increase administrative efficiency, CRHS had received authorization for a "billing clerk trainee employed through the Migrant and Seasonal Farmworkers CETA contract." RHI Application, 21 February 1979, CRHS, Annual Progress Report.

were provided through the additions to the original building plan. Although its hours changed over time, the original plan called for CRHS to be "open five days a week, from nine to five, with the possibility of opening one evening and/or Saturday morning a week, if the needs of the working people require it."⁵⁶

While many health care services were provided on site, others were provided by "appropriate referrals to highly specialized diagnostic and treatment facilities in other settings." To do so, CRHS entered "referral agreements or working relationships" with the following health care or social service institutions and agencies: Scott County Rescue Squad, Scott County Public Health Department, Sullivan County Medical Society, Scott County Medical Society, Scott County Social Security Office, Area Agency on Aging/ Division of Medical Services, Tennessee Valley Authority, Health Systems Agency serving Scott County, Indian Path Hospital and Holston Valley Community Hospital, Kingsport, Tenn., and St. Mary's Hospital, Norton, Virginia.⁵⁷

Up and operating, CRHS delivered primary care, the entry point of health care services for most people, pro-

⁵⁶NHSC Application, CRHS, V.

⁵⁷RHI Application, 28 December 1976, CRHS, VI. Implementation Approach, p. 12.

vided health education and preventive services, dental services, and through agreements with area medical institutions and social service agencies, arranged referrals for specialist care, hospitalization, or social services. Thus, it offered comprehensive care and coordinated and utilized area resources. Through its board of directors, it provided community representation and participation. After the community had provided the support, leadership, and service necessary to organize the nonprofit corporation, and had contributed funds, materials, and labor to build the facility, the RHI grant for federal funding had made it possible to begin operation, and PHS guidance had steered the center in the right direction. Here at CRHS, a community health center serving the rural communities of Dungannon and Fort Blackmore in southwest Virginia, all the major components were assembled for the successful delivery of affordable, comprehensive, primary (curative and preventive) health care.

Chapter Five analyzes the operation of CRHS from 1979 through 1987, through periods of growth and decline in utilization affected primarily by the presence or absence of physicians. The chapter focuses on the composition and role of the board of directors; the difficulties in recruiting and retaining medical personnel; the health status of the

community and the services to improve it; and the cooperative spirit of the PHS in funding the center through its difficult periods. Despite the difficulties, with continued funding and the use of mid-level medical personnel and cooperative arrangements with outside agencies, CRHS was able to continue to provide primary health care to the communities.

CHAPTER 5

SERVICE AND CRISIS, 1979 - 1985

When Clinch River Health Services (hereafter CRHS) began delivering primary care to the population of the Dungannon-Fort Blackmore area, one of the most distinctive features about the community health center design was its governance. Those who owned and governed CRHS were the center users themselves, acting through an elected board of directors. The board managed the operation; set policies, programs, and non-medical procedures; applied for funding; hired physicians and other health care and administrative personnel; established and reviewed the financial system; and received regular reports from the medical and administrative staff. Because so much of the success or failure of the center resulted from the board's managerial style and decisions, it is important to understand who the board members were and how they related to the consumers, to the community, and to the health care and administrative staff.

According to Public Law 94-63, the 1975 legislation giving separate and distinct identity to community health centers, the majority of board members had to be "consumers who used the center" and "who, as a group, represent[ed] the

individuals being served by the center."¹ Over the years, the board members have qualified as consumers of the center's services, even though some of them also patronized doctors in Kingsport or elsewhere.

The issue of consumer representation is much more difficult to judge, not only at CRHS but at all community health centers -- rural and urban. The PHS in its Program Expectations for Community and Migrant Health Centers explained the terms of representative as follows:

As a group, the user board members must reasonably represent the individuals served by the center in terms of factors such as ethnicity, race and sex and should be representative in respect to age and economic status. These² factors are not, however, meant to impose quotas.

In a population which is 95 - 99 percent white -- with the majority of Scotch Irish stock -- race and ethnicity are not factors. However, economic status is a consideration. In the 1970s forty percent of population to be served was reported as below the poverty level and of the remaining 60 percent many were near poor. The majority of users were on

¹Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986 (Pittsburgh: University of Pittsburgh Press, 1988), p. 101.

²U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Program Expectations for Community and Migrant Health Centers, Attachment A., 1 May 1991, p. 7. (hereafter PHS, Program)

Medicaid or the sliding fee schedule.³ To what degree has the CRHS board represented the majority of the center users? And if they haven't and are instead economically better-off individuals and/or members of the local power structure, does that matter in CRHS's success in serving the community?

Before considering whether board members, especially several prominent long-time members, belonged to the local power structure, it is necessary to establish what qualified one as belonging to the "local power structure" in a small, poor, rural community. Conventional descriptions that associate class and power with wealth can be misleading here. Compared to middle class, urban and suburban economic standards, most of the board members, including teachers and farmers, were low income. Farmers especially were often land rich and cash poor. Heads of households frequently combined several occupations, for example, a little lumbering plus farming, or farming and work in Kingsport's factories, situations which left them underemployed and uninsured or underinsured for health care coverage. Even with several jobs, these people often reported incomes below state and

³U.S. Department of Health and Human Services, Public Health Service, Region III, National Health Service Corps Application for Placement of Personnel, 1976, Community Information Form, #8(51), (52), Clinch River Health Services Inc. Collection, Dungannon, Va. (hereafter NHSC Application, CRHS).

national levels for middle class. Therefore, low income did not eliminate one from being part of "the local power structure" in these communities.

Membership in the local power structure often depended on length of residence, for example, being the descendent of a founding family versus a "newcomer" of fifty years, or on location, for example, farming fertile, flat bottom land rather than steep, rocky land up a hollow. If an individual combined above-average local income with founding family status, he or she -- and especially he -- might be considered a prominent individual within the local power structure.

In these poor, rural communities with few professionals, teachers -- especially if they were from local families -- held higher status, even if they earned less than coal miners or truck drivers; consistently teachers were well represented on the CRHS board. Long-time residents with ties to other communities, to the county seat, to regional institutions gained status, for instance, a farmer with ties to the county farm bureau, or a postmaster with ties to county political leaders.

Because several of the original members remained on the board for most or all of its existence, often serving as officers, special attention is given to the socioeconomic status of these members. Curtis Mays, the individual most

people would name as the founder of CRHS, was the board's first president. Over the course of his seventeen years of service on the board, he held many positions. A native of the area, Mays taught Vocational Agricultural Education at the local [Twins Springs] high school, and was a long-time member of the Scott County Farm Bureau and Farmers Home Administration boards of directors. In addition to teaching, he raised beef cattle. His wife, Sue B. Mays, Ed.D., commuted to East Tennessee State University in Johnson City, where she taught in the Department of Home Economics (later the Department of Applied Science) from 1976 to her retirement in 1990.⁴ With land, advanced educations, and professional positions that linked them to county and urban centers, Curtis and Sue Mays were at or near the top of their community's social order. Certainly Curtis Mays was one of the "right people," whom RSHC leader Kevin McDonald referred to when he commented that the success of the health fair and clinic needed "sanction by the right people."⁵

⁴Virginia Primary Care Association, Inc., "The Dunganon Story: Small Town Spurred by Medical Center Development," A Word ... From Our Board Rooms (April 1987): n.p.; Interview with Curtis Mays, Dungannon, Va., January 7, 1993 (hereafter Mays Interview).

⁵Kevin McDonald, "SHC Final Evaluation," 18 August 1976, p. A, Center for Health Services Collection, Vanderbilt University, Nashville, Tenn. (hereafter McDonald, "Final Evaluation," CHS).

The board included several other individuals who fit this category, for example, Phil Osborne, co-owner of the local hardware store, S.I. Osborne and Son Hardware, and Jim Scott, principal at the local [Twin Springs] high school and later assistant superintendent of schools for Scott County. These two men represented the most prominent families in the history of the town of Dungannon. In 1782 Stephen Osborne settled at Hunter's Ford which later became known as Osborne's Ford. Then, between 1833 - 1839, Joseph Hagan bought considerable land in the area. His nephew, Patrick Hagan, bought more land and in the 1860s built his manor house, Hagan Hall. When the railroad reached Osborne's Ford, bringing it the potential for growth and prosperity, Patrick Hagan renamed the town Dungannon, for his birthplace in Ireland. Phil Osborne is a descendent of Stephen Osborne and Jim Scott is a descendent of Patrick Hagan. Whether one considers Osborne's Ford or Dungannon, as one respondent commented, "If you're the people the town is named after, you've got a good position."⁶

The most prominent woman on the board was Charlotte Nickels, a member of the family for whom the nearby town of

⁶Dungannon Historical Society, "Dungannon: A Place in History" (Dungannon, Va.: Dungannon Historical Society and Clinch River Educational Center, n.d.), n.p.; Interview with Vance Sherwood, Knoxville, Tenn., March 22, 1993 (hereafter Sherwood Interview).

Nickelsville was named and the aunt of Phil Osborne. As one respondent said, "She has a leadership style that cares for community in Dungannon and when she asks, no one says no."⁷

Arthur Farmer, owner and operator of an auto repair shop, was the first treasurer of the board. He also served as treasurer for the Masons and the building fund for his Baptist Church. Farmer had sat for a term on the Scott County Board of Supervisors.⁸ The occupations of other members included farmer, secretary, merchant-contractor, factory worker, and retired miner; the postmaster/mistress was usually a board member.⁹

In the context of the small, poor, rural communities of Dungannon and Fort Blackmore, most of the members of the original board of directors (and subsequent boards) were less poor individuals and part of the "local power structure." They were not bankers and professionals, but as one respondent explained, "You're talking about the same kind of strata, if you will, the reference points are just

⁷Correspondence with Anne Leibig, Dungannon, Va., July 15, 1993 (hereafter Leibig Correspondence).

⁸Interview with Arthur Farmer, Dungannon, Va., November 13, 1990 (hereafter Farmer Interview).

⁹NHSC Application, CRHS, VI.

different. We didn't have any bankers in Dungannon, we didn't have any bank."¹⁰ The board members came from the respected class and the community understood this. As another respondent explained:

There was a social stratification in the town. ... Class played a big role. ... The [traditional] terms don't really apply because nobody had any money. But still people had a place and role, and knew the definite pecking order. You knew where everybody was. ... I don't think they [lower-status individuals] would have been terribly welcome if they had wanted to play a leadership role. I think it¹¹ would have been viewed as moving outside of rank.

Karen Davis and Ray Marshall examined structural variations of community health center boards, and their findings shed light on this question of representation. They differentiated between consumer-board and community-board sponsorship. In a consumer board structure, the project was sponsored and governed by "an elected consumer board" that exercised "a strong active role in policy setting." In a community board structure, the project was sponsored and governed by a [non-elected] community board "composed of leading members of the community (local power

¹⁰ Interview with Raymond (Robin) Feierabend, M.D., Bristol, Va., November 14, 1990 (hereafter Feierabend Interview).

¹¹ Sherwood Interview.

structure -- banker, head of school board, county commissioner, etc)."12

The CRHS board was "an elected consumer board which takes a strong active role in policy setting." And after examining the occupations and roles of CRHS board members in the context of their poor, rural community, one may conclude that it had strong representation from leading members of the local power structure. Did it matter that the majority of the board -- especially the most long-term and prominent members -- were not representatives of the lowest-income and lower status majority?

In its Program Expectations for Community and Migrant Health Centers, the PHS explained the value of consumer representation: "The governance requirements for C/MHCs are unique among health service programs and are the basis of ensuring that each center is responsive to the needs of its community."13 Could a largely non-representative board such as CRHS's be responsive to the needs of the consumers and the community?

Again, Davis and Marshall shed light on this question. By differentiating between communities, Davis and Marshall

¹²Karen Davis and Ray Marshall, "New Developments in the Market for Rural Health Care," Research in Health Economics 1 (1979): 74.

¹³PHS, Program, p. 6.

identified the board structure that was better suited for particular needs. If a community had minority or poor people for whom health care services had been restricted by local powers, then "an indigenous, patient-elected board" was important "as a lever" for improving the health care as well as the "economic and social position of these groups." However, Davis and Marshall pointed out:

In other communities where poverty and racial discrimination are not factors, a community board made up of the local power structure -- bankers, lawyers, and politically powerful figures -- has been of assistance in obtaining requisite legal advice, financial assistance, and local and state governmental support. Whether such a constituted board membership is desirable or not depends largely on whether it identifies¹⁴ with and shares the goals of the health project.

Dungannon and Fort Blackmore more closely resemble the second community in that racial discrimination was not a factor. However, poverty was a factor. Was the board sensitive to the needs of the lowest-income individuals, for example, those on Medicaid or assigned to the sliding scale? From evidence in the interviews and reports, one finds a sense of paternalism on the part of the better-off members towards the less-advantaged individuals. For example, a respondent explained:

We didn't have anybody on the board who represented the "folks who lived two miles up in the hollow without running water, and so forth."

¹⁴ Davis and Marshall, p. 74.

Although I think many of the board members had an understanding and respect for those individuals. Many had a very paternalistic sort of an attitude, which isn't all bad. In some cases, it's appropriate. But still, what they felt like was needed was not always in agreement....¹⁵

The OEO bureaucrats had originally stressed maximum feasible participation and community action for community health centers as a means to overcome paternalism and to empower individuals. But over time with changes in the political climate and the transfer of the centers to the PHS, the emphasis on empowerment had been lost. The PHS bureaucracy hoped the centers would reasonably represent the consumers, act in their behalf, and also receive approval from county and state authorities. As Davis and Marshall pointed out, having members of the local power structure on the board facilitated relations with authorities.

The CRHS board's generally mainstream profile worked to the community's advantage in its efforts to quickly and smoothly secure health services. Several of the members held elected or appointed positions in county politics and professional organizations, giving them a stake in the existing political power structure. Their positions and consequently their project did not threaten the county political and medical power structure, thus helping to

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¹⁵Feierabend Interview.

secure the politicians' and physicians' approval. As McDonald of the RSHC had commented, "they [the board] knew how to work with Scott County people."¹⁶ Throughout its history but especially in critical times, the community health center program's success depended in part on local control and approval and its noncontroversial character; CRHS was able to achieve approval and success.

Along with economic and social class, gender must be considered in terms of both representation and responsiveness to needs. Women were consistently represented on the board and served as officers, on several occasions as president. Whether their presence translated into real participation in decision making or remained as token representation is open to question. Charlotte Nickels, one of the original organizers and members of the board, enjoyed personal power as a matriarch in the community. However, one of the medical professionals who attended board meetings made this observation, "It was obvious in attending Board meetings that women were not to be heard from and although there were women on the board, they were not regarded as equals by the men."¹⁷

¹⁶ McDonald, "Final Evaluation," CHS, p. D.

¹⁷ Correspondence with Alice Coblentz, M.D., Asheville, N.C., September 22, 1993 (hereafter Coblentz Correspondence).

Whether representation by economic and social class ever approximated the ideal is not as important as whether or not the board members ensured that the CRHS was responsive to the needs of all groups in the community. An analysis of CRHS's operation over its sixteen-year history will help decide whether the board served the needs of the entire community, poor, near poor, and non-poor alike, as well as male and female, young and old. The analysis must begin with an understanding of what were the center's and the board's stated objectives, and these are found in CRHS's Articles of Incorporation. An examination of the Articles also reveals how the rhetoric of the founders followed a pattern familiar to the American ideal of community volunteerism, but at the same time was short on specifics. As expressed in the "Articles of Incorporation," the purposes for which CRHS was organized were as follows:

(a) To improve the health services and health education available to the residents of that area.... (b) To encourage closer cooperation among the residents of the several communities ... in pursuit of better health and welfare for all the residents of these communities. (c) To ... lessen the burdens of government, to promote the social welfare of the area, and to encourage local initiative in solving health problems and relieving the poor and distressed and underprivileged residents of these communities.¹⁸

¹⁸Clinch River Health Services, Inc. "Articles of Incorporation," Article 2(a - c), 12 March 1976), Clinch River Health Services, Inc. Collection, Dungannon, Va.

The Articles use the phrase, "to promote the social welfare of the area," but do not describe what was included in "social welfare," or how it would be promoted. While the very operation of CRHS improved "the health services" of the community, the board and staff were much weaker on improving the "health education" of the community, as will be demonstrated in a review of CRHS's operation.

CRHS had already started "to encourage closer cooperation among the residents of the several communities," as noted earlier. The very choice of the building site for the clinic -- on the border between Dungannon and Fort Blackmore -- reflected the joint nature of the project. The interaction continued throughout the process of building and operating the clinic.

The vague phrase, "to lessen the burdens of government," reverberates with the pervasive American belief in "voluntary action." The historian Rosemary Stevens explored the "voluntary ideal" as applied to community hospitals and medical institutions, identifying "volunteerism" as "a major, unifying rhetoric" which countered "government intervention." This American value underscored the founders' expressions of pride in having built CRHS solely with community contributions of money, labor, and materials, without any local or federal government assistance or interference. As one resident declared, "I feel better over

having us paying for our own clinic than having some grant to do it. They try to tell you what to do."¹⁹

Of course, to operate the clinic the community had to rely on federal funding, but the very foundation for local health care, the building itself, was evidence of their hard work and support. That support continued at a high pitch during the period 1978 to 1982, which represented CRHS's honeymoon with the community. While there were stresses and adjustments, this was a time of optimism as the people's dreams were realized through the services of "Dr. Alice" and "Dr. Robin," as the physicians were known by their patients. Both physicians had plenty of work to do to remedy the decades of inadequate service. The patients brought an accumulation of untreated chronic problems to the physicians. For example, Feierabend explained:

I saw many, many patients who said they'd never seen a physician or hadn't seen a physician in thirty - forty years. ... I felt that particularly by those individuals I was very well

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 Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (New York: Basic Books, 1989), p. 140; Richard A. Couto, Streams of Idealism and Health Care Innovation: An Assessment of Service-Learning and Community Mobilization (New York: Teachers College Press, Columbia University, 1982), p. 64.

received, because I was there to help them. They had not had anybody else they could turn to for help before.²⁰

Coblentz discovered that the medical treatment her patients had been receiving had relied heavily on prescription drugs. She explained:

I saw those folks who weren't getting medical care ... and I also saw people getting bad medical care -- lots of people who got shots of penicillin for a cold; Valium on a regular basis for "nerves." Little or no health education, in terms of preventive life style information.²¹

She not only noted the lack of care, she also noted the socioeconomic and behavioral causes of common illnesses.

She recalled:

My impressions of the area's health needs were that a good many problems were related to smoking, poor nutrition, and low economic status. There were also issues related to women's relative poorer status within the community and sense of powerlessness in their lives.²²

These "impressions" would be reported in greater detail in later years, in statistics on teenage pregnancies and in complaints of "nerves" and chronic depression. The effects of widespread smoking would be found in the high incidence of upper respiratory infections in the population, especially among children suffering from second-hand smoke.

²⁰Feierabend Interview.

²¹Coblentz Correspondence.

²²Ibid.

Situated adjacent to the coal fields in neighboring counties, CRHS counted coal miners among its patients, including some who suffered from verified cases of pneumoconiosis, commonly called black lung, or from general respiratory problems. Without medical verification that their ailment was black lung, the miners did not receive occupational disability benefits, regardless of their suffering. Feierabend explained the difficulties encountered in treating these cases,

I saw a lot of people who came to say, "I have black lung disease," but they were not receiving black lung benefits. Their X-rays didn't show the changes that would be consistent with black lung disease. They certainly had respiratory problems and may well have had mild pneumoconiosis, but also may have just had emphysema from their smoking history. That [black lung] is one of those diseases that is very much a bio-psycho-social disease. It's not just disordered lung physiology.²³

As stated in center reports to the PHS, besides providing "diagnosis, treatment, and follow-up of acute and chronic medical conditions," CRHS undertook an extensive program "to assure that an immunization level of at least 90% for all of its registered population 17 years of age or

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²³Feierabend Interview. For a discussion of black lung disease and its social costs, see Barbara Ellen Smith, "Black Lung: The Social Production of Disease," International Journal of Health Services 11 (1981): 343, and Digging Our Own Graves: Coal Miners and the Struggle over Black Lung Disease (Philadelphia: Temple University Press, 1989).

under [was] achieved...." CRHS also offered "Voluntary Family Planning Services" which at that time consisted of "counseling, IUD insertion, diaphragm fitting, [and] pill prescription." As part of its health education effort, CRHS reported to Region III that it "had planned on making an application for the adolescent grant program but found that this money was not available because of lack of appropriations." Unfortunately, because this early effort at securing funding for health education outreach had failed, the board may have been discouraged from initiating future efforts.²⁴

Utilization is one of the strongest indicators of a center's success, and during the practices of Feierabend and Coblentz, and the dentist Bagden, the figures are as follows:

fiscal year	Medical ²⁵	
	Users	Encounters
1978/79	637	1116
1979/80	1770 ²	2559
1980/81	3082 ²	5471
	[1760]	
1981/82	1600	5340

²⁴U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program, Application for Federal Assistance, signed 21 February 1979, Accomplishments/Compliance; Budget Justification, Clinch River Health Services Inc. Collection, Dungannon, Va. (hereafter RHI Application, 21 February 1979, CRHS).

