

The

POWER

of

# Community in Health

A Showcase of Community Health Center Advances

September 16-17, 2004 | Oakland, California

## CONFERENCE PROCEEDINGS



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*Thank You to Our Funders*

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Waianae Coast Comprehensive Health Center  
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## FOREWORD

In this age of rising health costs, when more and more Americans find themselves without medical coverage, community health centers must be regarded as a precious national resource. The struggle to reduce the ranks of the uninsured in the United States is directly related to the struggle to provide affordable, quality care. Community health centers are the battle-hardened veterans of this fight. These institutions have led the way in learning how to treat patients and populations efficiently, for the simple reason that they never had any other choice.

Likewise, the wider world is finally coming to grips with the issue of disparities in health care, something community health centers have confronted since their inception. The local providers and leaders whose achievements are chronicled here have paid close attention to the needs of underserved people. Those in the mainstream medical system can learn much by studying what community health centers already know. ■

*Mark D. Smith, MD, MBA  
President and CEO, California Healthcare Foundation  
Oakland, CA  
April 2005*



# Congress of the United States

Washington, DC 20515

September 16, 2004

## Message from the Congressional Asian Pacific American Caucus, Congressional Black Caucus and the Congressional Hispanic Caucus Welcoming All to the Power of Community in Health Conference

Dear Community Voices Project:

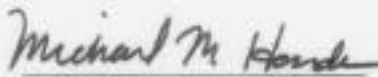
The Congressional Tri-Caucus commends the Community Voices Project on convening the upcoming conference, **The Power of Community in Health: A Showcase of Community Health Center Advancements**, September 16-17, 2004 in Oakland, California.

We congratulate you on the release of your new policy report, "**Covering All Residents: The Case for Immigrant Coverage in Health Reform.**" We support the principles of making stronger health policy through expanding health coverage for all rather than continuing to have uninsured children and adults rely on expensive emergency room care. Additionally, we support the efforts of local communities who are successfully providing low-cost health coverage for low-income communities.

The Congressional Asian Pacific American Caucus, the Congressional Black Caucus and the Congressional Hispanic Caucus have worked persistently to eliminate racial and ethnic health disparities in our communities. In the 108<sup>th</sup> Congress, we joined together with House Democratic Leader Nancy Pelosi to introduce the Healthcare Equality and Accountability Act which would guarantee that all Americans receive equitable and affordable quality health care. Additionally, we have convened two Tri-Caucus Health Summits that brought our diverse communities together to address the common good of educating one another on critical health care issues affecting our communities.

Please rest assured that together, the Tri-Caucus will continue to provide a strong and influential voice for people of color. Again, congratulations on your good work. Every resident deserves access to health coverage and health care, and working in partnership together, we can ensure good health and quality of life for all families.

Sincerely,



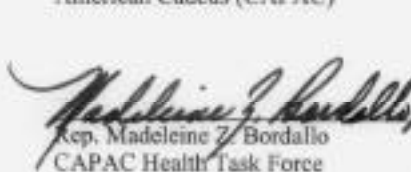
Rep. Michael M. Honda, Chair  
Congressional Asian Pacific  
American Caucus (CAPAC)



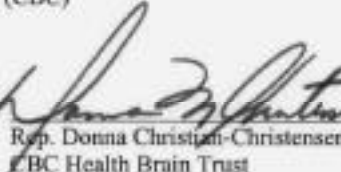
Rep. Elijah Cummings, Chair  
Congressional Black Caucus  
(CBC)



Rep. Ciro Rodríguez  
Congressional Hispanic Caucus  
(CHC)



Rep. Madeleine J. Bordallo  
CAPAC Health Task Force



Rep. Donna Christian-Christensen  
CBC Health Brain Trust



Rep. Hilda L. Solis  
CHC Health Task Force

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## INTRODUCTION

**Born out of the Civil Rights Movement, the community health center movement continues to be on the cutting edge of providing culturally competent health access to underserved communities.** In three decades, community health centers matured from fledgling volunteer services to vital community institutions that provide comprehensive health services as well as a critical advocacy voice for patient rights and community empowerment.

