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Marianne O'Hare: Welcome to Conversations on Health Care. This week we're the tables as we mark a half century of the first free community clinic in Connecticut, Veteran Journalist Thalia Assuras interviews host Mark Masselli and Margaret Flinter on their 50 years of transforming community care. FactCheck.org's Lori Robertson takes a look at monkey pox, and we end with a bright idea transforming everyday lives. Now here's our guest host Thalia Assuras.

Thalia Assuras: Welcome to Conversations on Health Care. Don't worry, your longtime hosts Mark Masselli and Margaret Flinter are here for what is a special edition. Special because we are marking the 50th anniversary of Community Health Center and also celebrating this very show that these two created.

As you know, CHC is a nonprofit based in Connecticut has offices in Colorado and California and programs right across the country through its Weitzman Institute. Let us begin after 50 years already. Congratulations, Mark, let's start with you. Mark, you founded CHC Inc, in 1972, when you were barely out of your teens and that's significant. What motivated you?

Mark Masselli: Well, first of all, thanks so much Thalia. It was a great opportunity that I was presented back in the early 70s an opportunity to work with other young people. We were setting up a drop-in center, 24-hour crisis hotline for young people who were facing all sorts of problems and difficulties. They were running away from home, there was issues around drug use. It's a real opportunity to hear people directly talk about the challenges they faced.

It turned out that the common theme, whether it was a run away or someone on the crisis line or somebody who just walked in with a problem, that access to health care, connected all of them. They simply didn't have access to affordable and comprehensive health care. Come 1972, I had heard about a conference that was being held in Washington D.C. by a group from California from the Haight Ashbury Free Clinic, hosted by them in Washington in January of 1972. I made my way there to hear the voices of people who would become friends, who were thinking about the same thing that I was thinking about. How do we solve this health care problem for people who we're engaged with? We heard from people who like us who were just thinking about setting up a health center to people who are running free clinics around the country.

I think from that day, to this day, it has animated all the work that I do, that Margaret does, in terms of trying to build a system. There were enormous challenges along the way. Pretty naive about what it took to get a free clinic going, but we found our way to a second floor

walkup in the building that we're in with sort of a ramshackle apartment building. But we made the best out of a second floor apartment. You could have been in San Francisco it had a tie dye on the walls that were beaded curtains that separated the rooms and that slight scent of incense was in the air.

We opened up and the great news was that we found some local dentist who said they wanted to volunteer. I reached out to the Christian Dental Association, they donated to chair. Friends at Wesleyan got their physical plant to install the dental chair. We converted the bedrooms and two exam rooms and we opened the door, and that was exhilarating. But back to the naivete, a few months later got a knock on the door and they said we're from the State Health Department, where's your license? We need a license?

Thalia Assuras: Right. One of several challenges all along the way, I'm sure and you really started chair by chair really, street by street, and you talk about challenges. What do you think are the biggest challenges you faced, and how you overcame them over the 50 years?

Mark Masselli: Yeah, I think the biggest challenge is trying to find resilience when crisis's arise because they're bound to, or being shut down by the state of Connecticut because our hallways were one inch too narrow. Most of our volunteers left. Didn't seem like there'd be a possibility of doing this work that they wanted to do, that's always been the case. There's a setback that you have when you're knocked down that you need to get back up and you need to propel forward. I would just say to everybody who is doing anything that you're bound to find that heady moment when, you know, for us when we open the free clinic to that moment of despair when we got closed down, you have to find some equilibrium and not get too high over the excitement of something or too low in the despair of a setback.

Thalia Assuras: Right equilibrium is a key word there. Margaret, I'd like to bring you in now too. I have mentioned the Weitzman Institute, which you spearheaded, you're also a nurse practitioner and you've expanded the profession itself through CHC. What inspired you to actually team up and stay with this CHC for more than 40 years?

Margaret Flinter: Yeah, I was a few more years out of my teens than Mark but not much. I think I was probably 27, when I arrived, a newly minted nurse practitioner from the Yale School of Nursing. My choice of the health center was somewhat both pragmatic and fortuitous. I was a National Health Service Corps scholar, meaning I had a period of service commitment in exchange for the Federal Government graciously funding my time at Yale. But I had a choice and I visited around New England and a number of community health centers.

I say about my first meeting with Mark, my first visit to Middletown, I

had found my people, this banner of health care as a right and not a privilege, this model of a community health center that made health care available to people regardless of their finances. Not just any health care, but a kind of health care not available to the wealthiest people in America, fully integrated. Even in that one hallway that existed after the second floor walkup, we were on the first floor hallway on Main Street.