²⁵Figures for 1978/79 take into account CRHS's startup with staggered additions to its practice from August to December. CRHS's administrator (continued on next page)

fiscal year	Dental ²⁶	
	Users	Encounters
1978/79	223	495
1979/80	1007	1388
1980/81	1322	1664

Besides the services of the physicians and dentist, the community received health education from Susan Hutchinson. TVA was so pleased with her program that they renewed her contract for six additional months. Margaret Feierabend, the physician's spouse, also had experience as a health educator and volunteered her time. Working together, they took health education into the elementary school, offered weight control classes to adult patients at the center,

 (continued) questioned the reliability of this high user figure (3082) as it did not correspond to any other yearly usage from 1978-1993; the sudden increase, then decline could not be explained. The figure (3082) might represent the total medical and dental users, in which case 1,760 would be the medical user figure, much more in line with the pattern. Figures compiled by Carolyn Bowen, Administrator, CRHS. As explained by Davis and Schoen, an "encounter" is "the basic unit of utilization" in a health center's reporting system. When a patient visits a center and receives a service or services from one or more provider(s), that constitutes one encounter. Repeat visits for continuation of treatment, for example, having blood pressure checked, are each considered an encounter. Davis and Schoen, p. 179, fn. 32.

²⁶ Figures for 1978/79 take into account CRHS's startup with staggered additions to its practice from August to December. Figures compiled by Carolyn Bowen, Administrator, CRHS.

and parenting classes for young people. The center added a Patient Education Library to its services.²⁷

To continue the health education after TVA's funding expired, CRHS included a request for such funding in its budget, reminding the PHS that "health education was mentioned as a priority supplemental service." To press its case, CRHS explained:

It is very important in the first years of health service delivery to provide health education in order to develop preventive health attitudes. Our health educator is assisting us in meeting our quality indicators, (family planning counseling, immunization, nutrition education.)²⁸

Unfortunately, the supplemental funds were not approved and after the TVA grant expired, the center's funding was not sufficient to cover the health educator and her services were not continued. Even though the CRHS total funding may not have been cut, it was not adequate for these "priority

-----²⁷ John C. McClellan, Jr., "Series of Events Involving Establishment of a Primary Health Care Project at Dungannon, Virginia," typed report (JCM:NK:R. Hunigan--8/17/79), p. 4, In possession of John C. McClellan, Jr., Knoxville, Tenn., and copy in my possession; Interview with Anne Leibig, Dungannon, Va., November 14, 1990 (hereafter Leibig Interview); Mays Interview; RHI Application, 21 February 1979, CRHS, Budget Justification. According to federal policy, voluntary family planning services were to be provided "regardless of the race, creed, sex, parity, marital status, or age of the individual." RHI Application, 21 February 1979, CRHS, p. 7.

²⁸ RHI Application, 21 February 1979, CRHS, Budget Justification.

supplementary" services. Typically, throughout the community health center program, when faced with budget constraints, outreach workers were the first clinic employees to be dismissed. Here again CRHS's health education outreach plans were cancelled due to insufficient appropriations and these repeated disappointments may have discouraged the staff and board from submitting proposals.

Although the health care delivery system was successfully in place at CRHS, its existence always depended on two factors, the continuance of federal funding and retention of its physicians. Over the course of its history, one of CRHS's major problems would be physician retention, especially given the two-year service commitment schedule of NHSC recruits. This problem presented itself early in its operation, when Coblenz completed her NHSC commitment and left in late summer 1980. The board did not seek to replace her, as they believed "that the services of two full time physicians were not necessary."²⁹

Feierabend continued until 1982, when he left to join a family practice group in Bristol, Va. Unfortunately, the

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²⁹Coblenz Correspondence; U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 23 January 1984, Part IV, 2, Project History, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 23 January 1984, CRHS).

board was thoroughly unprepared for his departure. All along, the board members were reluctant to plan for this eventuality, hoping their popular physician would stay. Even though he had given them a year's notice, they did not begin the tedious search for a new physician until several months before his actual departure. By then it was too late to get a replacement and CRHS was left without a physician. According to one respondent, in a pique of anger and disappointment, the board "summarily fired the whole staff," citing the need to cut down on expenses, and notified the community that "a nurse practitioner would be taking over." For the community, the board's actions created "a lot of unsurety as to what was going to happen."³⁰

While the physicians' reasons for leaving were many -- including the lack of hospital privileges -- certainly the board's attitudes and working relations were factors. One health care professional believed that from the beginning the board regularly interfered with minor details in the center's operation, such as setting hours and determining which evening the center would be open. This health care provider believed those decisions were better left to the staff who had to work them.³¹

³⁰Feierabend Interview.

³¹Ibid.

While the locus of decision-making on such details is open to debate, to be successful the center's hours of operation had to reflect the needs of the community, making some provision for those who worked at a distance or on irregular shifts. As Milvoy Seacat pointed out, this attention to the needs of the community was a major distinction between a hospital's outpatient department and a community clinic. In the hospital's clinic, the hours were set for the "convenience of the institution," rather than the needs of the patients. In a community health center, the needs of the patients were to take priority.³²

A CRHS health care provider contrasted its board with others, explaining:

Some boards see their roles as facilitating the health care providers, ... letting the health care providers decide how they're going to do it. Other boards get bogged down in day-to-day running of business. Unfortunately, the board in Dungan was very often like the second kind of board. Very well meaning. Good people but just not, I think, always constructive in the way that they tried to oversee.³³

Various commentators on community health services stressed that communities had to pay more attention to retaining physicians once they were recruited. For example,

-----³² Milvoy S. Seacat, "Neighborhood Health Centers: A Decade of Experience," Journal of Community Health 3 (Winter 1977): 59.

³³Feierabend Interview.

Gordon H. DeFrieze and Thomas C. Ricketts reported that "where physicians have the ability to modify the structure and operation of the centers," they registered "higher levels of work satisfaction and retention after any obligated service commitments are met."³⁴ Years later, Coblentz summed up the difficulties, when she explained:

As young and naive physicians we were in a very difficult situation. We were required to answer to the Federal government, the local Board of Directors and lastly our individual patients. I would never again voluntarily put myself in a position of₃₅ having to answer to so many divergent interests.

After a healthy beginning, CRHS entered a period of decline and the community was forced to swallow a bitter pill and accept more limited health services. But as one health care provider recalled, the center's early success was not something to be taken lightly, explaining, "I think it's a testimony to the amount of good will on the part of the community and personnel working at the clinic that the whole thing didn't fall apart."³⁶

Helen Lewis, a community activist and Dungannon resident, recalled that during crisis periods -- such as this --

³⁴Gordon H. DeFrieze and Thomas C. Ricketts, "Primary Health Care in Rural Areas: An Agenda for Research," Health Services Research 23 (February 1989): 957.

³⁵Coblentz Correspondence.

³⁶Ibid.

some board members had seriously considered transferring the clinic to a private physician who would operate a traditional fee-for-service practice.³⁷ That action would have adversely affected service to sliding fee (and perhaps also Medicaid) patients. Community activists protested such thinking and successfully halted the transfer.

Along with not serving the poor, a private practice might not set high priorities on preventive care and outreach. For example, in addressing the issue of rural private practice, Davis and Marshall recognized that "it is not at all clear that private medical professionals can or will provide the leadership for environmental health and preventive medicine," two areas rural health care needed to address.³⁸ While it is not known which board members seriously considered transferring CRHS to a private practice, surely board members who sincerely represented lower-income residents would be concerned for their continued access to care. Since the transfer was forestalled, the care -- intermittent as it was -- for low-income and middle-income patients continued.

³⁷ Interview with Helen Lewis, New Market, Tenn., March 24, 1994.

³⁸ Davis and Marshall, p. 87.

The most difficult years for CRHS were those from 1982 to 1984 when the clinic's operation fluctuated, leaving residents in a state of confusion and anxiety as to their consistent source of health care. Should they stay with CRHS or try to find another physician? One resident, herself an emergency room nurse at Holsten Valley Hospital & Medical Center and a former board member, recalled:

My father-in-law ... was at that time doctoring at Nickelsville.... Well, we talked him into coming to Dungannon. It was closer, the doctor was right there. We moved all his records over, convinced him that's what he should do. So what happens, the doctor left. So he had to go back to Nickelsville. And his remark was, "I'm not doing this anymore now; I'm going to stay where I'm at, because you can't keep anybody there."³⁹

For a brief period Alice Coblentz returned to work at CRHS on a part-time basis, supervising a nurse practitioner.⁴⁰ However, the situation was less than satisfactory for all, as Coblentz recalled:

It became increasingly difficult for me to deal the Board. My belief at that time was that there were members of the board who were angry that I wasn't willing to simply work full time and, therefore, remove the problem they had of finding practitioners to work at CRHS.⁴¹

³⁹ Interview with Carol Sluss, R.N., Dungannon, Va., January 7, 1993 (hereafter Sluss Interview).

⁴⁰ In 1977 Congress passed the Health Clinic Services Act allowing rural centers to be reimbursed for the services of nurse practitioners, nurse/midwives, and physician assistants. Sardell, p. 129.

⁴¹ Coblentz Correspondence.

In 1983, CRHS experienced major disruptions of services and frantic efforts to patch together some health care provision. In June, the nurse practitioner left, followed by Coblentz's departure in July, resulting in several months when CRHS was without any medical providers. Utilization rates plummeted. CRHS's problems could not have come at a worse time. Upon becoming president in 1981, conservative Republican Ronald Reagan worked to impose his stringent version of New Federalism, which, according to Theodor Litman, "sought total cessation of public sector spending on social programs."⁴² Reagan and his policymakers targeted the community health center program for destruction, since it represented government responsibility for providing health care to poor and medically underserved populations by means outside private sector, market forces. The AMA, the Heritage Foundation, and conservative congressmen expressed their fears that the growth of the community health center program during the Carter administration had suggested the creation of "a national health service."⁴³

⁴²Theodor J. Litman, "Government and Health: The Political Aspects of Health Care: A Sociopolitical Overview," in Health, Politics, and Policy, eds. Theodor J. Litman and Leonard S. Robins (New York: John Wiley & Sons, 1984), p. 8.

⁴³Sardell, pp. 180, 173-74, 183.

Funding had always been the weapon of choice to destroy or defend the program, depending upon whose hands wielded it. Reagan's policymakers attempted to submerge the program's categorical funding in a Health Services Block Grant to the states, giving them complete discretion in allocation, with no federal regulations as to eligibility or services. During the most brutal Congressional battle in the program's history, Senator Edward Kennedy (D-Ma.) attacked the block grant system, pointing out that "[t]hese Federal programs were developed precisely because states and local governments were either unwilling or unable to meet basic health care needs."⁴⁴ The outcome of the ideologically heated debates was noteworthy. The community health center program was placed in its own "primary care block grant," but overall funding was cut.⁴⁵

Although PHS officials had to maintain a low profile within the Reagan administration, they worked assiduously to

⁴⁴Bernard Weinraub, "Kennedy, Schweiker Spar on Aid to Poor," New York Times 3 April 1981, p. A:18.

⁴⁵According to the 1981 [Budget] Reconciliation Act, unless states specifically applied to take over the administration of their community health center programs, the PHS would continue its administration. Any state making application had to agree to complicated funding and operating requirements. Only West Virginia requested take-over and that was a short-lived arrangement of only one year. From fiscal year 1981 to 1982, the program suffered a twenty five percent reduction in funding, with some of the money later restored. Sardell, pp. 166-75.

protect the program. In cutting funds of individual centers, they exercised great dexterity, and developed guidelines which showed considerable wisdom. They ceased funding poorly managed centers that had embarrassed the PHS and created political risks to the entire program and protected centers that demonstrated great need and honest effort to correct their problems. When CRHS was unable to meet its service obligations and efficiency and cost effectiveness goals due to its problems in recruiting a physician, the board received a waiver from Region III officials. Working in the center's favor were the great need for health services, and -- despite its troubles -- the center's good reports from local agencies and medical organizations.⁴⁶

At this time, CRHS joined the National Association of Community Health Centers (hereafter NACHC) and the Virginia Primary Care Association, an organization that serves as an liaison between the state's community health centers and the government. The NACHC, founded in the mid-1970s, lobbied Congress vigorously and effectively during the battle over funding status, supplying key senators with "detailed information" about the health centers in their states.⁴⁷

⁴⁶Sardell, p. 182; RHI Application, 23 January 1984, CRHS, p. 17.

⁴⁷RHI Application, 23 January 1984, CRHS, p. 18; Sardell, pp. 173, 176, 178.

While the PHS was attempting to protect the center, the board had to show full intention of resuming services, so their efforts to recruit a full-time physician continued despite frustrations. As explained by one former member: "We had one [physician] who came through the front door and the first thing he said was 'Where's the nearest golf course?'"⁴⁸ While there are reports in the literature of interviewing physicians with similar attitudes, most physicians objected to serving a rural community because of their isolation and lack of hospital privileges. Seacat examined the problem and made recommendations:

...[I]f center physicians were granted admitting privileges in the back-up hospitals and were allowed to follow their patients into the hospital, the physicians would personally find their practice more stimulating. The physicians who are working in centers need to participate in hospital rounds, conferences, committee work, and teaching, for their own professional development and continuing education.⁴⁹

Throughout the center's history, the lack of hospital privileges afflicted its physicians and it remained a deterrent to working at CRHS.

⁴⁸Sluss Interview. When they could not secure a NHSC physician, the board contacted a recruiting agency, Medical Services of America, Inc., who "indicated that it could provide a physician from a foreign background." The board interviewed three physicians, considered one candidate as "a real possibility," but the arrangements failed to work out. RHI Application, 23 January 1984, CRHS, p. 18.

⁴⁹Seacat, p. 164.

Although the center was reduced to minimal operation, it managed to provide some health education, especially for its hypertensive patients. In 1983 the board hired Sister Rosemary McClain, CRN, EdD., to develop a comprehensive health teaching plan, including home visits, and efforts to teach the clients and their families to "set health goals as a basis for continuing health care." CRHS also employed a local resident to "assist with the weekly weight control meetings." In May the center offered a special hypertensive clinic, "offering free blood pressure checks."⁵⁰

These health services were desperately needed, especially to treat chronic illnesses. CRHS listed the "Major health problems in [the] target area" as: "1. Hypertension, 2. Arteriosclerotic Cardiovascular Disease, 3. Black Lung, 4. Chronic Obstructive Pulmonary Disease, 5. Poor Nutrition, 6. Unplanned pregnancies, 7. Cancer."⁵¹ With "unplanned pregnancies," as the sixth major health problem, CRHS worked to "[p]rovide full family planning services to female adolescent users age 13-19, attempting to maximize family involvement...." However, its efforts were restricted to individual counseling, rather than public education, as explained

⁵⁰ RHI Application, 23 January 1984, CRHS, pp. 18, 19, 17.

⁵¹ Ibid., p. 34.

in its RHI grant: "At the present time because of local sensitivities it is not practical to pursue active visible outreach programs related to family planning services."⁵²

While continuing their search for a full-time physician, in November 1983 the board sought immediate, limited coverage by contracting with East Tennessee State University's Kingsport Family Practice Center "for supervision of a nurse practitioner, consultation, and hospitalization coverage." In its February 1984 newsletter, CRHS announced its annual membership meeting to be held at The Depot Community Center. Besides the election of board members, the meeting would feature a guest speaker from the Kingsport Family Practice Center who would discuss "Being Healthy in the Hills." However, the newsletter's most important message ran under the headline: "Full Time Services Now Available at Clinic!"⁵³

The board had hired a family nurse practitioner, Tom Strickland, and his wife, Judy, a pediatric registered nurse. With his ability to operate the X-ray equipment and her ability to utilize the lab, CRHS offered a full comple-

⁵²Ibid., p. 34.

⁵³Ibid., pp 18, 19a-b; Clinch River Health Services, Inc., Newsletter 7 (February 1984): n.p., Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter CRHS, Newsletter, CRHS).

ment of services. As the newsletter explained, "The King-sport Family Practice Center [had] contracted with CRHS to provide physician care and hospitalization." Three physicians rotated in visiting the center and supervising the nurse practitioner.⁵⁴

Late in July 1984, in order to publicize the reopening of the clinic and promote its utilization, the RSHC sent two community workers and members of its medical team to Dungannon, "to conduct a simple two-day screening and health information fair." As reported by the RSHC, "various local groups ... set up booths on specific health topics and health services offered to the community." While the RSHC reported that the Dungannon-Fort Blackmore communities demonstrated "greater participation from community groups than in other sites," CRHS and the Vanderbilt volunteers were "disappointed in the number of people (75 per day) who showed up." The RSHC suggested "possible reasons" for the poor turnout, including "inadequate publicity, offering screening only -- no physicals, and having the fair at a local school, not at the clinic."⁵⁵

⁵⁴ CRHS, Newsletter, CRHS.

⁵⁵ ASHC [Appalachian Student Health Coalition], "Site: Clinch River Health Services, Dungannon, Virginia," Annual Report, 1984, p. 27, Center for Health Services Collection, Vanderbilt University, Nashville, Tenn.

Both the center and the RSHC appreciated the need for increased community support and utilization. Between 1982 and 1985, the user and encounter rates for CRHS dropped seriously. In contrast to high user figures in fiscal year 1979/80 (1770 users), the declining figures were:

Year	Users	Encounters ⁵⁶
1982/83	1326	3056
1983/84	897	1836
1984/85	1061	2777

As observed by Ronnie D. Horner in a study of federal health care policy in rural areas, "[h]igh turnover in providers is likely to discourage patients from forming an attachment to a center and influences them to use it for emergency and/or episodic care only."⁵⁷ While the contract with ETSU's Kingsport Family Practice Center kept the center operating, the rotation of consulting and visiting physicians was not conducive to the continuity of patient-physician relations. Davis and Marshall addressed this problem, explaining: "Part-time involvement of university faculty located in a more distant medical center is not as

⁵⁶Figures compiled by Carolyn Bowen, Administrator, CRHS.

⁵⁷Ronnie D. Horner, "Impact of Federal Primary Health Care Policy in Rural Areas: Empirical Evidence from the Literature," Journal of Rural Health 4 (July 1988): 17.

acceptable to rural communities as someone who can be more closely identified as their doctor."⁵⁸

In the beginning, CRHS had optimistically set the goal of self-sufficiency in three years, but the high turnover of health care providers, reduced utilization, and insufficient revenues destroyed this possibility.⁵⁹ DeFries and Ricketts reported on studies indicating that centers with "physicians as the principal providers were able to achieve financial self-sufficiency sooner." Also, centers that had "established relationships with local hospitals," allowing clinic physicians some supervision of their hospitalized patients, "were the most financially viable clinics."⁶⁰

However, under the best of physician retention circumstances and with the most cooperative hospital privilege arrangements, most community health centers in poor areas still suffered from insufficient revenues which prevented self-sufficiency. Their patients' lack of health insurance coverage contributed greatly to the centers' dependency. CRHS provided the RHI offices with a "Description of Economic Status of Patients," based on a sampling of 1983/84

⁵⁸ Davis and Marshall, p. 77.

⁵⁹ RHI Application, 28 December 1976, CRHS, IX. Project Continuation, p. 23.

⁶⁰ DeFries and Ricketts, p. 952.

users, which revealed the following:

<u>Third Party Coverage</u>	<u>Service Area</u>	<u>Patients</u>
Medicaid	6.6%	11.0%
Medicare	48.5%	11.5%
Private Insurance	35.2%	44.0%
No Insurance	9.7%	33.5%
Total	100.0%	100.0%

<u>Per cent of Poverty Income</u> ⁶¹	<u>Patients</u> ⁶²
People over 200%	29%
People at 150-199%	33%
People at 100-149%	19%
People below 100%	19%
Total	100%

The Third Party Coverage figures revealed a very real problem: 22.5 percent of the patients received federally subsidized insurance; 33.5 percent lacked insurance, most likely due to underemployment without benefits and with insufficient income to purchase insurance, complicated by ineligibility for Medicaid. The problems of the underinsured and the uninsured were treated by a number of health policy analysts. Here, as in their studies, the problems are separated into three major concerns: 1. inadequate Medicaid coverage in rural America; 2. inadequate reimburse-

⁶¹-----
 According to CRHS's report to RHI, "In a study taken in 1976, the percentage of people nationwide who were below 100% of Poverty Income was 9.0% and in Virginia that percentage was 8.3% in 1976. In Scott County according to the 1980 census, the percentage of people who were below 100% of poverty income was 22.2. Thus, the study closely approximates this figure, making our area considerably above the national average or the Virginia average."RHI Application, 23 January 1984, CRHS, p. 21.

⁶²RHI Application, 23 January 1984, CRHS, p. 21.

ment for health provider services, especially for Medicare;
3. inadequate private insurance.