*The Power of Community in Health: A Showcase of Community Health Center Advances* is the third in a series of leadership conferences organized by consumer board members of community health clinics. The “leadership conference” is a concept originated by community health center consumer board members from both the Pacific and continental United States.

The intent of the conference founders, Asian Health Services in Oakland, North East Medical Services in San Francisco and Bay Clinic and Waianae Coast Comprehensive Health Center in Hawai‘i, is to develop leadership among consumer board members by learning from each other, creating forums to dialogue on ways to address the needs of Asian/Pacific Island and other ethnic communities, and to develop skills related to governance of community health centers.

In September 2004, organizers from California held *The Power of Community in Health: A Showcase of Community Health Center Advances*. This two-day conference celebrated the accomplishments of community health centers, honored community board members, and shared lessons learned from health coverage expansion, eliminating health disparities, and linguistic/cultural access.

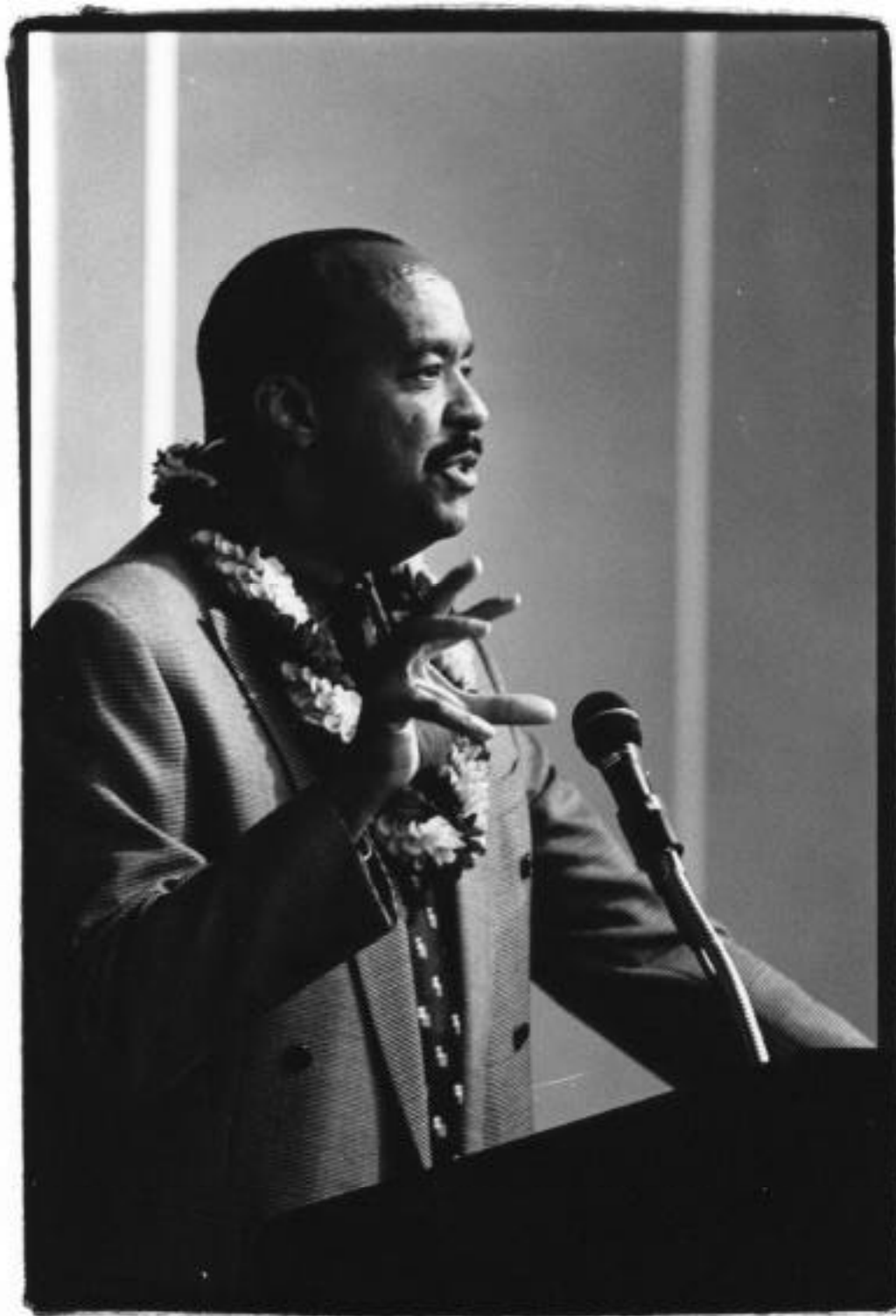
Day 1 of *The Power of Community in Health* conference provided an overview of the history of the Community Health Center movement, the broadening of the definition of community health, and the future of this movement. Community health centers grew out of community leadership, activism and empowerment. After three decades, community health centers have become community institutions that are large employers, community developers, service providers, and community advocates.