But it was really the original idea of a community based patient centered primary care home there was only one of each of us, a dentist, a doctor, a nurse practitioner, a medical assistant, a social worker and of course, somebody to sort of take care of the finances and the data. But that model would give rise over the next 50 years to what has been pretty universally acknowledged as this is the model of what really good comprehensive primary care ought to be, not yet fully realized for everybody in the United States, but it was the first step on a long journey that feels like it's just been overnight.

Thalia Assuras: Well, let's backtrack a bit and Mark I'll come back to you because the vision, the mission and who you serve. Can you give us just a quick overview?

Mark Masselli: Sure. I mean, I think the mission, vision, values, have always been that health care is a right, not a privilege. I think it animates so much of the conversations that we have. Even today with young people, it's something that courses through their veins as well. The population we care for were in 243 locations here in Connecticut, we're in 34 farms that were taking care of farm workers. We're in 10 homeless shelters, taking care of people who simply can't find affordable housing. We're in 185 school-based health centers, taking care of young people from elementary school all the way through high school and 16 fixed primary care sites across the state of Connecticut.

It's mostly a people who live in poverty, a very diverse population, and we care for around 150,000 patients. We run a battered women's shelter from gender affirming care, all the way over to primary prenatal care. It's also one where English is not always the first language spoken. 50 different languages a month, we've got a great translation service. We're seeing from single individuals to large families.

Thalia Assuras: Enormous. Margaret, not only are you serving the communities, you are helping the people who serve the communities. Why has that been important, and you've been involved in that very deeply, haven't you?

Margaret Flinter: Sure. We need the next generation always of people who will provide the health care and we need to support the people who are doing it today. Over the years, I think we've recognized that our partnerships

with academic universities and training institutions are so important and we've welcomed in from many universities and colleges. I think at any given time, we have 300 students and trainees within the organization. But we also recognize that there are elements that the service delivery based organization can provide as key educational learning experiences that can never be provided in the classroom.

We've taken on not just providing clinical experiences to students, but we've also developed our own tailored, accredited, rigorous training programs along the continuum for medical assistants, an idea whose time had come in terms of a new way of training medical assistants who are so creative on the health care team. We develop the model of postgraduate residency and fellowship training for new nurse practitioners to ensure that they had a solid period of time, in this case a year, to be fully embedded in the primary care setting, working as part of a team, taking on the most complex and challenging patients that we see but with the support and mentorship of expert clinicians as a way to, if you will, fortify them for long term careers in community health centers.

In the public's eye, I think sometimes primary care is about the simple, the easy and the quick. They have the idea of the convenience clinics or the -- with the walk-in center. But primary care in a community health center is about a commitment over time to people who are struggling with challenges that most of us never encounter in our lives, financial, social and often clinical, when people don't have resources it's often because of compounding physical and mental and emotional difficulties and so they bring all that to bear into the setting. We owe it to that next generation to train them with real optimism and purpose. That gave rise to postdoctoral clinical psychology residencies to a full pipeline for the behavioral health professionals of nursing students and much more to come. Dentists are well represented in that as well.

Thalia Assuras: Well, let me -- you wanted to talk a little bit more about medical assistants, why, just very quickly.

Margaret Flinter: There are a group, I think, that represent the people that maybe Mark and I have the softest spot for, right. The people who've grown up in families, who've worked hard, haven't had much in the way of resources. Often we could see that very bright and talented people, maybe the guidance counselors didn't work with them so much. Medical assisting has long been a first rung, it's a certificate-based program, it doesn't require an academic degree and that's something sought after by hard working people looking to do good in their community. Too often finding it only available through for-profit institutions with pretty extreme tuition that then put them in debt for many years following their education and didn't give them clinical

experience in that kind of high performing, highly mentored setting that we just talked about.

We thought we could do better by those individuals who are often people in our own community. Mark really led the development of the National Institute for Medical Assistant advancement, which I think has kind of turned medical assistant education on its ear a bit in a positive way and now operates nationally around the country. It's really on its way to becoming a powerhouse of training often that first generation and families and a first rung in the health care professions.

Mark Masselli: If I can just add some to that, the indebtedness that we see that happens through this training, so just understand that people pay between 30 and sometimes $40,000, for seven or eight months training, that's a little more than if you annualize it out maybe for Harvard or NYU for simply a certificate. We find them 15 years later still paying off that debt. We needed to find an affordable way of doing that.

As Margaret said, the classic training program is seven months in an academic setting and then a month where they have to go and find a placement. We really turn that on its head by embedding the student for the entire eight months in a primary care setting. It's a great job opportunity interview that extends over a period of time. We want people like we found our people to find their people, but we are very focused in on trying to transform the entire educational system. We're very concerned about that entry level. We want people to have a unique experience and opportunity.

Thalia Assuras: The people who come to your various clinics, a question for both of you. Margaret I guess I'll start with you. Is there one person or one family who remains seared in your memory and says to you this is why I'm doing this?