While poverty is widespread in rural America and Medicaid coverage is a prominent feature of rural welfare, compared to urban areas, fewer rural poor are covered and those covered often receive fewer benefits.⁶³ In 1987, for example, 44.4 percent of the urban poor were covered, "compared with 35.5 percent of the rural poor." Analyst Sophie Korczyk attributed this discrepancy to several factors, most prominently the fact that "[t]wo-parent families, which are generally not eligible for Medicaid, are more prevalent among the rural poor." Other factors were lack of information regarding eligibility; reluctance to submit to a means-tested program; and Medicaid eligibility rulings which "disqualified" low-income people because of their "farm or business assets."⁶⁴ Many rural people own land but are cash poor. In rural America, there are also

⁶³ Medicaid is "generally linked to eligibility for cash assistance under the Aid to Families with Dependent Children (AFDC)" program and in many states AFDC is limited to single-parent families. Although in 1988 there were some revisions in the legislation which expanded eligibility, gaps still persisted between urban and rural coverage. Sophie M. Korczyk, Health Care Needs, Resources, and Access in Rural America (Washington, D.C.: National Rural Electric Cooperative Association and Prudential Insurance Company, n.d.), pp. 41-42.

⁶⁴ Ibid., p. 28.

more working poor -- many underemployed, but their meager and often irregular incomes disqualify them from coverage.⁶⁵

Davis and Marshall focused on the South in their 1979 study of rural America and discovered that "public programs also have less extensive coverage in the nonmetropolitan South than other areas." According to these researchers, not only did the gap in Medicaid coverage hurt the centers at a time when RHI policy was insisting that they maximize third party reimbursements, but the Medicare program "systematically penalize[d] physicians practicing in rural areas by setting lower reimbursement levels for them." This was especially critical as rural America had "a greater proportion" of elderly.⁶⁶

In a paper delivered in April 1993, Bruce Behringer, Executive Director of the Office of Rural and Community Health at East Tennessee State University and President of the National Rural Health Association, addressed this reimbursement disparity as a major barrier to developing "rural health systems." He said:

Before health care financing reform begins, the almost mystical perception long held by the Health Care Financing Administration that there should be payment differentials between urban and rural providers has to be dismissed. ... With greater

⁶⁵Sam M. Cordes, "The Changing Rural Environment and the Relationship between Health Services and Rural Development," Health Services Research 23 (February 1989): 779-80.

⁶⁶Davis and Marshall, p. 69.

percentages of elderly in rural areas, this policy has made physician recruitment more difficult....
[emphasis in the original]⁶⁷

Besides these disparities in Medicaid and Medicare coverage and reimbursement, rural Americans also face inadequacies in their private insurance coverage. There is a degree of irony here. As Korczyk pointed out, "The rural poor are more likely to be employed than those in urban areas." However, these working poor are trapped in "rural employment patterns" of underemployment, due to a higher degree of part-time work and to irregular employment, the consequences of seasonal work and a system of patching together an assortment of odd jobs.⁶⁸ This disparity between urban and rural opportunities was seen in the Dungannon-Fort Blackmore residents' response when CETA jobs became available in the community in the late 1970s. The large turnout for these low wage jobs surprised officials who were accustomed to unemployed urban workers' disdain for the low-paying labor.⁶⁹

⁶⁷ Bruce Behringer, "Health Care Reform: What Are the Implications for Health Care in Rural Areas," Appalachian Health Care: New Ways of Doing Business, Johnson City, Tenn., 20 April 1993, p. 8, copy of presentation in my possession. Also Bruce Behringer, "Developments in rural health: Surviving on the edge of change," Medical Group Management Journal (September/October 1992): 18.

⁶⁸ Korczyk, pp. 6-7.

⁶⁹ Leibig Interview.

These low-wage, part-time, sometimes seasonal jobs do not offer health insurance benefits. Korczyk reported that "[r]ural residents ... have lower rates of employer-provided coverage than urban residents. ... Employees in small rural firms are 20 to 30 percent less likely to have employer-provided insurance coverage than employees nationwide." To compensate, more rural residents -- even the working poor -- purchase private insurance. However, according to Davis and Marshall, their coverage is usually "less comprehensive than that of urban residents."⁷⁰

In the case of CRHS, 44 percent of its patients carried private insurance. It was unclear whether this high figure was strictly patient-purchased insurance, or whether it included those with employer-provided coverage, for example, those residents who worked for Tennessee Eastman Corporation in Kingsport, or who were covered by the UMWA's Welfare and Retirement Fund.

The most disturbing figure in the 1983/84 review of patient coverage was the 33.5 percent of the patients who had "No Insurance," and most of this group was probably low-income or poverty level people. This high figure was contrasted with the 9.7 percent with no insurance in the Service Area in general, indicating that CRHS attracted the

⁷⁰ Korczyk, p. 28; Davis and Marshall, p. 69.

uninsured who had nowhere else to turn for health care. DeFrieze and Ricketts noted a study which found that physicians at NHSC sites were "clearly serving a different, less advantaged clientele..."⁷¹

Given the large number of uninsured, poor patients, CRHS offered a "Sliding Fee Scale, based on family income and size."⁷² However, to qualify for this reduced fee, a patient had to submit to a means test, which some may have considered an embarrassing experience to undergo in a small community where everyone knew everyone else. Based on field observation at CRHS, when a new patient announced his or her need to depend on Medicaid or the sliding fee scale, he or she was interviewed as to amount of family income, as well as any AFDC, rent, and food stamp assistance. The interview was conducted with the patient standing at the receptionist's business window, in full view and hearing of all seated in the waiting room.⁷³

Confidentiality was further threatened by the CRHS board's review of patients' billing records, especially of those with unpaid bills. As explained by one health care provider who attended board meetings:

⁷¹DeFrieze and Ricketts, p. 960.

⁷²RHI Application, 23 January 1984, CRHS, p. 9.

⁷³Field Observation at CRHS, July 30, 1993.

At every meeting, it seemed like, they'd get into the discussion about who didn't pay their bills and why hadn't they. ...[T]here were those that everybody knew could never afford to pay the bills, and the board was very unwilling to cut them off. There were a lot that were sort of in between. And some who the board members all knew, "Oh, they could really pay if they wanted to; they're just free loading."⁷⁴

On several applications, the CRHS board and administrator estimated the catchment area to include 3,950 to 4,400 patients. In one application, their stated goal was "[t]o increase the number of users to 4300" by "May 31, 1985," a number they never reached at any time in their sixteen year history.⁷⁵ Behringer believed that the low utilization at rural community health centers -- compared to the unmet need in most service areas -- was due in part to the embarrassment encountered in applying for Medicaid or sliding fee. He suggested that a person might prefer to keep his or her eligibility for Medicaid or the sliding fee scale secret and use the area hospital's emergency room with its greater anonymity -- or even go without care.⁷⁶

⁷⁴Feierabend Interview.

⁷⁵RHI Application, 21 February 1979, CRHS, p. 2; RHI Application, 23 January 1984, CRHS, pp. 20, 30.

⁷⁶Conversation with Bruce Behringer, Johnson City, April 21, 1993.

As long as health care coverage is tied to income eligibility, gaps will remain; in small communities means tests will be a source of embarrassment; and handling of eligibility and overdue accounts will be open to subjective judgments. As long as low-wage jobs for small, rural (and urban) businesses do not include health care insurance, many people will do without coverage, being unable to afford to be self-insured. And as long as gaps remain in the reimbursement levels between urban and rural practice, rural community health centers will be at a disadvantage.

By 1986, the health care honeymoon was long over for the community, the board of directors and the CRHS staff, both the administrators and medical professionals. All had learned that delivering consistent, quality care demanded much more than the initial surge of community and professional spirit. Operating a community health center was an on-going job of tedious meetings and review; of annually submitting a RHI grant, justifying decisions, explaining missed objectives, requesting exemptions, setting new, more realistic goals; all the time, maintaining services on the same funding even when costs increased. Operating a center meant struggling to retain patients when health care professionals, especially physicians, left and the clinic operated through less-than ideal arrangements with outside providers, and finally trying to recruit new professionals.

Perhaps CRHS might have been more successful if the board had been more communicative with the community, especially when it lost its physician. Perhaps if the board had worked more smoothly with its health care professionals, it may have retained them or recruited others faster. Perhaps CRHS may have increased its number of users and/or retained their loyalty during the crisis if it had encouraged more community participation and offered more outreach services. But even if the board had performed flawlessly, a difficult expectation considering its inexperience and the extent of its responsibilities, it was still dependent on forces which it could not control.

Ultimately, the board could not control the health care providers who had their own personal and professional priorities, especially their need for professional support, for example, hospital affiliation. It could not control NHSC or Medicaid/Medicare policy, or RHI funding which did not increase and did promote outreach. CRHS had opened its doors and gotten off to a successful start during the supportive Carter administration. When its physician crisis occurred during the early, unsympathetic Reagan years, CRHS was very fortunate that PHS officials in Region III had not slammed shut those same doors for the center's failure to meet national goals of efficiency, cost effectiveness, and user productivity.

Locally, CRHS succeeded in delivering primary health care despite crises, board weaknesses, and reduced community support by depending on temporary solutions to its physician problems, and by relying on the dedication and support of a significant portion of its board and community -- some of it given willingly, some of it forced by circumstances. CRHS survived in the RHI program because of obvious need, the mechanism of positive programming, and cooperative bureaucrats. This combination of support allowed CRHS to enter its next era scarred but more experienced and able to take advantage when opportunity again presented itself.

CHAPTER 6

GROWTH AND DECLINE, 1986 - 1990

During the early 1980s while Clinch River Health Services (hereafter CRHS) was struggling to remain a viable health care delivery system on the local scene, the community health center program was struggling at the national level against the conservative forces of the Reagan administration. The program had diligently gained allies in both parties who understood the value of the centers in delivering health care for their medically underserved constituents and votes for themselves from these same constituents. Therefore, while attempting to complete his "revolution," Reagan had to contend with a Congress with a will of its own. For example, in 1984, he had pocket vetoed community health center legislation that had unanimously passed both houses of Congress. Congress unanimously repassed virtually the same legislation in 1985-86; the President, knowing there were enough votes in the House to override a veto, signed it into law on April 24, 1986. The Act, P.L. 99-280, totally repealed the primary care block grant, instead

funding community and migrant health centers as separate categorical grant programs.¹

On the local Dungannon-Fort Blackmore scene in the mid-1980s, CRHS had also rebounded. The center's struggle back to success from the difficult years of 1982-85 came about through the diligence and hard work of many people on the staff and board, and through the loyalty of many in the community of consumers. But most importantly, it occurred because the center had recruited a physician. Todd A. Cassel, M.D., a full-time NHSC physician, arrived in June 1985, replacing the nurse practitioner who had worked under the supervision of the Kingsport Family Practice Center. His acceptance by the community was attributable in part to his enthusiasm for family practice and his appreciation of the community's support. He had entered family practice, he said, "because it still let me learn and practice the whole breadth of medicine -- from childbirth to death..." He chose Dungannon to "fulfill [his] NHSC stint ... [a]fter looking at several sites," noting that "at that time there were also less opportunities because there were a lot of Drs. [sic] needing to fulfill obligations - 1985." He remarked:

¹Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986 (Pittsburgh: University of Pittsburgh Press, 1988), p. 193.

CRHS became an easy top choice. The community was obviously involved and everyone on the interview in Dungannon was supportive and definitely had a goal of keeping the clinic running and successful. It was easy to relax in their enthusiasm....² The setting was to our liking, the people gentle.

Cassel tried to offer continuity in the provision of care through his "physician privileges at Russell County Medical Center," in Lebanon, Va., a travel time of thirty to forty minutes from Dungannon. Although he admitted a few patients there and followed them "through their stay," he was "unable to change the minds of most of [the] patients" who preferred to "use the hospitals in Kingsport," especially Holston Valley Hospital & Medical Center (hereafter HVH & MC, formerly HVHC). Unfortunately, given his patients' refusal to alter their long-established hospital pattern and the distance between CRHS and Lebanon, he was not able to develop "an effective hospital practice."³

-----²Correspondence with Todd A. Cassel, M.D., March 28, 1994 (hereafter Cassell Correspondence).

³U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, 18 February 1988; 3.1.8, p. 28; 3.2, pp. 35, 37; 3.3, p. 50, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 18 February 1988, CRHS); Cassel Correspondence. In the early 1980s, in anticipation of its 50th Anniversary in 1985, Holston Valley Community Hospital (HVCH) changed its name to Holston Valley Hospital & Medical Center (HVH & MC) in keeping with its identity as a "regional health care facility" with advanced medical technologies, equipment, and (continued on next page)

Because of the "one hour's driving time" from Kingsport, he was unable to obtain hospital privileges at HVH & MC which insisted that its "medical staff ... live within fifteen-twenty minutes away from the hospital." However, he developed "a good relationship with many of the doctors" there and visited the hospital for several hours each week "to get information on ... X-rays, blood work and other information needed for his patients...."⁴

Besides his practice during scheduled center hours, Cassel also handled "after-hour emergencies." Unfortunately, some of these "after-hour emergencies" presented a problem common to small-town physicians. As Cassel explained:

...[Because] we lived right on a main road and everyone knew where the doctor was, I had people knock on the door at 3 a.m. for stitches (domestic abuse); people knock on the door Sunday afternoon for their kid's rash that had been there for⁵ days; [and] a man having a heart attack in my den.

(continued) and services. "Where we are ... 1984-85 fiscal year in review," Supplement, Kingsport Times-News, 18 September 1985, Local History Collection, Kingsport Public Library, Kingsport, Tenn.

⁴Cassel Correspondence; RHI Application, 18 February 1988, CRHS, 3.1.8, p. 28.

⁵Cassel and his wife Shelley settled just three miles north of Dungannon. When they arrived, they had a one year old son and another child expected in two months. While there, they had yet another child, a third son, so they "spent most of [their] 'free' time raising very young children." Cassel Correspondence.

Recognizing the drain on Cassel's energies as the only physician at the center and his need for personal and professional time away from the office, the board began negotiations with Russell County Medical Center "to provide physician coverage" in his absence. They also "contacted the [ETSU] Family Practice Group in Kingsport ... to help ... with coverage of ... patients in Kingsport hospitals." Although, the Kingsport negotiations had not yet produced results, the board noted, "...we believe that with a will there is a way."⁶

CRHS was able to arrange effective linkages with other agencies, including sending "indigent parents" to Scott County Social Services, and making referrals of "many patients" to and from the Scott County Health Department, the county's school nurse, and the Maternal and Infant Health Outreach Worker Project (hereafter MIHOW).⁷

To insure proper care for elderly patients and to keep them "at home in lieu of a nursing home," Cassel worked "closely with the home health nurses from Scott County Health Department...." He also made "housecalls for some elderly patients" who could not get to the center. This

⁶RHI Application, 18 February 1988, CRHS, 3.3, p. 50.

⁷Ibid., 3.2 - Health Care Plan, p. 39, and 3.3 Workplan, p. 50.

delivery of care to the elderly was an essential part of CRHS's program, because the "65 Years and older" residents were the fastest growing part of the population. While nationally this group registered 22 per cent of the population, in the CRHS service area, they represented 27.5 per cent of the population, with 11.4 percent males and 16.1 per cent females.⁸

CRHS considered the "elderly and indigent" (often one and the same patients) to be at "the greatest risk for death and disability." The center noted that among its users, "...older patients continue to be more aware of the need for health maintenance and long-term care," and CRHS attributed their improved utilization of its health care services to "Dr. Cassel's acceptance and a more stable outlook for the center." The "most prevalent diagnoses" for the geriatric patients in 1987 were "arthritis, hypertension, COPD, upper respiratory infections, CAD, and depression/anxiety." As stated in the RHI application, the major problems contributing to the elderly patients' poor health included:

The distance from hospital services.... The lack of transportation to health care facilities ... especially for patients who live alone. A lack of proper nutrition.⁹

⁸Ibid., 3.2, pp. 38, 46; 5.9, p. 93; 3.2, p. 46.

⁹Ibid., 3.2, pp. 35-36; p. 105; 3.2, p. 46.

Two of these problems, transportation and poor nutrition, were to some measure correctable with proper non-medical intervention. CRHS informed the RHI officials that it made "referrals to Mountain Empire Older Citizens for meals on wheels, home health aides, transportation and shopping help." As a means of developing a health promotion program, the center listed "Work with other organizations in the community." However, the CRHS program narrative never mentioned networking with the Dunganon Development Commission (hereafter DDC), which operated food programs, and housing repair and rehabilitation projects.¹⁰

While the numbers of elderly grew, the portion of the patient population between ages 19 and 54 declined by 6.5 per cent. Their major health complaint was upper respiratory infection, followed by hypertension, and "work-related accidents." For women in the adult age group, one of their common problems was "untreated anxiety/depression." In Coblentz's years of practice at the center, she had noted this problem and its socioeconomic causes. In 1988, the center described the problem as "related partially to the economic environment, physical or mental abuse by family members and also to poor education." The center noted that

¹⁰Ibid., 3.2, pp. 46, 52.

it referred patients to the Scott County Mental Health Department and to area psychologists.¹¹

Dental problems among this adult group distressed the health care providers. Unfortunately, in June 1987 the "on-site private dentist left." Although patients with dental problems were referred to dentists in the Gate City area, transportation and economic barriers interfered with utilization. CRHS noted, "Dental care is solely lacking. People still feel they cannot afford this 'luxury'." The center studied the need for dental care in its patient population and handed out "toothbrushes, sample toothpaste and dental floss" when necessary. The board investigated recruiting a NHSC dentist or contracting for a "part-time on-site private dentist."¹² Unfortunately, many of the same deterrents to successfully recruiting physicians applied to dentists as well, for example, heavy work load, professional isolation, and low income.

Whether considering the stress on women due in part to the poor economic environment, the lack of financial access to dental care, or the nutritional problems among the elderly, economic difficulties plagued these communities. As the administrator reported, "Lack of money causes anxiety

¹¹Ibid., 3.2, pp. 44-45.

¹²Ibid., 3.2, pp. 38, 44.

and depression and health maintenance is not a priority."¹³

Besides negatively influencing physical and emotional health, the poor economics perpetuated the center's dependency on federal funds to cover the gap between revenue and expenses caused by the large number of uninsured patients. The economic profile which the CRHS board presented to PHS stressed the following:

The service area still has a high level of unemployment as shown by the high percentage of uninsured (52%) and medicaid [sic] recipients (12.5%). Our user population also has 20% more of people between 100 to 199% of poverty and 6% more of people below 100% poverty than our total service area.

The Louisiana Pacific waferboard plant in Dungannon has certainly helped the community but the other jobs in the area, farming, logging, and mining, are not stable. The industries in ... Kingsport, Tennessee (one hour's drive away) still have lay-offs and hiring freezes.¹⁴

Based on 1983 figures, Scott County's unemployment rate was 6.9 per cent, as compared with the state's rate of 5.5 per cent, but local officials figured that the immediate area's rate was higher due to "far fewer jobs and less industry" than in more developed parts of the county.¹⁵

¹³Ibid., 3.2, p. 37.

¹⁴Ibid., 3.2, p. 37. "The percent of population of Scott County eligible for Food Stamps is 13.9%, while the statewide average is 7.6%." Ibid., 5.9, p. 109.

¹⁵Ibid., 5.9, p. 108.

The Dungannon-Fort Blackmore communities had vigorously recruited the Louisiana Pacific Corporation. While directly bringing in jobs and indirectly affecting other sources of employment, for example, in the logging industry, the plant and the spinoffs did not satisfy the employment needs. Over the course of the next few years, the plant became the subject of environmental concerns and labor disputes, culminating in a temporary plant closing.¹⁶

In a linkage that benefitted both parties, CRHS provided clinic services to the LP plant. As explained by a clinic administrator, "If somebody was hurt there, they generally brought them here. ... We did a lot of drug screenings for them because they routinely did that for new employees."¹⁷ This is an example of the availability of health care being -- if not an inducement -- at least an advantage to local industry.

Besides providing health care services to the local industry, CRHS provided "sports physical exams" to the local schools' athletic teams at "reduced rates." Any effort to reach the fourteen to eighteen year old group was important.

¹⁶ Interview with Nancy Robinson, Dungannon, Va., November 14, 1990 (hereafter Robinson Interview).

¹⁷ Interview with Carolyn Bowen, Dungannon, Va., November 13, 1990 (hereafter Bowen Interview).

While only representing eleven per cent of the center users in 1987, that was a two percent increase over previous years. Their usage tended to be "only for episodic care," for example, coming in for treatment of "trauma, contusion, laceration and sprains," rather than for "health maintenance." The center planned to "screen for other problems" during "episodic visits."¹⁸

The major problem this group presented was teenage pregnancy. The area experienced a "34.4 [per cent] higher incident rate ... than the population of the U.S." For this age group, CRHS listed family planning counseling as one of its objectives; the counseling would be "conducted at the center usually by the doctor." The center hoped to "[e]ducate males and females as to the availability of birth control;" however, low-income females had to go to the County Health Department for free contraceptives, not a very convenient solution.¹⁹

The problem of "teenage parents, low-birth weight and/or indigent parents" contributed to worsening statistics in related areas, as CRHS reported:

The infant mortality rate for our service area increased 6.45 per 1000. The percent of births with low-birth weight has also increased by 2.3%. ... Cassel along with the MIHOW person in Dunganon held a prenatal clinic during the year to

¹⁸RHI Application, 18 February 1988, CRHS, 3.2, p. 42.