Day 2 covered the accomplishments of community health centers along with new opportunities for leadership. Health insurance coverage for low-income and immigrant communities fluctuate greatly with the economic conditions and financial health of state and local governments. As a result, community health centers play a key role in providing care to those most underserved in our communities. The health centers are now seen as premiere health care providers in our communities, working to eliminate health disparities by providing quality health care and empowering the communities to live healthier lives.

The conference was held in Oakland, California and was attended by approximately 250 attendees. The following are proceedings from the conference. Additional interviews were conducted with Henrie M. Treadwell, PhD from the Morehouse School of Medicine National Center for Primary Care, Robert K. Ross, MD from The California Endowment, and James Crouch, MPH from the California Rural Indian Health Board. ■

# REFLECTIONS ON THE COMMUNITY HEALTH CENTER MOVEMENT

*Robert K. Ross, MD, President and CEO of The California Endowment*



DR. ROBERT ROSS: Well, it's a pleasure to have the opportunity to talk about the value of community health centers and community health center movement in this country, in this the region. And when I reflect upon it, when you think about where we are and what we have as a result of the leadership of community health centers, you could say "Well, what if they had not existed?" If you just wiped away forty years of the community health center movement, what would we not have that we have today? And for me about four things came to mind.

The first is the obvious, which is the founding reason for community health centers: that is providing access to high quality health care. And those numbers speak for themselves on how critical it is that folks from low income, underserved communities have access to care.

Secondly, moving a prevention and primary care agenda in communities that need it, not only in terms of producing better health outcomes, but also reducing costs. Of all the complaints that we have about health care costs in this country, how much higher would they be if we did not have community health centers keeping people out of emergency rooms, avoiding terrible unnecessary hospitalizations?

The third benefit has been really leading the movement in culturally competent health care. That we have community health centers because of their location in underserved communities, because of their values, because of their vision, because of the type of staff they've been able to recruit, really at the forefront of really what is now another kind of national minority health quality side, that is culturally competent services (language access services, culturally responsive and customized outreach services, prevention services, services in primary care). Where would that movement be without community health centers? We would probably be 20 or 30 years behind the time from what we have now.

And finally, what I think is the most incredible of what I think is the most unanticipated benefit of community health centers in this country, particularly California from what we see in spades, is *changing the paradigm about how communities are viewed*. In the old paradigm, underserved communities—communities that need services, low income folks, immigrants—were viewed as people who need services. They were the recipient of a service—"we have a service, you come get it, we make you better because you come get our service." And what the community health centers have done, particularly here in California, as certainly from

Now you find community health center leaders being able to talk about social change, social justice and community organizing, while being accountable to their accreditation bodies around immunization rates, pap smear rates, and HEDIS measures, and being quite ambidextrous to go from one conversation to the next without skipping a beat, somewhat seamlessly.

what we've seen from Asian Health Services, La Clínica de La Raza in partnership, is a very different view of how communities are viewed. They're viewed as an asset, they bring strengths, they bring something to the table. And, it doesn't matter what their income level is, whether they can even speak English or not, how long they've been in the country, what kind of issues and challenges they are facing...but, viewing community as having strengths, strengths of resiliency, strengths of risks, strengths of being innovative, strengths of being creative, strengths of being able to survive some very difficult situations, and that they bring those issues and those assets to the table. And being a vehicle in turning community into a force for advocacy,

for system change, for informing legislators, for informing boards of supervisors, for informing county government, for informing the private sector—that we can make our community healthier because we bring some issues to the table. We bring some experiences, and we bring some ideas, and we bring some strengths. That really has been the most, I would say, the most unanticipated bonus of the community health center movement. Certainly as a foundation, our foundation The California Endowment has said, "Wait a minute, there's something to be said here about reducing health disparities." It's not just about services. Services

are important, but having partnerships with communities that bring resources to the table actually brings you all kinds of benefits that are always unanticipated.