Margaret Flinter: Not one, really truly thousands. I think one of the amazing elements of being in primary care, and I think this is true of primary care providers generally it's just writ so much larger. I think at the health centers that you know, people and you know families over time. There are the pivotal moments that are seared, a tough diagnosis, a family crisis, a great success and then there's just the evolution over time. Mark, I think you probably have the same experience, some of that is realized walking down the street when people call out to us and remember me from years ago, people that I took care of decades ago who will look you up on Facebook and say, do you remember me? You took care of me when I was a kid, a teenager, whatever.

But I think there are also the people and the families who are seared in our mind because what happened to them should never have happened to them. They became part of the galvanizing force to

create change. I can think of so many of those really that inspire me, particularly around the areas of women's health, women's rights, domestic violence, substance use disorder, what happens to people in the criminal justice system, that was their story. I think for everybody at the health center they have those experiences that really on the toughest days propel you forward, because we use those to create lasting systemic change. We have the opportunity at our size and our strength to influence policy and practice in the United States.

Thalia Assuras: Mark, a significant memory for you?

Mark Masselli: Yeah, one of the unique things that we did when we were starting the health center, we said we're going to organize ourselves at our board in a different way and that we're going to have the majority of our board members be patients, that's unique. Oftentimes, we have people just saying, how's that possible these are people who live in poverty. The reality is they make do with less and they're raising children, they're going to work and they're problem solvers.

One of the early board members and who was a mentor, to me was Reba Moses, born in 1920s in South Carolina, her dad was a sharecropper. She found her way in the 1940s of the Middletown and she was a foot soldier in the Civil Rights and the anti-poverty work that was going on at that time. She found me a young upstart, she was probably close to 30 years older than I was, but she became a friend, a mentor. She served on our board of directors, she is emblematic of so many people that Margaret and I get to work with on our board who are patients who come here and then they guide us and made such a profound impact. There are many people like that in the health center. They've made us who we are today.

Margaret Flinter: Yeah, one of the remarkable experiences that's begun to happen more in recent years, particularly with the training programs, people tell us that they used either this community health center or a community health center somewhere in the country as children, often children in immigrant families that did not speak the language. They speak of how in their family they heard their parents saying that the health center was the place that could trust and that their experience of getting care in a health center really fueled and propelled them into the health professions. It's a very special thing to realize the impact the experience of receiving care in a health center like this can have the future life of a child.

Thalia Assuras: I'd like to talk about the advances in caring for the underserved. But where have there been failures to?

Margaret Flinter: Good news, the Affordable Care Act came along in 2010. The Affordable Care Act did some very powerful, significant and sustained improvements. There are a whole lot of people who had not had

health insurance in decades who received health insurance and a whole lot of families, and we need to continue to build upon that. I think the biggest shortcoming is the failure to have absolutely universal access to health care to control the prices downstream. But the third has been around the model of care, it's hard to say thanks to COVID. But thanks to COVID, one of the big ones that a 15, 20-year overdue major addition of virtual care to the armamentarium of people and health care actually came to pass, and we all did it kind of overnight. Now we have to do the hard work of research and evaluation and testing to see what really works best, but that's been a huge plus.

What hasn't happened is we haven't recognized that as long as we're locked in this fee for service system, there will always be a bit of the rabbit wheel of running to do more visits, more visits, which means less time with patients and more focus on the episodes. There's certainly a lot of people thinking about it, studying it full a 100% access more for the people who need more. As we say in our health equity work, it's not about providing the same thing to everybody it's providing what people need, which may be much more in some cases, removing those financial barriers. But then really making sure that we have the time in the model of care with full integration of behavioral health, oral health, as well as medical services into primary care, that would be a good start.

Thalia Assuras: Yeah, and Mark if you would pick up on that. It's impossible to separate health care in this country from how we actually pay for health care. You've been through those budget battles in Washington for trying to help your construct and what are called and maybe people that don't know this they're called Federally Qualified Health Centers. What have you learned, and what are you looking for further?

Mark Masselli: This is a white system, I think we've maybe evolved a little but it is very much focused in on -- not on the population that we care for. None of the research has been done in terms of health outcomes until very recently and in only in very small steps have we researched the health conditions of African-Americans or Hispanics of native people and this is to the detriment of the health and wellbeing of tens of millions, hundred million Americans who've been left out of the entire Health Care system. It is been designed to limit the opportunities that the rest of us have, and so I think that's an enormous shortcoming. We do not have until very recently an equity lens on the health care system. When we put that lens on we see how far it has fallen short, in terms of delivering on the promise of that we articulated that health care is a right not a privilege.

We often say there's access, but what is there access to, right. It's care

that has been designed for populations that really not the population that we're seeing, and so I really worry, we're making progress but it's too slow. We simply haven't done all the research. If you think about all the research that has been done in health care has been done on sort of a white male population, but really no diversity at all. I think that's the biggest challenge.