¹⁹Ibid., 3.2, p. 42.

teach pregnant women about exercise, nutrition, labor pains, facts about their unborn & [sic] newborn child, etc.²⁰

Among the clinic users, the pediatric patients between twenty-eight days and thirteen years had increased two per cent over previous years. The major health problems for this age group were: Otitis media, that is, ear infections, followed by upper respiratory infections, pharyngitis, asthma, and bronchitis. Despite an aggressive, free immunization program, parents were still neglecting to get their children immunized. The center hoped to "increase parental education for immunizations and well-child care," and to "encourage non-episodic care so that potential problems [could be] avoided." Overall, the center staff noted the problem of "Poor growth and development due to poor social stimulation and poor nutrition." The staff planned a campaign to provide anemia screening for this age group.²¹

Across all the age groups, CRHS reported the number one medical problem as "Upper and lower respiratory infections (including black lung, pneumonia, bronchospasm, asthma, bronchitis, etc)."²² Respiratory infections, -- as well as

²⁰Ibid., 3.2, pp. 39, 36.

²¹Ibid., 3.2, pp. 40-41.

²²Ibid., 3.2, p. 35.

low birth rate, and otitis (ear infections), the number one pediatric problem -- are in many instances traceable to exposure to primary and secondhand tobacco smoke. For example, in its March 31, 1994 issue, The New England Journal of Medicine reported:

The EPA report ... reviews studies claiming that exposure to environmental tobacco smoke is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia in children.... It notes that exposure to environmental tobacco smoke is associated with an increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function.²³

Smoking is a predominant behavior among CRHS's target population; for example, of the adult users of the center, 50 per cent smoke.²⁴ This heavy usage is not surprising. In Smoking and Health, A National Status Report, the PHS presented data on cigarette smoking and socioeconomic status, including the following key findings: "Cigarette smoking and use of tobacco vary with education and income.

²³Carl E. Bartecchi, M.D., Thomas D. Mackenzie, M.D., and Robert W. Schrier, M.D., "The Human Costs of Tobacco Use," (First of Two Parts) New England Journal of Medicine 330 (31 March 1994): 910.

²⁴U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 31 January 1990, p. 20, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 31 January 1990, CRHS).

Those with higher education and who report higher incomes are less likely to smoke or use tobacco."²⁵

As well documented in the literature, the effects of smoking are costly: in the pain and disability of illness itself, in work and school days lost, and in the cost of providing health care to treat the patients. However, certain health risk habits, such as smoking, can be influenced -- to some degree -- by programs in behavior modification. However, at CRHS, the medical staff simply identified the patients who smoked, explained the hazards, and offered printed information, a tape, and a "Stop Smoking Kit." The success rate was very small.²⁶ CRHS did not undertake any aggressive outreach programs, such as preventive education programs in the schools or in community

²⁵Based on 1986 Survey of Adult Use of Tobacco, "[f]or those with 11 or fewer years of education, the prevalence is 31.4 percent; the proportion of smokers among those who have 16 years or more of education is 16.3 percent. ... Smoking prevalence falls from 18.9 percent for those with a household income of \$10,000 or less, to 21.8 percent for those with a household income of more than \$40,000. ... The smoking prevalence is 30.0 percent for those who fall below the poverty level and 27.3 percent for those who are above the poverty level...." U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Smoking and Health, A National Status Report: A Report to Congress, 2nd ed. (Rockville, Md.: DHHS, 1990) pp. 7, 16.

²⁶RHI Application, 31 January 1990, CRHS, pp. 19-20.

organizations, or programs utilizing lay health educators to work with the hard-to-reach, at-risk populations.

Among the many studies of lay health workers, one has shown modest success in the "use of indigenous lay health educators" to implement "a community-based smoking cessation program" among "hard-to-reach" young black women in an urban area. The researchers concluded: "Community-based health interventions that employ local individuals as lay health educators can have a positive impact on participation by populations that are generally considered difficult to reach."²⁷

In many ways, rural areas share or exceed the problems of the inner-city. In non-metropolitan areas there are often fewer employment, education or recreational opportunities. In both areas, there is considerable stress, generated by the poor economic conditions. The researchers had also concluded that any smoking cessation program had to address "the life experiences that affect the value placed on smoking as a behavior..." In the case of tobacco use in many Appalachian communities there is another dimension

²⁷ Loretta Lacey et al, "Use of Lay Health Educators for Smoking Cessation in a Hard-to-Reach Urban Community," Journal of Community Health, 16 (October 1991): 269; also, Alfred C. Marcus and Lori A. Crane, "A Rationale for Effective Smoking Prevention and Cessation Interventions in Minority Communities," abstract in PHS, Smoking and Health, pp. 55-56.

certainly not found among urban smokers, that is, tobacco farming. In commenting on the smoking problem, Cassel explained:

Eliminating smoking becomes such a difficult problem because of several factors. One is that it is highly addictive both as a drug and psychologically as an agent to reduce anxiety. (And there is a high percentage of anxiety/depression in a disadvantaged area.) Another is that these people are tobacco producers and derive a lot of their spendable income from tobacco farming. It is hard for them to declare their money crop America's #1 health hazard or to change their own behavior with it. Better education levels and social advancement would also decrease the acceptance of tobacco usage and help stop new starters.²⁸

A minister of a "tobacco church" in Kentucky explained the tobacco growers' denial of health problems:

Denial related to the seriousness of health problems caused by the use of tobacco is much greater among church going tobacco growers than originally believed. Psychologists have found that .. people do not change their habits ... but instead, justify them by either debunking the negative evidence, playing down the importance of the issue, overemphasizing other kinds of dangers to life, or seeking out social support.²⁹

Notwithstanding the complex problems involved in

²⁸ Cassel Correspondence.

²⁹ Bennett D. Poage, "Afterword," in The Tobacco Church: A Manual for Congregational Leaders, ed. Bennett D. Poage (Richmond, Ky.: Christian Church (Disciples of Christ) In Kentucky, Kentucky Appalachian Ministry, 1993), p. 102. A "tobacco church" is "any congregation ... where the economy supporting that church and community" primarily relies on the "growing, processing and/or marketing tobacco." Poage, p. 1.

smoking cessation programs for tobacco-growing communities, innovative health education was never tried. CRHS had not acquired another health educator and thus did not have a staff person who might have known about successful health intervention techniques. Neither the health care providers nor the board had undertaken any innovative, preventive, outreach programs, that is, PHS-designated "priority supplemental" services. Preventive health education programs depended on local initiative but also needed federal recognition and support, such as special funding and technical assistance, which were not yet forthcoming.

While the center's record in outreach was poor, it had demonstrated a strong performance in more standard medical services. After reviewing CRHS's performance during 1987 for its report to the PHS, the board was able to announce:

1987 has been the most successful since the center opened. ... [M]any of the patients who had not been to the center over the past 4 years have returned.³⁰

The number of users in fiscal years 1987/88 was 1,839, with 5,751 encounters, both setting records for the center; exceeding the projected user figure of 1800.³¹ Unfortun-

³⁰RHI Application, 18 February 1988, CRHS, 3.1 - Progress Report, p. 25.

³¹Figures provided by Carolyn Bowen, Administrator, CRHS; RHI Application, 18 February 1988, CRHS, 2.8.4 - Budget Information Narrative, p. 20.

ately, in June 1988 when Cassel's NHSC commitment was up, CRHS once again faced losing its "very well-liked" physician, initiating a crisis that could again drive down utilization rates. Thus, the board cautioned the PHS office, "Dr. Cassel's acceptance in the community has been a great asset to the center and we certainly hate to lose him in June." ... [W]e do expect a small amount of opposition to [his] leaving, we have tried to take this into consideration."³²

Overall, as Cassel's practice at CRHS came to a close, much had been accomplished in restoring stability to the center, in establishing linkages to outside agencies and services; yet much still needed to be achieved in improving the health status of the community and meeting its primary care needs. And, for the long term, certain problems, such as isolation and burnout, inherent in the rural physician's solo practice needed to be addressed. Cassel acknowledged his problems with a rural, solo practice:

I had difficulty because I felt some obligation to be available to the practice (after hours calls, weekends) but I had no one to share that responsibility with. I wore myself out trying to accommodate the practice, my family and my personal needs. I had difficulty setting those limits and it was part this and part professional and family

³²RHI Application, 18 February 1988, CRHS, 3.1 - Progress Report, p. 25. 2.8.1 - Budget Information Narrative, p. 20.

isolation that led to our decision to return to Pa. and enter into a private practice.³³

The CRHS board was understandably concerned that possible decreases in the utilization rates would once again affect their ability to meet the PHS's efficiency and cost effectiveness goals. However, the PHS officials had been very supportive in the center's crises and in more mundane matters. For example, the CRHS board had been a month late submitting the 1988 RHI application because they had just hired a new administrator who was unfamiliar with the process. Region III officials had accepted the delay and guided the new staff person through the process.³⁴

However, this time CRHS was well-prepared for their physician's departure, having recruited another full-time NHSC physician to carry on the practice. Henry Wing Sek Tam, M.D. arrived at CRHS in July 1988 to serve his two-year NHSC commitment. Born in Hong Kong and a naturalized United States citizen, he had graduated from the Columbia, S.C. public high school system, and had received his medical training at the University of South Carolina School of

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Cassel Correspondence.

³⁴Janet Falin, Acting Administrator, CRHS, Letter, to DHHS, Region III, 19 February 1988, Clinch River Health Services, Inc. Collection, Dungannon, Va.

Medicine in Columbia. Like his predecessors at CRHS, his specialty was Family Practice.³⁵

Despite the fears of the board, the utilization rate did not decline when Cassel left. Rather, during Tam's service period, the user and encounter figures rose to their highest levels, as follows:

Year	Users	Encounters ³⁶
1988/89	1,962	5,863
1989/90	2,034	6,298

These increases reflected several forces at work, especially the community's preference for a physician-centered practice. Interestingly, the high utilization also demonstrated the acceptance of an Asian-American physician by the totally white, predominately Anglo-Saxon population served by the clinic. Here is a clear indication of the rural population's eagerness for health care. Once barriers of travel and cost were removed, the population sought the best medical care available, regardless of the racial identification of the provider. The increase in users also reflected other economic and legislative changes outside the community.

³⁵RHI Application, 18 February 1988, CRHS, p. 83

³⁶Figures provided by Carolyn Bowen, Administrator, CRHS.

The "Executive Summary" submitted to RHI reported happenings in southwest Virginia that illustrated "the trend towards doctors leaving rural areas." The Hanging Rock Primary Care Clinic in St. Paul, Va., northeast of Dungan-
non, had recently closed. Several years before, the clinic had operated at full capacity with six physicians. In Castlewood, a town adjacent to St. Paul, one of its two physicians had moved away "to a more suburban area."³⁷ CRHS attributed this trend to worsening economic conditions and stressed the importance of CRHS's presence in the area, noting:

The impact of last year's [UMWA] coal strike and the low reimbursement by Medicare and Medicaid has taken its toll of primary care doctors in areas surrounding Scott County. ... This outflowing of doctors makes it essential that our center remain open to meet the needs of the low income people of Scott County.³⁸

CRHS administration also reported a major increase of 6.5 percent in "the ... users below the federal poverty,"

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Also, the Scott County Health Department had just engaged a new dentist, after going without one for almost a year. RHI Application, 31 January 1990, CRHS, "Executive Summary," p. 8; "Project Description," pp. 21-22.

³⁸Ibid., pp. 21-22. On April 5, 1989, UMWA miners throughout southwest Virginia, Kentucky, and West Virginia went on strike against Pittston Company which had refused to honor its health care and retirement fund obligations to current, retired, and disabled miners and widows. The strike, lasting ten months, was settled on February 19, 1990. Settlement brought peace to the coal fields but many insecurities surrounding health care benefits remained.

bringing the figure to 36.1 percent. During the previous year, the percent of Medicaid recipients among the users had also increased from 10.8 to 27.3 percent. CRHS explained how changes in Virginia's Medicaid policy caused this increase: the state had adopted a program whereby pregnant women and children up to 100% of poverty were now eligible, and the contiguous property restrictions for eligibility for Medicaid had been eliminated. As CRHS explained, "These new provisions have allowed more people to get Medicaid cards." Some patients moved from the sliding fee schedule to Medicaid coverage and other newly eligible recipients were attracted to the center. Other provisions of the state law increased Medicaid reimbursements and provided "for repayment of Babycare services for health centers." These changes improved the center's utilization, collections, and overall revenues.³⁹ However, CRHS still did not meet its earlier stated goal of 4,000 users and, of course, it was still dependent on federal subsidies.

To increase the center's visibility and credibility in the region, Tam established a "contract" as an "assistant clinical professor" with the Department of Family Medicine at James H. Quillen College of Medicine at ETSU to "precept residents," serving two half days per month. ETSU's

³⁹Ibid., p. 22.

Appalachian Preceptorship in Family Medicine was "aimed at training medical students to practice rural primary care in a manner sensitive to the culture." Besides attending "didactic sessions" at the college, students participated in "clinical preceptorships in rural southern Appalachian communities," working with a physician who served as a "role model" and who offered the students "experience in direct patient care." Interacting with the faculty and students, Tam helped CRHS in "becoming known outside [the] service area." Tam and CRHS's board considered his participation in the program as part of their "Recruitment and Retention Plan," hoping to attract a resident physician to their center.⁴⁰ In 1990, his association the College of Family reaped benefits for the center, although not as expected.

In order to gain "active privileges" at HVH & MC, Tam, a bachelor, moved to Gate City, Va., twenty miles from the center but closer to the hospital. Whenever he was in Kingsport, he was able to admit patients to the hospital and follow their care. The center had an agreement with ETSU's Kingsport Family Practice Center, so that whenever Tam was at the center, out of the area, or unable to be reached "by

⁴⁰Ibid., pp. 16, 23, 29c; Department of Family Medicine, East Tennessee State University, "Appalachian Preceptorship 1993 in Family Medicine or Psychiatry (Johnson City, Tenn.: East Tennessee State University, 1993), pp. 1, 3-4.

phone or beeper," their physicians would handle "hospital admission workup" and any necessary followup. Between April and December 1989, Tam "hospitalized" thirty two patients. His hospital privileges also helped to increase utilization, making the center's services more attractive to residents. When Tam was away for periods of several days, CRHS obtained coverage from an emergency room physician at an area hospital. On one occasion, the center gained a full week of coverage by a NHSC commissioned officer/physician "from Washington state who wanted an `Appalachian experience.'"⁴¹

Tam's preceptorship role, "active privileges" at HVH, and coverage arrangements were very much in line with CRHS's objective "[t]o develop and strengthen linkages with other providers and organizations." The center continued to be a site for the county's Women and Infant Care program (hereafter WIC). Once each month at the center, Scott County Health Department personnel dispensed WIC vouchers, provided nutrition counseling and helped the CRHS staff "to certify or recertify patients" for the program. This arrangement increased state revenue to the center and brought at-risk mothers and children into CRHS for preventive care.⁴²

⁴¹RHI Application, 31 January 1990, CRHS, pp. 11, 22, 12.

⁴²CRHS reported that 535 persons received WIC vouchers during 1989. Ibid., pp. 10, 18.

In a similar fashion, the center provided services for area children enrolled in the Virginia Department of Health's Division of Children's Specialty Services Primary Care Project. The staff cared for thirty four patients in this program, of whom thirty were new patients to the center. Many of the families traveled a considerable distance to bring their children to CRHS, as it was one of only two community health centers in southwest Virginia which offered the program. As with WIC, this program brought additional revenue to the center. In an agreement with the Tuberculosis Section of the state health department, CRHS also performed chest X-rays for individuals who had been referred there "because of a positive TB test or history of TB." Treatment was handled through Scott County's Health Department, but this service broadened the center's base of operation and earned additional revenue.⁴³

Tam contributed personal time to serve as a member of the Policy Council Board of the Scott County Head Start Program. CRHS formally assisted the program, providing medical attention for "ill or injured children," free immunizations, and "counseling ... on health related issues dealing with families in [the] community."⁴⁴ This relation-

⁴³Ibid., pp. 11, 62; Bowen Interview.

⁴⁴RHI Application, 31 January 1990, CRHS, p. 62.

ship benefitted both parties, in services rendered to Head Start and in community support of the center.

Although CRHS offered pre-natal care and supervision, because the center lacked obstetrics services, it could not follow its pregnant patients through to delivery, but normally referred them elsewhere in their eighth month. If they were at "high risk," the referral was made immediately. However, the center reported that problems existed in the health care plan for this group. "Referral OBGYN" physicians neglected to send information on the care of patients enrolled with the clinic, and prenatal classes were poorly attended because of the distance patients had to travel from their homes. In its report to the RHI office, the center listed as one of its objectives: "To start prenatal classes with qualified volunteers from this area." To do so, the center planned to: "Enlist help of qualified volunteers. Arrange place for classes to be held. Use VCR tapes and educational material from center and other sources."⁴⁵ In many ways, this proposed activity would duplicate the

⁴⁵For 1989, CRHS reported that all its seventeen pregnant patients had sought care in their first or second trimester, and three had been identified as "high risk." Eight other women "preferred to be referred immediately or obtained prenatal care with another physician themselves," and of the remaining six, three were also "referred to the Maternal Infant Health Outreach Worker (MIHOW) program [Project] for prenatal case management." Ibid., pp. 18, 37.

on-going work of the MIHOW project in the community.

MIHOW assists women "before and after birth to give babies a fair start in life." The service is offered through a partnership of "over two dozen grassroots organizations" working with Vanderbilt's Center for Health Services," the center that coordinated the RSHC's health fairs. Over the years, CRHS had a very ambiguous relationship with MIHOW. Although in some areas, the local community health center sponsored MIHOW, in the Dungannon-Fort Blackmore area, the DDC assumed that responsibility.⁴⁶

The MIHOW project sent trained community women into the homes of at-risk mothers. The worker visited informally, for example, sitting at the kitchen table or on the floor playing with a child while listening to the mother, answering her questions, supporting her. The workers offered information about nutrition, labor and delivery, family planning, infant development, and provided referrals to welfare and medical services. The program attempted to bridge the distance between formal, medical institutions and

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Community health centers that sponsored the MIHOW Project were: New River Family Health Center, Scaro, W.V.; St. Charles and Western Lee County Clinics, Lee County, Va.; Tug River Clinic, Gary, W.V. Maternal Infant Health Outreach Worker Project, MIHOW brochure, n.d., n.p., distributed by MIHOW offices and Center for Health Services, Vanderbilt University, Nashville, Tenn.; Interview with Barbara Greene, Dungannon, Va., July 30, 1993 (hereafter Greene Interview).

the home. The use of lay workers, the informal approach, the advocacy, all these attributes of the program made it foreign to CRHS's formal operation. One MIHOW director acknowledged that she was glad the program was located at the DDC offices. She explained that at-risk mothers were more willing to come to MIHOW's cluttered office in DDC where they were accepted as friends, then they were to gather at the more formal space in CRHS, where they were labelled and treated as "clients."⁴⁷

For all its health care plans, the center relied on the "use of VCR tapes and educational materials displayed in [the] waiting room." While the health messages probably reached some patients, given the distractions in the waiting room and the poor reading skills of many in the population, this passive program without more aggressive outreach seemed inadequate.⁴⁸

CRHS had a stronger record in screening programs, including a cholesterol program in the area high schools, a hearing problem program in the elementary schools, and free blood pressure checks during office hours. On the occasion of community events, such as the Fourth of July celebration,

⁴⁷Greene Interview.

⁴⁸RHI Application, 31 January 1990, CRHS, pp. 37-41.

the center set up a booth and offered "blood sugar" tests. Although its publication was sporadic, at times, the center marketed its services through a newsletter, using the publication to remind residents to get their "flu shots, immunizations, cholesterol screenings, blood pressure checks, blood sugar checks, cancer screenings, etc." CRHS reported that the "number of flu and pneumovax shots" had increased 100 percent over 1988.⁴⁹

Although the center did not operate a pharmacy as it could not justify its utilization, it offered assistance, especially to sliding-fee patients, in obtaining prescription drugs -- a form of outreach. The center kept a "small stock of prescription drugs and samples" which were "given at cost plus packaging" to sliding-fee patients, to those who were "very ill and need[ed] to begin immediate treatment," or who had been treated after the nearest pharmacy closed. CRHS also inaugurated a plan with cooperating area pharmacists, as explained by the center's physician:

A pharmacy ... would bill the center for the prescription at cost plus 35%. The patient would have an authorization from our center for this program and would be responsible for paying the pharmacist \$7.50 or the cost of the prescription, whichever is less, at the time of the purchase. This \$7.50 payment would be subtracted from center's bill as partial payment. Only generic

⁴⁹Ibid. pp. 14, 17.

drugs would be used ... unless specifically stated otherwise on the authorization.⁵⁰

Distance to travel -- to a pharmacy, to prenatal classes, to dental services, to the hospitals, even to the center itself -- and means of transportation were constant factors in seeking and delivering health care. In answer to questions raised by the Program Management Office of DHHS, PHS Region III, the center administrator explained:

Transportation for patients with appointments may be provided by friends, family, cab service for Medicaid patients, home health nurses or, on occasion, one of our workers will pick up and return a patient who has an appointment at the center and is unable to find transportation.⁵¹

For emergencies, the Dungannon, Nickelsville or Duffield Rescue Squads provided transportation -- at "no charge for this service." Local emergency transportation had not always been available, and the organization of its service may be indirectly linked to the development of CRHS. Originally, the Dungannon-Fort Blackmore residents relied on the Scott County Life Saving & First Aid Crew, Inc. in Gate

⁵⁰ CRHS increased its RHI request for pharmacy funding to meet this increased expense. Ibid., pp. 29, 29A, 29B, 8.