So it's with that framework in mind that we salute, and I salute, the extraordinary leadership of community health centers in this movement, and being adaptable along the way. Thirty years ago, 40 years ago when a lot of community health centers were born, they were born out of the free clinic movement. People didn't have services. We had to make sure people had services and that's okay.

Well the health care world as we all know has changed remarkably in that period of time and people are now talking about outcomes and data and efficiency and effectiveness and HEDIS measures. And now you find community health center leaders being able to talk about social change and talk about social justice and talk about community organizing, but at the same time being able to be accountable to their accreditation bodies around immunization rates and pap smear rates and HEDIS measures and being quite ambidextrous to go from one conversation to the next

without skipping a beat, somewhat seamlessly. It says something about the adaptive nature and the resiliency and the adaptability of the community health center movement. And you see it in their boards of directors. The board of directors of community health centers these days are different than they were 30 years ago. There are more competencies being brought to bear in the issues.

So it is with a great deal of pride that we feel able to participate in what community health centers have done—celebrate it, acknowledge it, appreciate it, continue to learn from it. And I can't help but salute in particular Sherry Hirota's outstanding and terrific leadership over the years...Jane García, her partner in crime. My nickname for them: they are the "Thelma and Louise" of the community health center movement. Partners in bringing forward a lot of change, and challenging old notions, and bringing forward new ideas and suggestions for how to make things work for underserved communities.

[Serving immigrant families] is another area where community health center leadership have been able to rethink a paradigm, frame it in a way that is useful to advancing the productivity of this country. The historical paradigm has been, particularly in recent years because of various politics, that 'immigrants are a burden, they are costing us more money and they are not doing their fair share and they are not this and they are not that.' And what we've seen, particularly through the lens of what community health centers have been able to do is, number one: this is not the case, that they do bring assets to this country. This country was built by immigrants. Our railroads were built by immigrants, our cotton fields were picked by slaves. New ideas and new approaches have always been forged by immigration. And I am not sure why because we happen to be in the year 2005, it might feel any different. It shouldn't feel any different. We continue to have problems and challenges that are going to require different kinds of approaches.

So for example: infant mortality. We know that Mexican families, given the same social economic status, have better infant mortality rates than low income families in the United States. And, in fact when they do come to the

Of all the complaints that we have about health care cost in this country, how much higher would they be if we did not have community health centers keeping people out of emergency rooms, avoiding terrible unnecessary hospitalizations?

United States and spend more time here, their health status measures actually worsen, even though they are in a better social economic environment. That means there is a lesson to be learned. What is it about the nuances of the culture that we can tap into that benefits how we do health education? How we do outreach? The messengers that we use, the key informants that we decide to use? And not depend upon the age-old traditional measures of private sector health care. So if we're willing to learn what community health centers have been able to do better than the rest of us, then we will find that not only can we serve the immigrant population better, but that they have answers to challenges that make us better as a health care system for everyone, not just for the Hmong or for Mexicans or for this population or that population.