I will add to that the paucity of African-American providers, Latino providers that really need to be front and center in the movement, federally qualified health centers who all have been fighting this battle to make sure that there's equity across the spectrum. I think the one thing I come away with it and I think one of the brilliant things and I give a shout out to Ted Kennedy, and maybe somebody like an Orrin Hatch, who just passed away, health centers found common ground on both sides of the aisle. That is the only way we can move forward.

Health centers back in the late 60s and early 70s realized that we needed to define this common ground, and so we had leaders like Ted Kennedy and Orrin Hatch who stood together, who were ideologically so far apart. But they said funding community health centers make sense. They have this sense of local community control where patients are engaged in that. They are serving these neighborhoods for whom no one else would go to, and whether you're in Kentucky or whether you're in Boston, Massachusetts, they're making a profound difference. While there are enormous struggles, there's enormous hope that this model has built this incredible network all across America. 1,400 community health centers, tens of billions of dollars invested in them, and that all comes about because there was common ground.

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Marianne O'Hare: That was part one of our interview with Conversations on Health Care hosts Mark Masselli and Margaret Flinter. Next week in part two, our special guest host Thalia Assuras continues the conversation, exploring Mark and Margaret's vision on the quest to see equity driven transformation of health care in America.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: In the midst of the ongoing COVID-19 pandemic, a viral outbreak once

again has health officials concerned. This time it's monkey pox, a much less dangerous relative of smallpox. Monkey pox is endemic in central and West Africa. But in early May cases of the disease began cropping up in Europe and other places, including the US. With hundreds of confirmed or suspected monkey pox cases reported before the end of the month, the outbreak is abnormally large, but experts say the risk to most individuals is very low.

Monkey pox is a zoonosis, meaning that the virus is transmitted to people from animals. People typically become infected sporadically in the forested parts of Central and West Africa after an interaction with an infected animal. Once infected, people can spread the virus to others but that requires close contact.

The recent outbreak was first recognized in the United Kingdom in May. The CDC is conducting contact tracing to limit further transmission and it has offered smallpox vaccines that can help prevent monkey pox to those who had been exposed to the virus. Symptoms of monkey pox typically begin with fever, headache, muscle aches, back pain, swollen lymph nodes, chills and exhaustion. The CDC says a few days later, patients develop a distinctive and frequently painful rash.

Patients who have symptoms can pass the virus on to others through close physical contact. The rash and the scabs and fluids from the skin lesions are especially infectious, which means contaminated clothing or bedding can spread the virus. Monkey pox is also spread through large respiratory droplets. But because these larger droplets don't travel more than a few feet, it takes a lot of face-to-face contact to spread the virus.

A large number of the cases worldwide in the recent outbreak have been in men who have sex with men. Experts are in general agreement that the monkey pox outbreak is something to be aware of and take seriously but not something that people need to worry that much about. And some vaccines and treatments already exist. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like check, e-mail us at www.chc.radio.com we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make

wellness a part of our communities and everyday lives. It's no secret that baby boomers are aging in large numbers, and that means that those suffering from age related dementia are on the rise as well. Four million Americans live with Alzheimer's disease and we know that number will double by 2025.

Daniel Cohen has devised a tool that is improving the experience for these patients whose quality of life declines along with the loss of brain function. He wondered what happened if you provide iPods for patients in nursing homes that are loaded with their own personal playlist of the songs they loved when they were younger. In his first pilot program called Music & Memory, patients in a nursing home were given the iPods with their own personalized song list. The results patients went from being non communicative and disengaged to being animated and engaged. Patients like Henry featured in this documentary on the program called Alive Inside.

Daniel Cohen: Do you like music?

Henry: Yeah, I'm crazy about music, you played beautiful music.

Daniel Cohen: What was your favorite music when you were young?

Henry: I guess, Cab Calloway was number one band.

Daniel Cohen: What's your favorite Cab Calloway song?

Henry: I'll be home there for Christmas. You can come ---

Margaret Flinter: Cohen explains one of the theories as to why this program works so well.

Daniel Cohen: The reality is because our memories of music are co-located in the brain with our autobiographical memories. When you play a song, it's familiar you're kicking off memories that you had.

Margaret Flinter: The results from the Music & Memory program were so impressive that Cohen's personalized iPod program is now being used in 50 nursing homes throughout North America and many more are lining up.

Daniel Cohen: We've done some research and the feedback from the frontline from the nursing homes is that their ability to provide care is facilitated, and so that allows them to get their job done to pay attention to all the residents as much as possible. That's been a big win as well.

Margaret Flinter: A simple, personalized application for a readily available piece of technology that could dramatically impact the quality of dementia patients lives. Now that's a bright idea.

[Music]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

[Music]

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. The show is brought to you by the Community Health Center.