⁵¹ Mountain Empire Citizens Transit provided inexpensive public transportation for Lee, Wise, and Scott counties. However, forty eight hours advance notice was required for this service which picked residents up at their homes and returned them there. Ibid., p. 29A.

City, at least one-half hour away over a two-lane mountain road. In the mid 1980s, Mountain Empire Community College offered Emergency Medical Technician (hereafter EMT) classes at The Depot, the community center that had been established in the surge of community organizing following the founding of CRHS. A core of volunteers received basic EMT and advanced intravenous and cardiac technician training, and established the Dungannon Rescue Squad. The need for emergency medical care and transportation for rural communities was recognized in the passage of the Emergency Medical Services System Act of 1973 (P.L. 93-154), providing a framework for organizing local squads.⁵²

With very few exceptions, the officers and members of the Rescue Squad and the DDC were not represented on CRHS's board. Over the years, the relationship between certain members of the board and DDC has been strained. Although CRHS has an excellent record of working with formal, area

-----⁵² Ibid., p. 29A; U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 28 December 1976, Letter, Scott County Life Saving & First Aid Crew, Inc. to CRHS, 27 January 1977, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application 28 December 1976, CRHS); Interview with Carol Sluss, Dungannon, Va., January 7, 1993 (hereafter Sluss Interview); Roger A. Rosenblatt and Ira S. Moscovice, Rural Health Care (New York: John Wiley & Sons, 1982), p. 146.

agencies in coordinating health and welfare resources and services, it has not established a positive working relationship with its local, grassroots organization, the DDC. In its RHI applications' references to coordinating referrals and resources, CRHS rarely mentioned networking with DDC, although it complained of problems such as poor nutrition which DDC addressed through food distribution programs. Curtis Mays, the board's longest serving member, said, "I'm not familiar with their [DDC's] program. What I've heard of it, they don't really reach a great number of people."⁵³ As the RSHC leader had pointed out a decade earlier, projects had to be endorsed by the right people to gain legitimacy with the power structure. Obviously, Curtis Mays had not endorsed DDC, and therefore, CRHS's interaction with its programs (other than MIHOW) was minimal.

The twelve-member CRHS board had at its core a nucleus of original members headed by Curtis Mays. Each year at the annual meeting in March, six board positions were open for election. Along with the reelection of long-time members, some newcomers won those positions; however, most newcomers stayed only one, two, or three terms. Since there were no restrictions on term limits in the by-laws, over the years

⁵³ Interview with Curtis Mays, Dungannon, Va., January 7, 1993 (hereafter Mays Interview).

the core of original members remained intact, winning reelection over and over. Thus, the governance remained under the influence of its founding members, all prominent individuals in the power structure of Dungannon and Fort Blackmore. Despite its declarations to the RHI office to do so, the board had not recruited representatives from among the sliding fee or Medicaid patients, or from "the other communities serviced by [the] center." In 1990, 42 percent of the twelve-member board were women (that is, five), but this was short of the "percentage of women users" (that is, 55 percent).⁵⁴

In 1988, the board had admitted that it had "not reviewed the by-laws ... for several years," and needed to do so to incorporate "changes ... made over the years." However, in 1990, the administrator informed the RHI office, "The board feels no update of the by-laws is necessary." The board also acknowledged that it "[had] not discussed any short or long range fund raising plans." Efforts to secure

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 Often a husband or wife would be elected to succeed a spouse retiring from the board, thus keeping membership within the family group. In a few instances, a board member resided in Gate City, which was on the very outskirts of -- if not outside -- the service area. From 1978 to 1993, three residents had served ten terms and several more had served six, seven, or eight terms. RHI Application, 31 January 1990, CRHS, pp. 35, 34.

"[N]on-grant support ... mainly United Way" funding had not been successful and the board "[had] not pursued this to any great degree."⁵⁵ Because the center did not engage in any activities involving community volunteers, it also did not gain contributions in-kind from volunteer time and services.

The PHS had never insisted that community health center boards pursue fundraising as a means to economic self-sufficiency, stressing instead higher utilization, cost-effective operation, and more efficient collection practices. Scott Otterbein, a regional project consultant with the PHS's Region III, said the PHS considered it "unrealistic" to expect continual fundraising and understood that "local fundraising can not underwrite operations." John Cafazza, executive director of the Virginia Primary Care Association of which CRHS is a member, estimated that "only one third of the centers pursue fundraising and other grants."⁵⁶ However, Otterbein remarked when centers were

⁵⁵ RHI Application, 18 February 1988, CRHS, 3.3.12, p. 53; RHI Application, 31 January 1990, CRHS, p. 16.

⁵⁶ Otterbein said that there were no federal funds available for adding on to existing centers, for new building programs, or for upgrading. This had to be accomplished by local fundraising. Also, for some other community programs, Congress had written into the statute that ten or twenty percent of the funding must be raised locally. There was also a precedent of a state government establishing a community fundraising requirement; as explained by Davis and Marshall, "All health centers funded by the State of North Carolina are required to (continued on next page)"

successful with securing funds locally it was usually due to the "energy and attitude" of the administrator and board. However, some boards were "shy" about going to the public with their hands out, and preferred to be "comfortable" with the level of funding they received.⁵⁷

The CRHS board had grown "comfortable" with their portion of federal funds. After its initial fundraising activities in 1975-78, the board never again organized a formal fund drive or fundraising activities, such as cake sales or community dinners. Thus, it lost opportunities to promote community center spirit, that is, to develop a real sense of community ownership and loyalty to the center. In one of the oldest and most straightforward guides for laymen to develop and operate rural health centers, the authors explained:

This [fundraising] effort has the threefold benefit of producing funds while publicizing the project throughout the entire community and establishing a strong sense of community pride.

(continued) raise \$1 locally for every \$5 contributed by the state for renovation or construction of a health facility." Interview with Scott Otterbein, U.S. Public Health Service, Region III, Philadelphia, Pa., February 9, 1993 (hereafter Otterbein Interview); Interview with John Cafazza, Virginia Primary Care Association, Richmond, Va., February 4, 1993 (hereafter Cafazza Interview); Karen Davis and Ray Marshall, "New Developments in the Market for Rural Health Care," Research in Health Economics 1 (1979): 75.

⁵⁷ Otterbein Interview.

People who have contributed money -- even just a few dollars⁵⁸ -- have an extra identity with the program....

The CRHS board of directors relied solely on federal funds and special program funds, such as WIC, to supplement its patient revenues. While adequate over the years, the total revenues left nothing for innovative programming. But innovative programming, as with fundraising, would have required an activist board, not simply a caretaker board -- as efficient and diligent as it was. Bruce Behringer, president of the National Rural Health Association and former executive director of the Virginia Primary Care Association, had experience with centers that did fundraising based on their belief that "the government can't do everything for you." He called these centers and their communities "pro-active" versus the other centers which tended to be "more reactive" and "placid."⁵⁹

⁵⁸James D. Bernstein; Fredrick P. Hege; and Christopher C. Farran, Rural Health Centers in the United States, The Rural Health Center Development Series (Cambridge, Mass., Ballinger Publishing Company and Harper & Row., 1979), p. 34.

⁵⁹Interview with Bruce Behringer, Johnson City, Tenn., February 12, 1993 (hereafter Behringer Interview). NOTE: It is important to clarify here that the fundraising being promoted is entirely separate from the concept of matching funds which would have crippled most of these rural communities. The community health center program has been lauded throughout this dissertation for not having a matching funds (continued on next page)

When asked if the security of federal grants hurt community fund raising, a long-time CRHS board member and prominent resident replied:

Yes, I think so. It's like our aid programs and a lot of things. It just kills incentive to go ahead and work.

When asked what would have happened if there had been a year when the center had not received sufficient federal funding, he replied:

We would probably have been beat the bushes to raise it. In fact, it might help us in one sense. I'd say it would help us.⁶⁰

But circumstances had not forced the board to turn to the community and they had not chosen to do so. Although some centers continued to solicit contributions in money, or in kind, for example, volunteer service on outreach projects, it is difficult to make a fair comparison between communities and centers. For instance, Stone Mountain Health Services (hereafter SMHS), a consortium of three centers in southwest Virginia, demonstrated strong grantsmanship, operated several outreach programs, and estimated

(continued) obligation. The author suggests modest projects, such as bake sales or community dinners, like those used in 1976-77 to raise building funds. The modest funds collected could be used for small health education programs or to refurbish the center's waiting room, while building a sense of community ownership and involvement in the center.

⁶⁰Mays Interview.

the value of volunteer services to annually be \$50,000. But SMHS is a much larger operation with an super energetic administrator who had served for almost a decade, and a community activist physician who had been associated with the consortium's major center, St. Charles, from its very beginning.⁶¹

CRHS had suffered from repeated changes in physicians and administrators, and while it recouped or even grew stronger over the years, it had lacked long-term, dynamic health care providers or administrators who compensated for a lackluster board. Feierabend and Tam, its two most "pro-active" physicians, and Anne Leibig, the administrator most committed to community development, had served for only a few years each.

Although it is unfair to compare CRHS and SMHS, there is an organization within the Dungannon community itself that conducted fundraising and could serve as the model for comparison. The DDC with strong representation from lower-

⁶¹Stone Mountain Health Services, "a multi-site" consortium, includes St. Charles Community Health Clinic (and home office) and Western Lee County Health Center, both in Lee County, and Castlewood Community Health Center in Russell County, all in Virginia, adjacent to Scott County. Interview with Tony Lawson, St. Charles, Va., February 15, 1993 (hereafter Lawson Interview); Tony Lawson, "Innovations in Health Services for the Elderly, Appalachian Health Care: New Ways of Doing Business, Johnson City, Tenn., 20 April 1993, pp. 2, 6-8, copy in my possession.

income residents on its board conducted community fund-raising in connection with its housing rehabilitation program which refurbished below standard houses and built new homes for low-income families. As mentioned earlier, DDC offered outreach programs that addressed socioeconomic problems in the area. In the process, it brought capital into the area, either in the form of grant money or material resources, such as surplus food in its SHARE program. And in its housing program, it combined outside and community funding and volunteer labor. In fall 1992, the housing program discovered it had a \$3,300 debt. To raise funds, DDC organized a community five kilometer walkathon, walking the volunteers past some of its rehab and new houses. They increased community awareness, involvement, spirit, and raised over \$2,000. The fundraiser was so successful, the DDC made it an annual event.⁶²

One of the most cogent descriptions of the difference between CRHS and the DDC comes from Anne Leibig, one of the few individuals in the community who has been involved in both organizations. Remembering her services as CRHS's

⁶²Robinson Interview; Interview with Darrell Mays (no relation to Curtis Mays), Wanda Duncan, Eugene and Shirley Hunt, Dungannon Development Commission, Dungannon, Va., January 6, 1993; Dungannon Development Commission News n.d. (circa Autumn 1993), n.p., Dungannon Development Commission Collection, Dungannon, Va.

first administrator, she recalled

I kept getting more and more ideas of things we could do. ... The president of the board came and he said to me, "Don't bite off more than we can chew."

Leibig then recalled her active involvement with DDC, saying,

The Development Commission was the group that had more of the vision. And when I was working with them I felt this is where I can bite off more⁶³ and people can chew more. And it's still going.

With no aggressive outreach services, community health workers, or community fundraising, and with very irregular publication of its newsletter, CRHS did not actively engage the attention or participation of the community. Attendance at the annual meetings dropped. As one former board member and active emergency rescue squad member commented in 1993, "I don't even know who's on the board now." Thus, over the years, if one considered community involvement and not simply utilization, CRHS's motto, "a community supported clinic," lost its credibility.⁶⁴

However, the center's links to other health agencies guaranteed that it received favorable recommendations which

⁶³Interview with Anne Leibig, Dungannon, Va., November 14, 1990.

⁶⁴Sluss Interview. Motto on CRHS letterhead, Clinch River Health Services, Inc. Collection, Dungannon, Va.

became part of its RHI file. Letters from Head Start, the area health district, home health service providers, and others were submitted along with the annual RHI applications. During the Reagan administration, PHS bureaucrats had instructed the centers to solicit such support as a defense mechanism. Endorsements confirmed local needs and the center's contributions to delivering primary health care and to interacting with other agencies. The possibility of defunding increased if critical comments reached the regional office and substantiated other negative indicators. CRHS had never reached that critical stage.

As the CRHS administrator reviewed 1989 for the RHI funding officials, she pointed out progress initiated by Tam in linking CRHS with various health agencies and institutions, as well as record high utilization and encounters; yet persistent health problems remained, such as upper and lower respiratory infections, ear infections, and high blood pressure. The report on the board's performance showed diligence to ordinary details of budget and routine operation, and included optimistic plans, but recorded no achievements in aggressive health education, marketing programs, fundraising, or long-term recruitment strategies.

The lack of long-term recruitment strategies and the marketability of the center as a good professional environment for a physician created a major crisis in 1990. After

serving his NHSC commitment, Tam planned to leave CRHS on June 30, 1990. As the administrator explained in her report to PHS bureaucrats:

Our former physician, Dr. Todd Cassel, informed the center in September, 1989, that he would return and sign a 5-year contract. Since Dr. Tam had already informed the Board ... that he would not sign a 5-year contract but would consider a 2-year contract, the Board ... took Dr. Cassel's word that he would be coming to Clinch River. 3 months later, Dr. Cassel called ... to say that ... he would not be coming to Clinch River.[sic]⁶⁵

The Board then offered Tam a two-year contract but he had already made firm plans to leave. Although CRHS had lost its "loan repayment slot" when Cassel was expected back, the PHS reinstated it "in order to help [them] with physician recruitment," another example of PHS commitment. Although the board interviewed a Doctor of Osteopathy, he did not accept their offer. At the time the administrator filed the RHI grant application, CRHS faced a loss of physician services as of July 1, 1990.

Confronted with this dire prospect, the board contacted Virginia Primary Care Association, local hospitals and the Family Medicine Department of Quillen College of Medicine at ETSU in hopes of locating physicians "interested in rural

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⁶⁵ Clinch River Health Services, Inc., letter to Program Management Officer, DHHS, PHS, Region III, 5 March 1990, with attached sheet, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter CRHS).

practice." In case they were unable to find another full-time physician, the board considered three alternatives: 1) hiring a mid-level practitioner and contracting with an outside physician to supervise him/her; 2) buying physician time from another community health center; 3) contracting with a retired physician who would temporarily fill in until a permanent replacement was hired.⁶⁶

Fortunately, Tam's experience with ETSU's Appalachian Preceptorship in Family Medicine provided the clinic with strong contacts and a favorable relationship with the Department of Family Medicine. CRHS contacted Dr. Forrest Lang, Director of Medical Education, in ETSU's Department of Family Medicine, and he in turn approached his colleagues on the faculty. He explained that CRHS was "in danger of closing its door," and persuaded seven of his colleagues to "chip in and lend a hand." From September 1, 1990 through June 1991, Lang himself, as well as Dr. Robin Feierabend from the Bristol Family Practice Center, and five other faculty members took turns traveling to CRHS to provide coverage and supervision for the nurse practitioner who the center hired.⁶⁷

⁶⁶ Ibid.

⁶⁷ CRHS operated three days per week with physician services and three days per week with nurse practitioner (continued on next page)

In many ways, the situation resembled the crisis in 1984 with the same distressing results. After the center's highest utilization rates ever, occurring during Tam's service, its user/encounter rate fell, for example, from 2034 users in 1989/90, the last fiscal year of Tam's service, to 1,623 users in 1990/91, during the service of a nurse practitioner with supervision from the rotating team of ETSU physicians.⁶⁸ However, despite the inconveniences and interruption of regular physician practice, the center remained open. As a result of their collective efforts to keep CRHS open and serviced, Department of Family Medicine physicians received Virginia Primary Care Association's "Physician of the Year" award.⁶⁹

CRHS's administration and board acknowledged the cooperation of the PHS during this crisis. All along, in

 (continued) service. Feierabend's continued popularity with the residents caused problems as they tried to get appointments on the day he would be in Dungannon, overloading his schedule. Ibid.; Interview with Forrest Lang, M.D., Johnson City, Tenn., March 23, 1994 (hereafter Lang Interview); U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, 27 January 1992, "Executive Summary," p. 11, Clinch River Health Services, Inc., Dungannon, Va. (hereafter RHI Application, 27 January 1992, CRHS); Bowen Interview.

⁶⁸ Figures provided by Carolyn Bowen, Administrator, CRHS.

⁶⁹ Lang Interview.

both liberal and conservative administrations, CRHS had received federal funding and guidance. While it had opened its doors during the supportive Carter term, most of its operation had been during the hostile Reagan administration. The officials in District III had worked with CRHS, for example, in guiding new administrators in preparing their RHI applications, in accepting late applications, and in upgrading the grant applications. Of utmost important, the agency had reinstated the "loan repayment" provision to allow the center to recruit a NHSC physician. While CRHS was not a stellar performer in utilization, reimbursement, or outreach services, neither was it a trouble spot or a failing center. Its consistent, solid record in delivering primary care protected it during intermittent crises.

CRHS had reached maturity from 1986 to 1991, during the practices of Cassel, Tam, and the ETSU team with an on-site NP, reaching high points in utilization, linkages to outside agencies and facilities, and survival strategies. But accompanying the admirable maturity in its health care delivery was a stagnation in its governance, best described as "tired blood." Cassel summed up the situation very succinctly,

The board and the community need to make sure that the clinic stays in a position and function to "stay in business" in the coming years. ... [They]

need to continue to foster the community support that got the clinic where it is.⁷⁰

In the next and final chapter, CRHS returned to stability with the services of a dedicated physician and nurse practitioner, and able administrator. The medical personnel and administrator ably implemented the new Clinical Performance Measures ordered by the PHS for community health centers across the nation. Utilization rates and revenue increased substantially and the center received authorization from the PHS for a second physician, who started in summer 1994. The new physician was not really new; Scott A. Cassel, M.D. rejoined the staff. Thus, after sixteen years of highs and lows, CRHS could justly claim success in delivering primary health care to its rural community.

⁷⁰ Cassel Correspondence.

CHAPTER 7

MATURITY AND SUCCESS, 1991 - 1994

In this final period in the history of a rural community health center, the components that had made the program successful were present: delivery of comprehensive primary (curative and preventive) care; a team approach, including a mid-level health provider; and continued federal funding and assistance from the PHS officials. While the record of Clinch River Health Services (hereafter CRHS) in providing outreach services remained weak, there was an increase in services focused on screening and a prescription program.

Overall, community representation and participation contributed to the community health center program's success by making the centers more responsive to and supported by the community. However, at CRHS an entrenched board of directors with minimal representation by the lowest-income segment of users came under criticism from the PHS. With its failure to conduct local fundraising, improve community relations, recruit community volunteers, seek additional grants, or promote aggressive outreach, CRHS's board demonstrated that it is their attitude and behavior that determined the center's level of success -- beyond the basic provision of primary care.

During these last years under review, the medical services improved greatly -- in part due to full staffing. Also, nationally the PHS introduced a new system of Clinical Performance Measures that made demands on each center to improve qualitatively and quantitatively its delivery and evaluation of health care. With its increased demands for centers to fulfill their responsibilities in community representation and its imposition of new quality controls, the PHS seemed to be signaling a change. The low-keyed, defensive posture that it had assumed during the very conservative Reagan administration was replaced with a more confident and aggressive posture, possible under the more moderately conservative Bush and the liberal Clinton administrations.

A prominent PHS official in Region III admitted that the agency was in a cautious mood, awaiting the outcome of the national health care coverage debate that had been initiated in 1991.¹ This official had great confidence in the community health center program's ability to success-

¹The first shots in the debate had been fired in Democrat Harris Wofford's campaign against Republican Richard Thornburg, President George Bush's former attorney general, in a race for the vacant U.S. Senate seat for Pennsylvania. Wofford, who had focused on health care, won. However, in the November 1994 election with its nationwide Republican landslide, he lost to the Republican challenger.

fully deliver primary care. The strong record was there in urban and rural centers in every region of the country. However, whether reforms would help or hinder the program's operation could not be foreseen. The PHS's no-nonsense attitude -- of continued support and increased scrutiny -- was readying the centers for future service. For example, in contrast to its crisis in summer 1990, by summer 1994 CRHS was in a vastly improved situation, far better prepared to meet the challenges any health care coverage reform would generate.

Although September 1990 through June 1991 was "a year filled with trials," CRHS's administrator reported "the center has come out on top as always." With the indulgence of the PHS officials in Region III, the dedication of the Family Medicine physicians at ETSU, and the continued commitment of the board and community, CRHS had survived its crisis and optimistically faced an improved situation. On July 1, 1991, Gary E. Michael, M.D. joined CRHS as its full-time physician, and the center retained the services of Judy Cole, its nurse practitioner (hereafter NP), as well.²

²U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 27 January 1992, Executive Summary, p. 11, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 27 January 1992, CRHS).