*SHERRY HIROTA: On the access side, on the coverage side, if we're not able to find the political will to cover all of our community in California, particularly immigrants, do health centers become the de-facto safety net for the uninsured immigrants in this state?*

*DR. ROBERT ROSS: Well, health centers have emerged, particularly for many communities, as you know, as the de-facto safety net. But what has happened is an interesting phenomenon (and not to get too political) from a very unlikely source. We've seen from a very conservative Republican administration that's in the White House right now lift up the community health centers as a hidden jewel requiring and demanding more investment to broaden the safety net. That's an excellent thing on the one hand. It's an excellent recognition of what community health centers have been able to do. And a really quite strong endorsement from the private sector. Democratic administrations have recognized what community health centers have been able to do for the safety net. We see it from the Republican administration as well.*

The concern I have, and the concern that many of us are having, is that the burdens and the challenges of the health care system go far and beyond throwing some more money at community health centers. The system really is in need of reform. I think there is going to be more pressure and expectation on community health centers to continue to be a voice of calling for systematic reform. So at one point, you might say that the chief advocacy role of community health centers was to fight for more money for community health centers. Well the pressure has been raised on that and it's now, 'wait a minute, folks are now looking to community health centers' leadership as very strong key informants about what the entire health care delivery system needs.' So weighing in on issues of cultural competency, of quality of care, of an accessible health system above and beyond what community health centers do is a very important challenge for the next several years for community health center leadership, but I think given their track records they're up to it.

If we're willing to learn what community health centers have been able to do better than the rest of us, then we will find that not only can we serve the immigrant population better, but that they have answers to challenges that make us better as a health care system for everyone.



**SHERRY HIROTA:** *George Halvorson from Kaiser Permanente spoke about really looking forward to a great partnership with health centers in addressing the health policies that frame all the work that a system like Kaiser Permanente and health centers and the Endowment are doing. How do you envision the partnership, if any, with health centers in the next twenty years?*

**DR. ROBERT ROSS:** Well, I think in the next twenty years we go beyond access. I think that's where I see the partnerships going. I think the first few decades of the community health center movement have been largely around issues of access, and they will continue to be. I don't think those issues go away. But this is one of the down sides of success: people will heap more expectations on you. What we heard from George Halvorson—who is the leader of the largest non-profit health sector organization in the world—is a recognition of community health centers as a partner above and beyond access, on quality as I mentioned, even further on issues of work force diversity, and even economic development in communities.

How many individuals from low income families, limited English speaking skills, got their first job at a community health center, got trained in their community health centers, got promoted, and are now heading up a department, having a key leadership role in a community health center, mentoring other people in their community? So the assets on what community health centers bring to the table again are well above and beyond access. And I think that's what we heard from George Halvorson: 'we view you as a key partner, not just because you're serving poor people in the safety net, but because we share some values and a vision.' A vision of a healthier community, a vision of a more productive society, a sense of value around folks as an asset who bring those assets to the table, dealing with issues of cultural competencies, and now as a key voice on what reform may need to look like over the long haul.

**SHERRY HIROTA:** *So not just to speak of the health centers. The Endowment has a really fabulous sense of mission. It speaks so well to the title of the conference The Power of Community in Health. Can you just speak to the theme a little bit and how you see taking the next step in this area of improving health using the power of the community?*

**DR. ROBERT ROSS:** I think it has to do with what is happening in public health at this point in the 200-year history of this nation, or even more broadly globally. We are at the third revolution of public health right now. The first revolution had to do with communicable diseases and infectious diseases. That's what killed most people, that's what injured most people—meningitis, polio, and smallpox. And most of that we've taken care of, most of those infectious diseases—at least that infectious disease burden on the community and the public—has been reduced. It has not been eliminated, but it's been reduced.

The second revolution of public health happened in the latter half of the last century, 1950s-1990s where we moved from infectious disease to chronic disease. So heart disease, cancer, stroke, diabetes rise up to the top of the list and more of an emphasis towards lifestyle, access to health care being important, but also what you do to yourself as an individual (do you smoke, do you wear your seat belt, do you exercise, do you eat properly).

The third revolution of health care which Dr. Lester Breslow at UCLA School of Public Health is talking about has to do with the power of community—that we are not going to see significant improvements in lifespan, in quality of life, in productivity until we learn how to engage communities around healthier more livable communities and neighborhoods. So the individual lifestyle choices that you make around smoking, around eating or using drugs or using alcohol or exercising needs to be reinforced by the community that you live in.

So the obesity epidemic, as you well know is an example: 300% increase in obesity, 300% increase in diabetes among kids in the last 15 or 20 years. That is going to be managed, not just about your individual knowledge about eating better and exercising, but does your community offer fresh fruits and vegetables? Do they offer a safe place for kids to exercise? Does the school offer nutritious menus? All those. What about marketing of unhealthy food products to kids? That's about the power of communities. Can communities create places where people have healthier options and healthier lifestyles are enforced? And that's the next challenge.

The track record and the leg up that community health centers have is 'been there, done that.' They've engaged communities around advocacy. How many times have community health center directors worked with school districts to reduce smoking in kids? Or worked with a local medical

center to do breast cancer outreach prevention? So that's nothing new for community health centers. So it's not that we're asking or expecting community health centers to develop a new skill. I think we need to take that skill and build on a bigger platform, because it's the power of community that is going to really determine the next wave of public health innovation and strategic thinking for the next fifty years. And that is something that the medical care system has not done well. We still think about it as a retail transaction between a provider, a clinician, and a patient. The power of communities says 'No. Patients go back to families, they go back to neighborhoods, they go back to communities that are reinforcing health in those places.'

SHERRY HIROTA: *Thank you, Dr. Ross.*

DR. ROBERT ROSS: No, thank you. ■

# PRINCIPLES FOR REBUILDING THE HEALTH CARE SYSTEM

An Interview with Henrie M. Treadwell, PhD

Director of the Community Voices Initiative, Center for Primary Care, Morehouse School of Medicine

But where do clinics fit in? Where do hospitals fit in, within that total framework of a healthy community, which means a community that is without great inequities in the population base? And what voice should help inform the larger society of that need?

—HENRIE M.TREADWELL

SHERRY HIROTA: *Henrie, thank you for your time. Your perspective is so important in setting the framework that largely correlated from Community Voices to how we approached the conference.*

DR. HENRIE TREADWELL: Well I thank you all for giving me an opportunity to comment because obviously the work is something that is very near and dear to me, and I think central to our society quite frankly in the long run.

I try to think about the work along the line of *principles* for rebuilding the health care system. I'm not so sure we can transform [the health care system]. I think we have to almost *rebuild*, but use or be aware of some basic building blocks that we need to get in place. And of course the cornerstone would be health care coverage for all, but we all know that that's not sufficient.

We also have to have a diverse workforce. We have to honor every level in that workforce, from outreach worker to physician providers—throughout. In other words, all of those people contribute a diversity to the service and program framework that are important. So diversity is not simply racial or ethnic, but it's also diversity so that people can enter at levels of comfort to them.

One of the underpinnings too for our service and delivery programs are the research and data to let us know who has what, how they got it, and maybe what we can do. But we know all groups do not get to participate fully in collecting those data that are ultimately used to shape and frame what we do as a nation, and what we do as communities. We need to learn, at community levels, to be more cognizant of those pieces of evidence that are used to construct the system, and to examine them for truth with regard to where their own neighborhood or community fits in.

I would finally say, generically, that we need to change our language. And that language for health is... [for example] we say "primary health care." But our definition is not broad enough. One, it does not include, typically and intentionally, mental health care—routine and regular mental

health care, not just the severely disabled. Anxiety, depression needs to be given attention. Oral health care is certainly not given attention. And these too are health rights. And if we believe in this country, as we sometimes do, that health care is a right, then we need to look at what we mean by that. And to determine whether or not health care indeed is inclusive enough in order to reduce disparities.

And the language of health, meaning primary health care, and certainly from my work, has to take into account those elements in the social context that make it difficult for people to reach care, to have care, to have quality care—certainly we can say "education, economics, jobs with benefits, or a health care system that provides coverage." But we kind of say them, and acknowledge them, and then we don't do anything. There needs to be a program, a programmatic extension of that as a part of an overlay. It doesn't mean that I want physicians to do economic development or anything like that. But where do clinics fit in? Where do hospitals fit in, within that total framework of a healthy community, which means a community that is without great inequities in the population base? And what voice should help inform the larger society of that need?