During the absence of a full-time, on-site physician, Cole had been "an important element in the continuity of care for the patients," and the center considered "[h]er services ... invaluable." According to the administrator, Cole "not only serves as the backup person for Dr. Michael when he is unable to work, but also serves as an associate for Dr. Michael in an isolated situation."³ The health care provider team helped to solve a long-recognized problem of professional isolation.

Without doubt, another area of service had also been greatly improved in June 1990 when CRHS hired Carolyn Bowen as its full-time administrator. Bowen had worked as a dental assistant at the center in its early years and had returned to college for an associate's degree in business administration and accounting. As the grant application process and medical assessments became increasingly complicated, she brought a level of professionalism to their content and appearance that had been sorely lacking. Although she did not consider herself to be "developmental" in terms of supplemental programs, she worked with the medical providers to implement, audit, and report new,

³Ibid., pp. 11, 42-43.

complex measures of clinical practice.⁴

Beginning in 1991, important changes occurred at CRHS that were dictated by new requirements from the PHS. These affected the by-laws concerning the board and, more important, the delivery of health care to the community. That the center was very successful in implementing the new medical imperatives attested to the team effort of Michael, Cole, and Bowen. At the same time, the user/encounter rate rose steadily, attesting to the community's positive response to its new physician. From a low of 1,623 users in 1990/91, the numbers steadily improved: in 1991/92, the number of users increased to 1,710; followed by an even greater improvement in 1992/93, to 1,849 users.⁵ But that resurgence was not automatic; it was earned, and the new physician had first met with cynicism.

Although an extraordinary effort had been made in 1990-91 to keep the center open, Michael described "the patient clientele" attitude as, "Well, should we just use this like a 'doc in the box house,' a quick stop-in place?"

⁴Interview with Carolyn Bowen, Dungannon, Va., November 13, 1990 (hereafter Bowen Interview, 1990); Correspondence with Anne Leibig, Dungannon, Va., July 15, 1993; Interview with Gary Michael, M.D., Dungannon, Va., January 6, 1993 (hereafter Michael Interview).

⁵Figures supplied by Carolyn Bowen, Administrator, CRHS.

Since the residents did not look at CRHS as their center for "continuing permanent care," Michael recalled, "...we've had to change our image over the past year." At first, the patients confronted him with questions and comments, such as: "Are you going to stay? I guess you're going to leave in a year or two, aren't you? Should we really get to know you, because you aren't going to be here? I'd come and see you more often, but I know you're not going to stay."⁶

Michael tried to reassure them. Although he only had to fulfill two more years in his NHSC contract -- to June 30, 1993 -- he had made a strong commitment to the community health center program, based on factors in his personal history. Michael's brother worked as an administrator for a center and had convinced the physician that a center was the place to practice the family medicine for which he had trained. And the physician felt that CRHS provided the right professional environment, as he explained, "The board's been very good with me, in allowing me to do the medicine I want to do. You have to have room to be able to breathe and to do your style. And I'm very, very candid."⁷

⁶Michael Interview.

⁷Ibid.

Backed by the RHI grant, the center had the opportunity to administer health care in a comprehensive manner, something a private practitioner could not always do. Also, given the new health care directives, primary care would be practiced with a thoroughness a private physician was not obligated to match. According to Michael,

You cannot as a private practitioner see twenty five to thirty patients a day, and do everything that we do, because you can't make it [financially]. ...[T]hey usually have to see around forty to fifty patients a day. ...[W]e see patients who can't pay.... ...[I]f you're interested in a high level of care, that actually can take a lot of time from you. You can't do this in private practice....⁸

Michael was referring to the time-consuming but exciting medical methodology newly utilized by CRHS, the Clinical Performance Measures (hereafter CPM), a quality-assurance measurement system inaugurated by the PHS. The system, co-designed by the PHS and the center physicians, was based on field investigations started in 1988. The evaluation plan was the most innovative concept to come along since the community health center model itself was developed in the mid-1960s. The system encompassed "all five life cycles [perinatal, pediatric, adolescent, adult, geriatric], with different parameters, risks, and clinical topics in each

⁸Ibid.

life cycle." Each center designed all its "necessary protocols, formats, documentation sheets, and establish[ed] resources and referral systems."⁹

As discussed earlier, the effectiveness and quality of primary care had been very difficult to evaluate. Yet the centers were always under pressure to "demonstrate" to Congress and the PHS, "Yes, we do make a difference." The CPM would allow the centers and the government to judge the services delivered to each age group in relation to their needs. As Michael explained,

When the government in the future says, "Well, how is your clinic performing? Where is your data," we have to say we audited our charts and we're 80 percent compliant with asking our patients about cardiovascular risk assessments, with asking our adolescents questions. Are immunizations up? Fluoride supplementation? Things like that. And these are all things that are looked at as basic needs.¹⁰

The CPM also served another purpose. In September 1992 the centers gained relief from the high cost of malpractice insurance by being covered under the Federal Tort Claims Act; thus, litigations against physicians or centers became suits against the federal government with the

⁹RHI Application, 27 January 1992, CRHS, "Clinical Performance Measures," p. 28.

¹⁰Interview with Randy Bashore, M.D., New Canton, Va., February 9, 1993 (hereafter Bashore Interview); Michael Interview.

Justice Department handling the cases. Therefore, the centers had to provide assurances to the federal government that they were operating according to proper medical procedures. Using the CPM, centers would "demonstrate to the PHS their readiness and ability to be covered by the Justice Department."¹¹

Dr. Anita Batman, PHS Clinical Coordinator of Region III, explained the role of center physicians in developing the CPM and the built-in flexibilities and assurances to protect the individual centers in their implementation and reporting. "We asked the field physicians at health centers, 'What things would you monitor to judge health care progress at a well-run health center?'" The PHS theory was that a center needed to identify the health problems in each life cycle before perceiving solutions and monitoring progress. However, the initial survey developed from the field recommendations proved to be "too large a monitoring exercise," and the field personnel and PHS staff were "horrified by the extent of paperwork necessary to complete it." Efforts immediately got underway to simplify it, and a group of

¹¹The centers still needed to maintain "tail insurance" to protect themselves against litigation for "past practices before the federal takeover." Bashore Interview.

centers in Region III organized the Clinical Regional Advisory Network (hereafter CRAN) to assist the centers.¹²

Through CRAN the centers in Region III are involved in a pilot project, unique in the nation. Individual centers submitted their CPM data to CRAN, which in turn established a database and handed in an aggregate report to Region III. Batman explained that while the PHS policy statement assured the centers that no funding would be imperiled if their numbers were bad," a feeling persisted that bad numbers would reflect poorly on the center. Therefore, she said, "Most centers wanted to keep their numbers confidential. They were sheltered by the aggregate system of reporting." With anonymity, CRAN and Batman believed that centers would answer honestly, insuring realistic data that would be useful. She believed open reporting forced people to lie to protect themselves.¹³

CRAN grew out of yearly meetings at which Batman solicited opinions from the field physicians. She wanted

¹²Interview with Anita Batman, M.D., U.S. PHS, Region III, Philadelphia, Pa., February 4, 1993 (hereafter Batman Interview, 1993).

¹³In 1994, the PHS compared data from centers that had been submitted without anonymity with data from centers that had been submitted in aggregate form, and found that data in open reporting was indeed skewed towards excellence, while data submitted in anonymous reporting confirmed what was reasonable and expected. Interview with Anita Batman, M.D., U.S. PHS, Region III, Philadelphia, July 21, 1994.

"current information and opinions," feeling far more comfortable attending Department of Health and Human Services (hereafter DHHS) meetings when armed with field reports rather than her own opinions from her field work of years before.¹⁴

Dr. Randy Bashore, a physician at the Central Virginia Community Health Center and president of CRAN in 1993, explained the stress on Total Quality Management in the measurement process, meaning a center always tried to improve on its own overall results. For example, when reaching ninety percent in one area, rather than attempting to make the elusive ten percent, a center moved on to a weaker area and worked to bring it up. He reiterated Batman's belief that CRAN offered the centers some measure of privacy in reporting, making the CPM requirement less threatening to individual centers.¹⁵

To observe how the CPM requirement was implemented at CRHS, the "Clinical Program" for the geriatric group -- one of the largest and most vulnerable age groups in the communities -- is examined here. The problems and goal were described as follows:

¹⁴ Batman Interview, 1993.

¹⁵ Bashore Interview.

Problem: The number of people in the community over 65 years of age is gradually increasing. The center currently provides approximately 184 people in this age group with primary care services.

Problem: The county's poverty level is approximately 22.2%. For the elderly on fixed income and in the poverty level, the cost of adequate health care is a severe burden. Without proper medical attention, morbidity and mortality increases among the elderly.

Goal: Provide affordable health care to the elderly to decrease morbidity and mortality.¹⁶

The center's stated objective for March 1992 to March 1993 was to "review" 75 percent (140) of "the geriatric users for financial need" and "to enroll" them "into a costs effective health screening program." The methods for achieving this objectives were explained:

The appointment secretary will review with each geriatric encounter their medical coverage. Patients with no coverage or low coverage will be reviewed by the executive director for sliding fee scale. The executive director, nurse, physician, and nurse practitioner will coordinate with the social service department, health department, churches, and other₁ organizations to arrange other available services.

Michael described the interview he conducted to determine the need for social services:

I have to go through what's called Instrumental Activities of Daily Living: "Can you bathe yourself? Can you go to the bathroom? Are you incontinent? Can you use the telephone? Can you shop for your own groceries? Can you take care of

¹⁶RHI Application, 27 January 1992, CRHS, pp. 56, 66.

¹⁷Ibid., p. 66.

your bills? Do you write your own checks? Do you need someone to pay out your money for you?" Things like that.¹⁸

If Michael found a problem, he consulted a reference file of county social service agencies and contacted the appropriate service. "The social service department knows me very well by now," he said. There was a medical method in the Geriatrics Clinical Program as well:

The nurse will place the Geriatric Health Screening Sheet on every geriatric encounter. The screening consists of yearly results on: Hg, Iron, BS, Thyroid Test, hemocults, mammography, Pap exam, breast exam, pelvic exam, prostate exam, and rectal exam. The executive director will set up programs with the local hospitals, American Cancer Society, etc. for the mammogram screening.¹⁹

The CRHS team thus identified the problems within this age group, established objectives, and decided upon methods for reaching those objectives. They then established the method of evaluation; for example,

Every 3 months, the executive director will review 20 charts to ensure update of financial status. Every 3 months, the nurse will review 20 charts for completeness of the health screening sheet. The nurse will notify the patient of any needed updated testing or examination.¹⁹

The plan, drawn to meet local needs, was submitted with the RHI application and the yearly audit of the plan was submitted to CRAN to become part of the region's database.

¹⁸Michael Interview.

¹⁹RHI Application, 27 January 1992, CRHS, p. 66.

Dr. Michael provided a good example to illustrate the CPM's effectiveness in uncovering problems. In working with the geriatric group for the CPM, the health care providers discovered a high incidence of hyperthyroidism and "a great number of low iron" patients. He explained,

Eventually when we get time, we'll try to get into other aspects of why there is such low iron in these people ²⁰when they get a lot of greasy greens in this area.

He theorized that something such as tannic acid in their water source was precipitating out the iron in the food. When they drank the water or used it in preparing food, it broke down the iron; thus, he said, "It's not absorbed and you can have low iron, even though your iron intake might be adequate."²¹

In the late 1970s and early 1980s encouraged by their success in receiving funding for CRHS, the Dungannon community leaders applied for and received funding for a public water and sewage system for the small business and residential district on the main road through Dungannon; the system has since been upgraded and extended. However, most of the

²⁰Ibid.

²¹Michael Interview.

people of Dungannon and the surrounding area rely on private wells or springs; the water quality is often questionable.²²

In a similar manner -- identifying problems, stating goals and objectives, specifying methods and evaluation procedures, the center's medical and administrative staff established a Clinical Plan for each life cycle and a timetable for putting them into operation. With the adult users, the center stated that "Cardiovascular disease remains the number 1 cause of mortality, 47% in the community." It recognized that "untreated and/or uncontrolled hypertension," was a "major contributor to heart damage and heart diseases." Again, the staff acknowledged that because of the high poverty levels many adults "cannot afford the medical services and medications necessary for hypertension control." The methods they chose to attack this problem were threefold: a screening program, a medication program, and continued promotion of the sliding fee scale for low-income patients to encourage their compliance with follow-up visits.²³

In pursuing these methods, Cole, the NP at the center, "in cooperation with the Scott County Health Department,"

²²Ibid.

²³Ibid; Interviews with Anne Leibig and Nancy Robinson, Dungannon, Va., November 14, 1990.

received an "Integrated Services Grant Award" from the state of Virginia. The grant, which Cole wrote "using some ideas of her own and some given to her by the staff at the health department," provided "limited funds to initiate a free cholesterol screening program and medication program for one year." Cole conducted two "community wide screening clinics." At one of the screenings, of the sixty persons examined, seventeen percent had "abnormal initial readings," and these persons were monitored and treated.²⁴

Also, on every second Thursday of the month at the clinic, the NP held a "free cholesterol screening, using a cholesterol machine purchased in cooperation with the local Health Department and another nearby community health center."²⁵ The center also established a "special anti-hypertensive medication-pharmacy program" which provided medicine "free of charge to the [indigent] patients." These programs were in addition to the center's general screening of "at least 80% of all patients... age 15 and over," for hypertension. The "consistent care plans for the hypertensive and diabetic patients," resulted in "improved outcomes and patient compliance." For example, chart audits

²⁴RHI Application, 27 January 1992, CRHS, pp. 63-64.

²⁵Ibid., p. 54.

indicated "improved Fasting Blood Sugar levels" in seventeen percent of the diabetic patients, and "lower blood pressure" in fourteen percent of the hypertensive patients.²⁶

This overt effort to reduce specific causes of morbidity and mortality within patient populations is noteworthy. While there had always been established care plans that set objectives to reduce the major problems afflicting the different age groups, nothing as dynamic or interventionist as this had been undertaken at CRHS. The only drawback was that the new CPM plan -- like the old health care plans -- relied, for the most part, on patients walking in the clinic's front door. The center still did not have an ongoing plan for taking health education into schools, churches, organizations, even workplaces, where it was greatly needed. A commitment to health education outreach required an increase in personnel, for example, a professional health educator and/or community (lay) workers and the funds to support them, whether through a federal, state, or philanthropic grant. But securing additional funding required an activist board, and CRHS had a passive board.

Beginning in summer 1991 with the resumption of full services at CRHS and the development of the CPM program, the

²⁶Ibid., pp. 43, 64, 54.

center's staff made great strides forward. Despite the unwieldy process involved in submitting the CPM report to CRAN, in 1993 Michael was able to brag, "We did complete ours, ours is all done. We're probably the first clinic in Virginia to have it totally written. ... And ours is ninety five pages long."²⁷ (This was in addition to the annual RHI grant application with supporting data which also ran over 90 pages.) Just in time to tackle the CPM plan and report, CRHS finally got a computer.

A request for an additional appropriation to purchase a computer had been included in the RHI grant application for several years. According to Bowen, CRHS was "the only clinic in Virginia that did not have a computer system." For example, in the January 1990 RHI application, the administrator requested "money for purchase of a computer ... for storage and retrieval of data...." She cited the "time consuming and costly" process of compiling financial and statistical data without aid of a computer. In a two-page "Justification for Computerization," the center set forth its case, beginning as follows: "Clinch River Health Services has been in operation for 12 years during which time

²⁷Michael Interview.

all patient accounts, financial systems and correspondence have been manually completed."²⁸

The request cited the advantages gained with a computer system: improved "internal management of the health center;" participation "in the statewide computer network" of centers and the Virginia Primary Care Association; as well as utilization of "electronic filing of [insurance] claims." Besides listing the obvious improvements in billing and inventory control, the request mentioned two other areas where a computer system would make a substantial difference, Marketing and Practice Epidemiology.

The administrator suggested that a computer would create "a modern image of the center" that would "project a professional and efficient image to our users," and "be an advantage when recruiting or in retaining a physician." In practical terms, it would permit the center to do "direct mailing of ... reminders" to select groups of patients, and enable the center to analyze exactly who were its users, providing information needed for the annual "project and

²⁸ Interview with Carolyn Bowen, Dungannon, Va., January 6, 1993 (hereafter Bowen Interview, 1993); U.S. Department of Health and Human Services, Public Health Service, Region III, Rural Health Initiative Program for Clinch River Health Services, Inc., Application for Federal Assistance, signed 31 January 1990, p. 57, Clinch River Health Services, Inc. Collection, Dungannon, Va. (hereafter RHI Application, 31 January 1990, CRHS).

community needs assessment." The report cited a "noticeable emphasis" in the grant application "for centers to begin long-term practice research, either around our patients or around our community's health problems." The prospect of doing this epidemiology "manually" was daunting in terms of time, energy, and administrative costs.²⁹

Despite obvious need, the PHS denied the request for additional funding. According to Otterbein, the Region III consultant, at this time there were no federal funds available for additions to existing centers, new building programs, or upgrading. To accomplish these, the centers needed to turn to local fundraising. A computer system would have upgraded the center's capabilities in many areas, but the board did not consider local fundraising. Then, in 1992-93, according to Bowen, the center "had grant money left over that wasn't going to be used just for regular operations, so the federal government said, 'well, send us in a revised budget asking for money to do that,'" which the center did and succeeded in getting a computer.³⁰

²⁹ RHI Application, 31 January 1990, CRHS, pp. 57-58.

³⁰ In 1978, Congress had authorized other means for centers to expand facilities, increase services, or improve managerial capacity, etc. Among its provisions, P.L. 95-626 allowed centers that generated additional income through increased efficiency in the collection of patient fees and third-party reimbursement to retain "at least 50 percent of (continued on next page)

Even with a computer, the medical audits required for the CPM were very time consuming, often preempting the time the physician would have given to patients. "That," said Michael, "is why getting a second physician will help us, because one physician can be working on the audit..., while the other physician can still be seeing patients and the [clinic] door can still be open."³¹ To receive authorization and funding for a second physician, Bowen and Michael stressed need and readiness. As Michael explained:

Outside of our grant period, we made a proposal to the government that we can use one, how we would use one, and what not. So we finally got the ok to go ahead and get a second physician. ... Usually it's done with your grant and we really worked hard and Philadelphia's [Region III] been very good to us....³²

Their success may be attributed to Bowen's increasing ability and assertiveness at grantsmanship and Michael's "can do" attitude: "If you give them a good presentation and

(continued) such income" to be used for such improvements. CRHS, however, had never been able to take advantage of this offer. Interview with Scott Otterbein, U.S. PHS, Region III, Philadelphia, Pa., February 9, 1993 (hereafter Otterbein Interview); Bowen Interview, 1993; Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965 - 1986 (Pittsburgh: University of Pittsburgh Press, 1988), p. 146.

³¹Michael Interview.

³²Bowen Interview, 1993; Michael Interview.

you tell them you can do it, and you prove it, and you stick with it, you can get things."³³ Michael renewed his contract and the board hired Todd A. Cassel, the physician who had served CRHS from 1985-88.

In considering his choice to return, Cassel mentioned professional and personal reasons, as follows:

We feel a calling to return to the Dungannon area. I feel it is where I can use my skills as a doc in an area that needs consistent care-givers. It is also an area (rural, more surrounded by natural things) where I can sense a gentler way of raising our children and a way to some personal growth and spiritual development of my own.³⁴

While Cassel hoped to find "some land or a farm in the Dungannon/Fort Blackmore/Gate City area," he knew that would hinder him from acquiring "active hospital privileges." He said, "What I would like to do is to at least get courtesy privileges so that I can use some of the educational and professional programs in Kingsport and not isolate myself from medicine too much." The solution to the problem of professional isolation may rest not with the community health centers, but with revisions at the area's hospitals and medical schools to offer "courtesy privileges" or access to continuing education to rural physicians. However,

³³Michael Interview.

³⁴Correspondence with Todd A. Cassel, March 28, 1994 (hereafter Cassel Correspondence).

Cassel expected the two-physician practice to relieve some of the burnout he experienced during his previous, solo practice at CRHS, explaining:

This is something that having two Docs at the clinic will really help. There won't be guilt or a backlog from a vacation or sick day. There will be someone else to discuss medicine with -- without bending someone's ear in Kingsport on a telephone consultation.³⁵

Besides the special request for a new physician, the center requested additional funding in the RHI grant to increase the NP's work days from two to three. Bowen, in writing the proposal, stressed the NP's presence as "an important factor in the retention and recruitment of physicians for the center," reiterating the NP's relation to the physicians as a "back up person" and as "an associate in an isolated situation." The proposal made it clear that increasing the number of days the NP worked would also insure "retention of her services," as she needed a three day week to feel "fully satisfied with her position."³⁶

With two physicians and a NP at CRHS, the center's ability to offer continuity of care in hospitalization might improve. Unlike Cassel who planned to settle in the countryside, Michael had moved to Kingsport. But as a solo

³⁵ Ibid.