The health care system is really the place where we see what's wrong in our communities. We see it in terms of the disease condition, the sickness. But do we in fact then exercise what I think is a responsible voice in saying "they are here mainly and simply because of the *social context* in which they must live and work." And I am certainly not suggesting that there aren't some personal behaviors that everyone should pay attention to, but when you have a little more money and a little more of an upward mobility in this society you have choices that you can exercise that other people may not see as clearly. So we need to do a better job of using the health care voice as that entity that can speak toward, and in support of, total social change or rebuilding of our system.

I really do believe that our system is bankrupt. And I don't necessarily like to use words with negative connota-



tions, but I firmly believe that we can't simply tinker around the edges. We have to create something almost all over again, but use the valuable pieces that we have.

The final thing I would say is that as the part of doing work of delivering health care: we have to keep our eyes peeled for the "least of these," those individuals, those groups within our communities that are less likely than others to get care. We need to examine the reasons that they don't get care and then to do something affirmative. Now the easiest group for me to identify right now would certainly be poor men, and men of color. But there are other groups within our neighborhoods who are not on the radar screen. And they're either not there because somebody's not paying for it, because they're not viewed in that social image of "success" that this nation sometimes uses. The lens is not set correctly. And I would say that at times, as I've done this

work, my lens has not captured those things that were missing in the picture that I was examining.

I believe the health care system of the future has to begin to see whose face is *not* here. We know they are within our nation. But they are *not* within our clinic setting. We know they have health issues because they are within our emergency rooms. Where are they, and how do we gather the information needed to affirmatively and even aggressively inform policy? And how do we help those individuals tell their own story in their own words?

There is a readiness in our nation to do the right thing. There are so many people...there's a readiness to do things in the way that they need to be done, and many people are working at it. And I think that when you have a meeting like yours, it just affirms that what we're doing is right and we think it's right. And we think it can work. ■

## WELCOME AND OPENING REMARKS



Jane García talks with Merrie Aipoalani and Ginger Fuata.

### **Merrie Aipoalani**

Member of the Board of Directors  
Waianae Coast Comprehensive Health Center

### **Connie Chang**

Chair of the Board of Directors, Asian Health Services

### **Sherry Hirota**

CEO of Asian Health Services

### **Jane García, MPH**

CEO of La Clínica de La Raza

### **Tom Van Coverden**

President and CEO of the National Association of  
Community Health Centers

### **MERRIE AIPOALANI**

#### **Member of the Board of Directors**

#### **Waianae Coast Comprehensive Health Center**

Aloha. I will do my best to provide you with a brief background of how this conference first came about. Several years ago, a number of board members from various clinics—Asian Health Services in Oakland, Bay Clinic in Hilo Hawai'i, North East Medical Clinic in San Francisco and Waianae Coast Comprehensive Health Center—got together in Washington, DC and commenced discussions on board members' roles and responsibilities, and where and how board members fit into the organization. It was evident that most board members did not fully understand their roles, nor did they come to grips with their installed

fiduciary responsibilities. It was then that the idea of organizing a training conference for board members came to fore.

Today's conference in and of itself is a vision realized, but most importantly a work in progress. It is here that board members share information on what works and what would be best left alone. Sharing is very important to us at Waianae Coast Comprehensive Health Center, Hawai'i. For example, when we came here to Asian Health Services, we noticed that their dental clinic is very high tech and we took a liking to the concept and its added value. When we went to Philadelphia, we learned that they own their own building and property. For the sake of sustainability, the idea of acquiring the deed to our health center's property became a priority. Simply put, this conference serves to empower and network board members, thereby, ensuring that know-how is shared and utilized to best serve the interest of our respective clinics and the network in general. We remain vigilant in our roles as advocates for our clinics and for this reason we hold such training conferences.

The first conference was held in Waianae (O'ahu, Hawai'i). Attendees spanned the nation from as far as Louisiana, to Texas, and California. All was made possible by receipts of two grants. Waianae hosted the subsequent year's conference as well, and this year we are here in Oakland, allowing other founding members to take an active role in the process. We are very grateful to be a part of this conference and we do want to thank Asian Health Services for hosting us today. Thank you, Connie.

**CONNIE CHANG****Chair of the Board of Directors, Asian Health Services**

Well, I'd like to thank the staff for putting this together because they really worked really hard all day and all night. And board members: Donn Ginoza, Gin Pang, Carl Chan and Anh Tran. Thank you. They're going to be helping us run this conference.