³⁶ RHI Application, 27 January 1992, CRHS, pp. 25, 78, 78A.

practitioner at the clinic, he had not attempted to acquire active hospital privileges, as he knew from past experience that he could not adequately care for patients at CRHS and in the hospital. Therefore, the prior arrangement remained in effect with the Kingsport Family Practice Center of ETSU's Quillen College of Medicine.³⁷

If Michael or Cole felt that a patient needed to be admitted to the hospital, they called the Kingsport Center and one of its physicians reviewed the case and arranged admittance, usually to HVH. The Kingsport Center physician handled the case and kept the CRHS provider updated on the patient's condition, sending copies of all hospital notes to the center to be placed in the patient's chart. As Bowen explained, "After dismissal from the hospital, the patient returned to the center for any follow up suggested."³⁸ Although this arrangement with the Kingsport Practice was generally satisfactory, it was not ideal. There was still a break in continuity of care.

Following PHS policy, CRHS also arranged referrals to the "specialty medical and diagnostic services provided through Holston Valley Hospital." CRHS provided the patient

³⁷ Bowen Interview, 1993; Michael Interview.

³⁸ RHI Application, 27 January 1992, CRHS, p. 26. Bowen Interview, 1993.

with a referral letter, giving a "brief medical history and the problem or purpose of the visit." The center kept a log book of all referrals and checked to see if all appointments were kept. As with the hospitalization procedure, the CRHS provider received "a report for any diagnostic services provided" or the specialist's "opinion of the patient's condition."³⁹ The two-physician practice could better monitor the referral situation, as well as in-patient care, as explained by Cassel:

We need to form some consistent and dependable way to have our patients followed in the hospital setting and return to us with good communication; then we will be more consistent and expert in the outpatient forum.⁴⁰

With the exception of an ideal tertiary care arrangement, the CRHS's medical and administrative team met or exceeded the PHS's expectations. However, the CRHS board failed to comply with the PHS guidelines in its rules for representation and service. Although the board had insisted in 1990 that its by-laws did not need to be changed, the PHS thought otherwise. In reporting on governance in the 1992 RHI application, CRHS acknowledged the problem, stating, "The number of consecutive terms a board member may serve is not set forth in the center's By-Laws, as is recommended in

³⁹Ibid.

⁴⁰Cassel Correspondence.

the Program Expectations." To comply with RHI policy, the board planned to write a proposal to be presented to the membership at the (1993) annual meeting, where it would be discussed and a revision adopted, a a copy of the revision would be forwarded to Region III.⁴¹

While the PHS's request for compliance seemed simple enough, it met with resistance. One long-time board member complained,

The people up the road [Region III officials in Philadelphia] now are complaining that the bylaws here should have a limitation. ... They think two terms and that should be it. I agree with them if you can keep the interest up and people want on. ... I don't think it's such a big thing but they've⁴² got to have something up there to be doing.

⁴¹ RHI Application, 27 January 1992, CRHS, p. 57. According to PHS expectations: "A C/MHC's [community/migrant health center's] By-laws must specify a process for member selection. This process should provide for turnover among members yet sufficient continuity to ensure familiarity with issues and effective participation. Staggered terms are one means to assure continuity. [CRHS employed staggered terms.] The By-laws should specify the number of terms a member may serve and provide for regular elections of officers and periodic changes in leadership positions." U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance. Program Expectations for Community and Migrant Health Centers, Attachment A., May 1, 1991, pp. 7-8 (hereafter PHS, Program Expectations).

⁴² Interview with Curtis Mays, Dungannon, Va., January 7, 1993 (hereafter Mays Interview).

A member of the CRHS staff explained further,

The board has been upset because they feel like the government is actually trying to take over -- I guess that's the right word. They [the government] want to be in every aspect of everything. And there's not been⁴³ any problems here so we don't really know why....

The two most cited arguments against term limitations centered on the difficulty in finding people willing to serve and in electing people who would attend regularly. The complaints, "It's hard to get people to come and get on the board," and "We told them that we don't have people knocking down the door to serve on the board," may or may not have been true.⁴⁴ However, there is no evidence that CRHS ever conducted a serious recruitment campaign.

The lack of fundraising activities, community outreach, the infrequent publication of a newsletter, coupled with the center's intermittent difficulty in retaining a physician,

⁴³Bowen Interview, 1993.

⁴⁴The argument that local people were not interested in getting involved had been used before. Carol Sluss reported: "I had approached the principal [who had also served on the CRHS board] with 'Why don't we have a PTA?' I was told, 'It never works. We just can't get people out.' So I said, 'Give me a chance.' ... So at our very first PTA meeting, we ended up not being able to get inside the building, because the building was locked, so we met in the school yard. ... It got organized. ... But he was trying to tell me you just can't get parents interested." Interview with Carol Sluss, Dungannon, Va., January 7, 1993.

all worked to reduce community participation and enthusiasm in governance. One indication of lowered public interest was the decline in attendance at the annual meeting. For example, Bowen remembered approximately fifty people attending in 1990, and only thirty or thirty five in 1993.⁴⁵

The second complaint -- new members might fail to attend and without a quorum, decisions could not be reached -- could have been remedied by invoking the clause in the By-laws which stated:

Article VI, Section C - Any director moving out of the afore-mentioned area or missing three (3) consecutive meetings without an adequate excuse will automatically be removed from the board of directors.⁴⁶

However, Curtis Mays, the board member with the longest record of continuous board service -- thirteen years -- readily acknowledged that poor attendance was not a new problem. In the early years it had been a severe problem. He explained that several people including Phil Osborne, the member with the second longer record of "continuous board service" -- twelve years, had violated that clause with impunity. Mays said, "Phil comes pretty good now. But one

⁴⁵ Mays Interview; Bowen Interview, 1993.

⁴⁶ Clinch River Health Services, Inc., "By-Laws," Article VI - Board of Directors, Section C., 1976, Clinch River Health Services, Inc. Collection, Dungannon, Va.

year [he] came one time. He's changed. He's got much more interest now." In 1993, Osborne was elected board president, because, as he said, "they needed someone to serve."⁴⁷

In summer 1993, while serving as board president, Osborne acknowledged that "some members" of the board hoped to turn the center over to a private physician practice, preferably a group practice. Their ambitious goal rested mostly on their fatigue in governance. They did not know how the community could financially support a private practice without RHI funding. Nor had they considered how uninsured, medically-indigent patients would be covered in a private practice that might not be able to afford a sliding-fee program.⁴⁸

At a community health center -- in practice -- indigent patients were expected to pay to the extent they were able. In theory, as long as the center received PHS funding, it was "expected to assure access to [its] services without regard for a person's ability to pay."⁴⁹ Thus, Medicaid and uninsured, poor members of the community received care.

With the 1990s debates on health care coverage reform

⁴⁷Mays Interview; Interview with Phillip G. Osborne, Dungannon, Va., July 30, 1993 (hereafter Osborne Interview).

⁴⁸Osborne Interview.

⁴⁹PHS, Program Expectations, p. 14.

underway, the future financial foundation of centers might improve. As Cassel observed, "If universal health insurance existed, the uninsured (those that require the most per capita dollar support) would have the same access and same reimbursement to the clinic as everyone else." According to Cassel, with guaranteed reimbursements -- also requiring "increases in clinic utilization [and] economic recovery to the area" -- CRHS might be able to "stand free of outside support as a `private practice.'"⁵⁰

There were some definite signs that Scott County's economy had improved substantially, even as the population figures fell. According to the 1990 census figures, the county reported 28,204 persons, a decline in over a thousand persons from 1970. The town of Dungannon reported 250 persons, a drop of 26.3 percent from 1980 - 1990. Figures from the 1990 census indicated an upswing in the economy since the 1970s. The big change came in Scott County's "median family income in 1989," reported as \$22,497, a dramatic increase from \$5,957 in 1969. Of course, in considering inflation the difference is not so striking. The percent of families below poverty level fell from 27.0

⁵⁰ Cassel Correspondence.

percent in 1970, to 17.3 percent in 1990.⁵¹

A spokesperson for LENOWISCO, the Planning District Commission for southwest Virginia, attributed the improvement to a growth in the manufacturing sector of Scott County's economy with a subsequent rise in employment. Small manufacturers in the new industrial park in Duffield employed 1500 people. An increasing number of people commuted to the Kingsport - Johnson City, Tennessee area for employment. Overall, Scott County was becoming less dependent on agriculture. The neighboring counties of Lee and Russell experienced improvement but not as great a degree. The LENOWISCO bureaucrat attributed the slower growth in Russell County to a decline in coal mining on which it is dependent; in Lee County, on a continued dependence on agriculture.⁵²

⁵¹ Scott County population density dropped from 47 persons to 43.2 persons per square mile. Russell and Lee both experienced a population increase: Russell growing from 24,533 persons in 1970 to 28,667 in 1990; Lee growing from 20,321 persons in 1970 to 24,496 persons in 1990. The Scott County figure for "all persons below poverty level" was at 20.9 percent. Figures supplied by Charles Cleland, Ph.D., Rural Sociology, University of Tennessee, Knoxville, and Eddie Wells, LENOWISCO Planning District Commission, Duffield, Va.

⁵² For median family income, Russell County improved from \$6,155 in 1969 to \$21,777 in 1989; Lee County improved from \$3,901 in 1969 to \$17,783 in 1989. Ibid.; Information supplied by Wells, LENOWISCO.

Increases in CRHS utilization had also occurred. Figures for fiscal year 1993-94 showed approximately 2,000 users (up from 1,849 in 1992-93) and 7,503 encounters (up from 6,606 in 1992-93), with optimism that they would continue to grow. Cassel started practicing on July 1, 1994. Unfortunately, the nurse practitioner had resigned due to a family move that took her out of easy commuting distance. The center had not replaced her, expecting Michael and Cassel and the two nurses to be sufficient for the work load.⁵³ However, the loss of a mid-level provider decreased the optimum team of health care professionals and put more stress on the physicians to perform duties that could easily be handled by a NP.

Cassel had included universal health care coverage in his equation for an economically successful private practice to replace the federally-funded community health center. But successful conclusion of the health care coverage debate and full implementation of reform -- ideally, universal health insurance with no disparity between urban and rural reimbursement -- was still a very long ways off. As the debate continued, the likelihood of universal coverage had fast disappeared. Even though most of the manufacturers in

⁵³Figures supplied by Carolyn Bowen, Administrator, CRHS; Bowen Interview, 1993.

Duffield's industrial park offered health care benefits and some of CRHS's users were employees there, many others in the area were still underemployed.⁵⁴ For example, seasonal and service economy jobs still did not offer health insurance. With less than universal coverage, the medically-indigent people would still need affordable health care.

Even with financial independence for the center other issues remained, for example, outreach, preventive care, health education, and quality and comprehensiveness of care, such as instituted through the CPMs. As long as a center receive PHD funding, it was required to meet basic health care delivery expectations, and to include community representation and participation through its board of directors. In a change from a community health center to a private practice, independence might be gained but much of value to the community might be lost.

While the PHS set regulations, the officials were not rigid or punitive in applying them. Although the board and staff of CRHS accused Region III officials of interfering in local affairs, a PHS spokesperson admitted that if the board could not or would not comply with the policy guidelines on term limits and representation, no punitive action would be

⁵⁴Information supplied by Wells, LENOWISCO.

taken. The program expectations were the ideal. Term limitations and staggered elections were the suggested means for "blending new blood with old," for "bringing in new voices" while preserving and continuing experience. The PHS recognized the difficulty of finding new board members, new volunteers, in a small community. But the pressure on the board to try to comply came from the government's experience with boards that had entrenched members who developed "too cozy a relationship with the administrator and auditor."⁵⁵

However, PHS patience with the CRHS board -- or at least with its long term, prominent members -- may have been wearing thin. According to a top-level official in the PHS Region III office, one prominent member had a great deal of difficulty in dealing with female PHS officials and accepting recommendations, especially concerning physician recruitment practices.⁵⁶ Bringing new leaders on board, bringing more diversity to the board might help the Region III bureaucrats guide CRHS into a more active position in the community. There is some evidence to indicate that all along the PHS had wanted CRHS to do more in offering services and programs. In comparing CRHS's federal funding

⁵⁵ Otterbein Interview.

⁵⁶ Batman Interview, 1993.

with other centers, a prominent board member remarked:

Percentage wise, nothing like what most of the other clinics [get]. They [Region III] always insisted on us doing this or doing that. We should do this and they would furnish money for it.⁵⁷

The board chose neither the federal funds nor the activities. It is in the areas of community representation, community relations, and outreach services that CRHS is least successful, demonstrating that a center's success is dependent not only on national forces out of its control, but also on local forces that it can control.

With the history of CRHS's operation from 1978 through 1994 complete, its performance will be analyzed in view of its own stated objectives in its Articles of Incorporation and the objectives which the National Rural Health Association and researchers identified for successful rural health centers. With few exceptions, this review will concentrate on local factors, rather than national or federal policies, in determining success.

To recall the original objectives of CRHS, the purposes as stated in the Articles of Incorporation are repeated here:

(a) To improve the health services and health education available to the residents of that area ... by determining the health needs of these communities and then taking the action necessary

⁵⁷ Mays Interview.

to obtain the medical staff and financial resources to meet these needs.

b) to encourage closer cooperation among the residents of the several communities ... in pursuit of better health and welfare for all the residents of these communities.

(c) to ... lessen the burdens of government, to promote the social welfare of the area, and to encourage local initiative in solving health problems and relieving the poor and distressed and underprivileged residents of these communities.⁵⁸

Considering CRHS's stated purposes, the center was generally successful. Over its sixteen years of operation, it certainly improved "the health services and health education available to the residents." From a total lack of local health services in the 1950s and 1960s, CRHS provided primary care through the services of physicians and a nurse practitioner. Although its services were reduced in two crisis periods, it managed to recruit and retain physicians for most of its operation. However, its health education services were generally passive. Its outreach in health education was limited by lack of a professional health educator for most of its existence and its board's failure to pursue aggressively additional grants to hire an educator and create dynamic programs.

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⁵⁸Clinch River Health Services, Inc., "Articles of Incorporation," March 12, 1976, Clinch River Health Services, Inc. Collection, Dungannon, Va.

Through representation on its board of directors, "the residents of the several communities" worked in "closer cooperation ... in pursuit of better health and welfare for all...." However, by its own admission, the board needed to recruit members from the smaller, outlying hamlets, as its board members were predominately residents of Dungannon and Fort Blackmore. It also fell short of federal compliance in setting term limits and its board was dominated by a core of founding members, all prominent residents. Throughout its history, the board lacked real representation by its lowest-income clients, although on several occasions, one or two members could -- but did not -- claim eligibility for Medicaid or sliding-fee status. The board's reliance on a core of prominent individuals promoted continuity in governance but resulted in "tired blood" and stifled innovation.

It is more difficult to judge if CRHS met its third purpose, because the wording is vague: "To ... lessen the burdens of government, to promote the social welfare of the area, and to encourage local initiative in solving health problems and relieving the poor and distressed and under-privileged residents of these communities."⁵⁹ CRHS lessened "the burdens of government" in the sense that it utilized

⁵⁹Ibid., Article 2 (c).

volunteerism in its governance, and had constructed the clinic building through local contributions in money, labor, and goods. But due to the economically depressed conditions of its area and the lack of national health insurance, it was forced to rely on RHI funding. After its initial success, the board never again pursued local fundraising that would have also promoted community spirit for the center. It rarely engaged in outreach programs that utilized volunteers.

The success of starting CRHS had encouraged "local initiative" to solve other problems. For example, the community organized a local, volunteer fire department and emergency squad and received grants to construct and/or improve the water and sewer system. The residents organized a Women's Club and the Dungannon Development Commission which created educational programs and housing rehabilitation and food distributions programs, all of which helped in "relieving the poor and distressed and underprivileged residents of these communities." Although CRHS itself engaged in few outreach efforts, given the vagueness of the expression, "to promote the social welfare of the area," one would be hard pressed to claim that CRHS did not fulfill this purpose. Therefore, according to its own objectives, CRHS was a success.

In 1992 the National Rural Health Association (hereafter NRHA) prepared a report for the federal agency, the Health Resources and Services Administration in DHHS. The NRHA proposed certain objectives for judging successful rural health care delivery systems. While the NRHA recognized the great diversity in rural communities and in their health care services, it also recognized "some common characteristics," were shared by all "successful rural health care delivery systems," including community health centers. Based on the NRHA's findings, a successful rural health care system responded to "community health care needs and concerns as perceived by the local residents." Administrative and medical staffs were in "regular contact with community leaders and involved a broad spectrum of community representatives in planning, administering, and evaluating efforts."

In such a system the medical staff included a "variety of health care professionals working in an atmosphere of mutual respect and support. The team established links with tertiary health care facilities that provided "specialized clinical and technological support not readily available in rural areas." The local program also received support from tertiary health care facilities and local, state, and federal government agencies, utilizing all available local, state, and federal resources.

While working to meet the "health care needs of all residents in the service area," the providers especially targeted programs to those groups who were at "high risk or traditionally underserved." In all programming, the administrative and medical staff developed "a sensitivity to the social, cultural, racial, and ethnic differences among people in the service area."

Effective administrative and medical staffs engaged in "both short-term and long-term planning," made "an effort to develop and maintain relationships in all sectors of the community," and learned to solve problems innovatively. To assist in planning and management, they used "state-of-the-art technology" efficiently and integrated "new advances in telecommunications, computer technology, and medical technology." The administrators and board of directors attended to "the professional development and personal needs of the health care professionals providing care."⁶⁰

In applying the objectives the NRHA suggested for "successful rural health care delivery systems," CRHS

⁶⁰ National Rural Health Association, "Study of Models to Meet Rural Health Care Needs through Mobilization of Health Professions Education and Services Resources," Executive Summary: A Rural Health Agenda for the Future (Rockville, Md.: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions, June 1992), pp. 3-4.

performed fairly well, doing poorly in those areas where it also missed its own objectives, principally broad community representation and interaction. CRHS responded reasonably well to "community health care needs and concerns as perceived by the local residents," although more interaction with the community may have generated a greater sense of those perceived needs and concerns. Especially with the implementation of Clinical Performance Measures, CRHS provided a comprehensive system of care, particularly addressing the needs of those groups who were "high risk or traditionally underserved." While the CPMs were mandated by the PHS, the center was diligent in complying and earned high marks from the PHS Region III officials.

Its administrators and medical staff were definitely in "regular contact with community leaders," as they were well represented on the board. However, as mentioned throughout, CRHS lacked genuine involvement by "a broad spectrum of community representatives in planning, administering, and evaluating efforts." Although the Medicaid and sliding fee patients were seriously under-represented on the board, board members did represent a "broad spectrum" of occupations and ages, and women were fairly well represented, although there is some doubt as to their power in its decision-making processes.

Although the center struggled through two periods without full-time physician coverage, for the greater part of its history, it "included a variety of health care professionals working in an atmosphere of mutual respect and support." Over the years, the board learned to attend "to the professional development and personal needs of health care professionals," working to secure professional backup and improved working conditions. CRHS did very well in establishing linkages with the area's "tertiary health care facilities ... and local, state, and Federal government agencies." The physicians had worked to establish good relations with the region's hospitals, especially HVH & MC. Their failure to secure hospital privileges was due more to CRHS's distance from the hospitals and hospital regulations than any neglect on the physicians' part. The center was especially strong in securing working arrangements with county and regional health and social service agencies.

Although the medical and administrative staff referred women to the MIHOW program and needy patients to the DDC's emergency aid program, the board's failed to recognize and interact with the DDC, one of the few "available local ... resources." If the community's health problems -- both those of strictly medical origin and those of social, economic and environmental origins -- were ever going to be fully addressed, CRHS and DDC would have to work together,

or at least, understand each other's programs and recognize the resources each could contribute to the community. The community was too small, the needs too great, and the resources too few to permit the luxury of bickering and obstructionism in forming working relationships.

CRHS's target population lacked "cultural, racial, and ethnic differences," being one hundred percent white, Christian, and of Anglo-Saxon (usually Scotch-Irish) origin. However, there were "social ... differences among people in the service area," and the board and staff needed to develop "sensitivity" to these differences. It lacked real representation by its Medicaid and sliding fee clients, thereby lacking their input on operational features, such as the procedure for interviewing people for sliding fee status. Because the center offered few outreach programs and the board no longer engaged in fundraising projects, its "effort to develop and maintain relationships in all sectors of the community" was minimal.

Even though the center had improved in its "short- and long-term planning" and in completing RHI grants on time, it was the last center in Virginia to get a computer system. Its repeated failures at securing additional funding were due in part to federal limitations and in part to its own timidity. However, with the arrival of Gary Michael and the continuation of Carolyn Bowen's administrative services, the

staff's assertiveness had greatly improved. With the addition of Todd A. Cassel, CRHS would undoubtedly continue to "improve the health services and health education available to the residents of that area." Unfortunately, the loss of the nurse practitioner's services and the continued absence of a health educator limited one-on-one health care instructions and group counseling.

A change in attitude and increased effort on the part of the board would be required for CRHS to improve its relationship with all sectors of the community and to take advantage of all local resources, especially those offered by the DDC. By acquiring a broader vision that took in the entire community, all CRHS's stated purposes would be fulfilled and CRHS would be able to confidently claim that it was promoting the social welfare of the area and was "a community supported clinic providing health care to [its] area."⁶¹

In the area of federal funding and relations with the PHS, CRHS scored a major success that in turn confirmed the success of the community health center program. As presented in the 1970s statistics and other reports on

⁶¹Clinch River Health Services, Inc., Letterhead, Clinch River Health Services, Inc. Collection, Dungannon, Va.

economic conditions and health services, the Dungannon-Fort Blackmore region suffered from the twin problems of poverty and lack of health care and desperately needed a community health center. The PHS through its positive programming concept in its Rural Health Initiative policy granted sufficient federal funds to allow CRHS to open its doors in 1978 and continue operating. Without that federal funding, it would not have been possible for CRHS to delivery comprehensive, primary (curative and preventive) care to the poor, medically underserved residents in its area. The PHS's Rural Health Initiative as demonstrated at CRHS is a major success.

In focusing simply on comprehensive primary care, the community health centers (as well as the migrant health centers) broke historical ground in delivering both curative and preventive care. In that sense it went so much further than the Sheppard-Towner clinics. In areas served, the PHS funded centers throughout rural America, not just in the South where the Farm Security Administration had concentrated its clinics or on the Navajo reservation where the Manyfarms PHS-IHS clinic operated. The community health centers under the PHS served indigent and middle-income/ paying users in the medically-underserved community, insuring a better organized and more politically active constituency of users to defend the program.

Most significant of all, none of the previous PHS projects reached the numbers of rural Americans, with the high level of financial support, over the period of time as did the PHS/RHI-funded community health center program. The thesis of this dissertation is confirmed. The community health center program, funded through the PHS's Rural Health Initiative policy, successfully delivers comprehensive primary care to rural communities. Clinch River Health Services, a community health center with Rural Health Initiative funding, has for sixteen years delivered comprehensive primary care to the people of Dungannon and Fort Blackmore and the surrounding area.

The second statement of the dissertation thesis has also been demonstrated. Although successful, at the national level the community health center program is vulnerable to political forces in the executive and legislative branches and to bureaucratic forces in the Public Health Service. Having survived the most threatening experiences during the Reagan administration, the PHS administrators wait cautiously to see how the program will fare in the outcome of the 1990s health care coverage debate.

Although successful, at the local level the community health centers, as demonstrated by Clinch River Health Services, are vulnerable to local economic conditions; problems in recruiting and retaining health care providers,

especially physicians; and to stagnation in leadership on its board of directors and lack of support from its community. With national and local commitment at all levels (executive, legislative, bureaucratic; medical and administrative staff, board of directors, users, and community) the rural community health center program can reduce or eliminate its vulnerabilities and proceed as a successful model for delivering comprehensive, primary health care.

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APPENDIX

THE UNIVERSITY OF TENNESSEE
KNOXVILLE



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Compliances
Grants & Contracts
Research Advancement
404 Andy Holt Tower
Knoxville, Tennessee 37996-0140
(615) 974-3466
FAX (615) 974-2805

06/25/93

CRP # 4149 B

Title: "Delivering Health Care to Rural America, A Historical Analysis
of Two Institutions in Tennessee and Virginia, from..

Quinn, Edythe Ann
History
1101 McClung Tower
Campus

Cobb, Dr. James C.
History
1110 McClung Tower
Campus

Your project listed above was reviewed. It qualified for expedited review
and has been approved.

This approval is for a period ending one year from the date of this
letter. Please make timely submission of renewal or prompt notification
of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project
include the following:

1. To obtain prior approval from the Committee before instituting
any changes in the project.
2. To retain signed consent forms from subjects for at least three
years following completion of the project.
3. To submit a Form D to renew approval, to report changes in the
project or to report termination at 12-month or less intervals. 

The Committee wishes you every success in your research endeavor.

Sincerely,

A handwritten signature in black ink, appearing to read "Sheadrick A. Tillman".

Sheadrick A. Tillman
Assistant Vice Chancellor for
Research

cc: John Finger
1109 McClung Tower

THE UNIVERSITY OF TENNESSEE
KNOXVILLE



Research Administration
Compliances
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Research Advancement
404 Andy Holt Tower
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09/14/94

CRP # 4149 B

Title: Delivering Health Care to Rural America, A Historical Analysis of
Two Institutions in Tennessee and Virginia, from..

Quinn, Edythe Ann
History
P. O. Box 977
Campus

Cobb, Dr. James C.
History
1110 McClung Tower
Campus

This is to notify you that your protocol, listed above, has been reinstated,
and the request for renewal with changes approved.

This approval is for a period ending one year from the date of this letter.
Please make timely submission of renewal or prompt notification of project
termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project
include the following:

1. To obtain prior approval from the Committee before instituting any
changes in the project (Form D).
2. To retain signed consent forms from subjects for at least three years
following completion of the project.
3. To submit at 12-month or less intervals, a Form D to renew changes
in the project; renew without changes; or to report termination of
the project.

We wish you continued success in your research endeavor.

Sincerely,

Lee L. Riedinger
Associate Vice Chancellor for Research

Attachment: Form D



FORM B

CRP # [4149 B]

Date Received in ORC _____

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

Application for Review of Research Involving Human Subjects

(In accordance with institutional assurance of
compliance to DHHS.)

I. IDENTIFICATION OF PROJECT Date: June 15, 1993

Principal Investigator: Edythe Ann Quinn, graduate
student working on her dissertation.

Dissertation Advisor: James C. Cobb, Ph.D.

Edythe Ann Quinn, graduate student/investigator
Department of History
1101 McClung Tower
615-974-5421

James C. Cobb, Ph.D., dissertation advisor
Department of History
1110 McClung Tower
615-974-7087

Title of project: "Delivering Health Care to Rural
America, A Historical Analysis of Two Institutions in
Tennessee and Virginia, from 1933-1993."

Department: Department of History

Starting date: Upon CRP approval.

Estimated completion Date: May 1994

II OBJECTIVE(S) OF PROJECT

The objective of this project is to collect historical
data for dissertation that studies the history of two
institutions delivering health care to the rural
population of northeast Tennessee and southwest
Virginia. The institutions are: Holston Valley
Community Hospital (hereafter HVCH), Kingsport, Tenn.;
Clinch River Health Services (hereafter CRHS), a
community health center,

in Dungannon, Va. To supplement research in archival sources, I plan to conduct open ended taped interviews with primary participants in the organization and administration of each institution, in order to learn more about the roles and activities of these individuals in relation to the institutions.

Because the archival sources are extensive and I am mostly concerned with the early period of the hospital, 1935-1965, I anticipate very few interviews with human subjects connected to HVCH. Most of the interviews will be conducted with human subjects involved in the organization and administration of CRHS.

III. DESCRIPTION OF SUBJECTS

HVCH: A long-time executive director, now retired; the present director or his/her official representative; and a registered nurse who lives in Dungannon and has served on the board of directors of CRHS and works at HVCH.

CRHS: Founding and/or long-time members of the board of directors; the first two physicians; the current administrator and physician; experts from outside agencies instrumental in establishing or operating the center, for example, a TVA resource person; and board members from other service agencies in the community that interact with the health center, for example, the director of housing with the community development commission.

The criteria for selection is length of time and level of involvement with the institution. For CRHS, members of the board of directors, center staff, health care professionals who have worked at the center, and outside experts who have advised its operation are the population from which I am seeking interviews. The general public is not involved. For HVCH, the criteria is even more limited, as I am only interested in interviewing the few people described above. Initial information on the participants has been gained from archival documents, for example, applications for funding from Public Health Service.

The duration of the involvement of the human subjects is limited to the introduction, the interview, and any follow-up telephone conversations/correspondence to clarify points in the interview.

IV. METHODS OR PROCEDURES

I will conduct open ended taped interviews with the human subjects and use quotes from the interviews in my dissertation. Taping the interviews will allow me to use the human subjects' own words in describing their participation in the institutions, rather than my paraphrasing from hurriedly written notes. Because of the formal nature of the topic - the history of two health care institutions - much of the information is rather "dry." The human subjects' expressions will enliven the prose and allow the readers to understand the commitment and -- most often, voluntary -- service of those involved.

My method of analysis is straightforward, fitting the human subjects' explanations into a historical context. Each of the institutions originated in specific health care reform impulses/movements and has been influenced by outside, political and economic forces.

V. SPECIFIC RISKS AND PROTECTION MEASURES

I believe the project holds only "minimal risks" for the human subjects, that is, "the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life," for example, in conversations. The human subjects I am interviewing had all voluntarily agreed to serve or be employed in a public capacity with the relevant institution, for example, as members of the board of directors of CRHS. General information about them and their roles is already public in the institutional records, press releases, newspaper accounts, and newsletters.

If at any time during the entire process, a human subject expresses discomfort at being interviewed, I will immediately stop and will not exert any pressure to continue. If asked, then and there, I will destroy the tape or give it to the human subject involved. The Informed Consent document will offer the human subject the right to review the tape.

All human subjects are participating strictly on a voluntary basis. There is "no penalty for refusal or withdrawal."

Because of the already public nature of their roles, and the nature of my questions, I do not anticipate a need for confidentiality. However, the Informed Consent document will offer confidentiality if desired by the human subject being interviewed. If a request for confidentiality arises, I will not identify the human subject on the tape. I will conduct the interview in as general a way as possible. If I use a direct quote from this human subject's interview in the dissertation, I will not refer to his/her name or any other distinguishing characteristics. I will simply refer to the human subject in a generic way, for example, as "a member of the board of directors," or even "as a member of the community associated with the health center," or as "a health care professional associated with the health center."

The interviews will be used for my dissertation and academic journal articles or professional conference papers that result from my dissertation. The interviews are not oral histories and will not be part of any archives. I will not use actual audio excerpts in any presentation.

Plans for handling audio tapes: in all cases, I intend to simply label the tapes numerically, e.g., as "CRHS Interview 1," and keep the tapes and the identifying list separate. In cases of requested confidentiality, I will label that interview generically; see above for examples.

The tapes will at all times remain in the possession of the principal investigator, Edythe Ann Quinn, and will be stored in a locked file cabinet in her home and the list will be stored in a separate file; neither the drawers nor the files will be blatantly labelled. No one other than the principal investigator, Edythe Ann Quinn, will have access to the tapes or list. After three years, she will destroy the tapes by magnetic erasure and discard them.

VI. BENEFITS VS. RISKS.

As each human subject to be interviewed has voluntarily associated him/herself with the institution involved, he or she has already expressed a commitment to its success. As each has either won election, been appointed, or successfully sought employment, their

very association is a credit to them, and their participation in the study should enhance their position in the community and/or profession.

My dissertation will provide 1) a history of each institution and in both cases, no in-depth history exists; 2) particularly in the case of CRHS with which most of the interviews are connected, the history will demonstrate a record of health care delivery that should help insure its continued funding by the Public Health Department, and perhaps help to insure the Clinton's administration continued support of the community health center program. Continued federal funding and support of CRHS will benefit the whole community. Continued federal funding and support of the community health center movement will benefit all rural America.

Therefore, with minimal risks, the human subjects, the institutions, and the community should benefit.

Also, the study of health care reform in rural America will benefit. The vast majority of studies have been done by sociologists and public health administrators, emphasizing theories and policies, but with few in-depth case studies of working models. Historians working the field have produced comprehensive overviews, for example, Rosemary Stevens's In Sickness and in Wealth, American Hospitals in the Twentieth Century. In contrast this dissertation offers a detailed history of two institutions actively engaged in delivering health care to rural populations.

VII. METHOD OF OBTAINING "INFORMED CONSENT" FROM SUBJECTS.

Please see the attached "Informed Consent" document that will be used in all cases. As stated previously, all human subjects participate on a totally voluntary basis and there is no penalty for refusal or withdrawal from the project. A signed "Informed Consent" document will be obtained from each human subject and kept on file for at least three years. Access to the signed "Informed Consent" documents will be limited to the principal investigator, Edythe Ann Quinn, unless requested by the advisor, the Coordinator of Compliances, or the Committee on Research Participation (CRP).

VIII. QUALIFICATIONS OF THE INVESTIGATOR.

The principal investigator, EDYTHE ANN QUINN, has recently received a University of Tennessee Hilton A. Smith Graduate Fellowship in recognition of her academic and personal standing. She has a 4.0 gpa and has successfully passed her Ph.D. preliminary exams. Ms. Quinn has experience working with Appalachian people, as she taught American History at Mountain Women's Exchange which serves the rural communities surrounding Jellico, Tenn. Mountain Women's Exchange college extension program is supervised by Carson-Newman Baptist College of Jefferson City. Ms. Quinn has taught the American History Survey Course at the University of Tennessee for the past five years, first as a teaching assistant, then as a teaching associate. Mortar Board and Omicron Delta Kappa Honor Societies have recognized her "as an outstanding faculty member at the University of Tennessee, Knoxville, 1991." Thus, she has demonstrated her commitment to scholarship and people.

IX. ADEQUACY OF FACILITIES TO SUPPORT RESEARCH. Not applicable.

X. RESPONSIBILITY OF PROJECT DIRECTOR.

By the compliance with the policies established by the University of Tennessee, Knoxville, Committee on Research Participation, the principal investigator subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville.

- a. Approval will be obtained from the University Committee prior to instituting any change in the research project.
- b. Development of any unexpected risks will be reported to the University Committee.
- c. A status report (Form D) will be submitted at 12-month intervals or as requested attesting to the current status of the project.
- d. Signed consent statements will be kept for the duration of the project and for at least three years thereafter.

Principal
Investigator EDYTHE ANN QUINN
Name

Signature

Date

Advisor JAMES C. COBB

Signature

Date

XI DEPARTMENTAL REVIEW

Acting
Department
Head JOHN FINGER

Signature

Date

The application described above has been reviewed by
the departmental committee and has been approved.

Chair,
Departmental
Review
Committee _____

Signature

Date

APPROVED Edith M. Szathmary
Coordinator of Compliances
Research Administration

Signature

Date

INFORMED CONSENT FOR INTERVIEW & USE OF INFORMATION
Research for Clinch River Health Service, Inc.

Project Title: "Delivering Health Care to Rural America, A Historical Analysis of Two Institutions in Tennessee and Virginia, from 1933-1993," a dissertation by Edythe Ann Quinn, Department of History, University of Tennessee, Knoxville, Tenn.

The objective of this project is to collect historical data for my dissertation that studies the history of two institutions delivering health care to the rural population of northeast Tennessee and southwest Virginia. The institutions are: Holston Valley Community Hospital (hereafter HVCH), Kingsport, Tenn.; Clinch River Health Services (hereafter CRHS), a community health center, in Dungannon, Va. This Informed Consent document only pertains to research on Clinch River Health Services Inc.

If you give your consent, I will conduct an open ended taped interview concerning your role and activities in relation to Clinch River Health Services Inc. Information gained from this interview will be used in my dissertation and academic journal articles and professional conference papers resulting from the dissertation. I will not use actual audio excerpts in any presentation. If my dissertation is published, this "Informed Consent" document will apply. No monetary incentive is being offered under any circumstances.

Your participation is strictly voluntary and your refusal to be interviewed or your withdrawal from the project carries no penalty. If at any time during the entire process, you express discomfort at being interviewed, I will immediately stop and will not exert any pressure for you to continue. If you ask, I will, then and there, destroy the tape or give it you. You have the right to review the tape.

Because of the already public nature of your role and participation in/or relationship to CRHS, I do not intend to maintain anonymity regarding your identity if I quote you. However, if you do request anonymity, I will insure confidentiality and anonymity in the following manner: I will not identify you on the tape. I will conduct the interview in as general a way as possible. If I use a direct quote from your interview in the dissertation, I will not refer to your name or any other distinguishing characteristics. I will simply refer to you in as broad a way as possible, for

example, as "a member of the board of directors," or even "as a member of the community associated with the health center," or as "a health care professional associated with the health center."

In all instances, I will provide security for the audio tapes in the following manner: I will simply label the tapes numerically, e.g., as "CRHS Interview 1," and keep the tapes and the identifying list separately. In cases of requested confidentiality, I will label those interviews as broadly as possible; see above for examples. The tapes will at all times remain in my possession and will be stored in a locked file cabinet in my home and the list will be stored in a separate file; neither the drawers nor the files will be blatantly labelled. No one other than myself will have access to the tapes or list. After three years, I will destroy the tapes by magnetic erasure and discard them.

Taping this interview will allow me to use your own words in describing your relation to CRHS, rather than my paraphrasing from hurriedly written notes. Because of the formal nature of the topic - the history of two health care institutions - much of the information is rather "dry." Your expressions will enliven the prose, and allow the readers to understand your commitment and service.

My dissertation will provide: 1) a history of CRHS that will be useful to the local community and to scholars of Appalachia and health care reform; 2) the history will demonstrate a record of health care delivery that should help CRHS receive continued funding by the Public Health Department, and perhaps help to insure the Clinton's administration continued support of the community health center program. Continued federal funding and support of CRHS will benefit the whole community. Continued federal funding and support of the community health center movement will benefit all rural America.

If you have read and understood this Informed Consent document and accept its conditions, please sign and date both copies of this document, retaining one copy for yourself. Thank you very much for your cooperation.

NAME _____

Signature

Date

Edythe Ann Quinn
Department of History
University of Tennessee
1101 McClung Tower
Knoxville, TN 37996-04111
615-974-5421

NOTE: Because Holston Valley Hospital was dropped from the
dissertation research and no interviews were conducted, the
protocol for that part of the project/permission has not
been included. EAQ

SAMPLE QUESTIONS FOR OPEN ENDED INTERVIEW

Research on
Clinch River Health Service, Inc.

Project Title: "Delivering Health Care to Rural America, A Historical Analysis of Two Institutions in Tennessee and Virginia, from 1933-1993," a dissertation by Edythe Ann Quinn, Department of History, University of Tennessee, Knoxville, Tenn.

FOR FOUNDING AND/OR LONG-TERM BOARD MEMBERS:

When you did you first get involved with CRHS?
Why did you first get involved?
For how long have you been involved and in what way?
What official positions have you held on the board?
How would you describe your contribution to CRHS?
How does CRHS interact with other community agencies?

GENERAL BOARD MEMBER QUESTIONS:

Why was CRHS organized?
How has the community supported CRHS?
How would you describe the contribution CRHS has made?
How has CRHS changed over the years?
Has CRHS conducted fund raising? Please explain.
Has CRHS conducted outreach programs? Please explain.
Current unmet needs? Plans for future?

CRHS DIRECTOR/ADMINISTRATOR:

How many people (aggregate number) are served by CRHS?
What is role of federal government re CRHS?
How has role of federal government changed over years?
Describe current staff positions?
Describe extent of CRHS services?
Current unmet needs? Plans for future?

CRHS PHYSICIAN(S)

Why did you choose to come to CRHS?
Are you involved with the National Health Corps Service?
Describe major health care needs of community.
Describe your experiences/contribution at CRHS.

GENERAL

Where do community residents go for acute care (hospital)?

What are the current unmet needs in this community?

VITA

Edythe Ann Quinn was born in Rutherford, in Bergen County, New Jersey, and attended elementary and high school in her home town. While working as an Editorial Assistant at McGraw-Hill Book Company in New York City for six years, she attended evening college at Fairleigh Dickinson University in Rutherford. After marrying, she continued to work and attend college, until the birth of twins, a boy and a girl, moved the center of her activities to her home and family. Her former husband's career with IBM involved the family in frequent moves throughout the Northeast. During this time, she wrote for local newspapers, including a column entitled Reminiscences, based on oral histories she collected. She also wrote poetry, receiving a number of awards from the Philadelphia's Writers' Conference and had a number of poems published.

Edie has always been a non-traditional student, resuming her education when her children were in middle school; completing a Bachelor of Science degree through the University of the State of New York, Regents College Degree program, graduating in 1985. While attending the State University of New York at Purchase, she produced an oral history of an Italian-American community. From 1982 - 1985,

she was municipal historian for Harrison in Westchester County, New York, and directed Harrison's History Center.

In 1986, she entered the Master's Program in History at Lehman College, The Bronx, of the City University of New York, graduating in 1988, with a 4.0 gpa. She received a full Lehman Foundation Scholarship for 1987-88, and the Hochberg Family Award, and Howard Weisz Prize in History. Her Master's thesis, "The Hills in the Mid-Nineteenth Century: The History of a Rural African-American Community in Westchester County, N.Y.," was published by the Westchester County Historical Society. Through an IBM Community Service grant, copies were placed in all area public libraries and selected African-American research institutions.

In 1988, Edie was accepted in the Ph.D. program in the Department of History at the University of Tennessee, Knoxville. For three years, she taught as a graduate teaching assistant and for two years, as a graduate teaching associate. In 1991, she received recognition by the Mortar Board & Omicron Delta Kappa Honor Societies' "as an outstanding faculty member." For academic year 1993-94, she received a Hilton A. Smith Graduate Fellowship from the University of Tennessee.

Through Carson-Newman College, she taught American History at Mountain Women's Exchange in Jellico, Tenn. MWE

serves low-income women from the mountain communities on the Tennessee and Kentucky border and is designed to use education as a means of empowerment. She also taught Latin American Studies for the University of Tennessee Evening Division; worked as a research assistant at ORNL, Oak Ridge; and researched and wrote a historical overview of the Tellico Reservoir Area for TVA.