Okay, I want to mention our sponsors. Funding for this conference was generously provided by the W.K. Kellogg Foundation, The California Endowment, Kaiser Permanente, and the Tides Foundation-Community Clinics Initiative. Our sponsors are: Alameda Health Consortium, Asian Health Services, Association of Asian Pacific Community Health Organizations, California Black Health Network, California Pan Ethnic Health Network, California Primary Care Association, California Rural Indian Health Board, Community Voices-Oakland, Kaiser Permanente, La Clínica de La Raza, Latino Coalition for Healthy California, NACHC [National Association of Community Health Centers], Native American Health Center, Operation Samahan, Waiānae Coast Comprehensive Health Center, The California Endowment, and The Tides Foundation-Community Clinic Initiative. Okay, Sherry, come on up. She's our CEO.

**SHERRY HIROTA****CEO of Asian Health Services**

Just before we came in to the center today, Connie and I stopped and took a moment because it was 28 years ago that Connie and I met. I was interviewing for the job at Asian Health Services and she was the head of the interview committee and called me to say that 'the entire interview committee of 18 unanimously agreed to hire you.' And it was just kind of interesting to look at each other and

say, "wow, we've all come a long way." So on behalf of Asian Health Services, and the boards and the communities that make up community health centers across the country, I would again like to welcome you here today.

You'll probably hear a lot of different versions of how the conference came to be. And they're all true. You know, this is about "talk story." So the concept of this conference does come out of this impulse that happened at a dinner of some clinics in DC. When we were all out there under Tom's [Van Coverden's] leadership at the NACHC meeting, and some board members caucused, they conspired. And after the dinner, they came up and informed me (3 years ago) that they wanted to get together as board members, as communities, and have a conference. And the rest is history.

I think that the context in that impulse was really that communities, as reflected in the boards and as reflected in the health centers, have the power to influence their health. And they are that vehicle that is essential to making fundamental change in our ever-expensive health care system so that access and cultural competence are realities.

So here we are. Asian Health Services is here, and we are celebrating our 30th Anniversary and there are many clinics here that have longer histories: 35 years, 40 years. And there are newer clinics that are just emerging. Together, as health centers, we are the powerful and cutting-edge institutions in our health care system. We look back now and reflect on that history. We look at our strengths, we look at new challenges, and we look at the vision for the future. And it's important as we look to the future that we remember our roots, that we come out of the Civil Rights Movement and the social justice health care movement. So as we do that reflection, we need to celebrate our victories, document our lessons and renew the fundamental principles that make us strong. This is community: the power of community in health.



Dr. Robert Ross, Sherry Hirota, and Dr. Sam Shekar



Jane García

**JANE GARCÍA, MPH**  
**CEO of La Clínica de La Raza**

Welcome. I'm so happy to see you all...and Connie where are you? I just want to thank you for hiring Sherry because I'll tell you that the successes in Alameda County would be significantly different without Sherry. We had a meeting with Alameda County last week and it was very respectful and it was very dynamic and after the meeting, we went, "whew, good thing we have Sherry on our side."

I want to quickly introduce our fellow community health centers that are here from Alameda County and just share with you the number of years we've been all working on this in this movement. Martin Waukazoo, with Native American Health Center for 21 plus years. Tiburcio Vasquez – Joel García, my brother, 25 plus years, depending on how you count it. Did I leave anybody else from Alameda County out? So many, many years – all working together.

And one of our partners that has 25 plus years that I have the pleasure of introducing today is Tom Van Coverden. If you haven't met him, please make it a point to do so before you leave our event. He's a dynamic leader. He is the president of our National Association of Community Health Centers. And I'll tell you that without him, we also wouldn't have had the victories that we've had over the years. In his 25 plus year tenure with the Association, he has built a strong and effective organization that has become a powerful force. And I'm very happy to tell you that the community health centers enjoy bipartisan support, which as you all know, is no small feat.

As our fearless leader, we always send him in front of us. Tom has enhanced the stature and the visibility of the health centers and it's great to see us move from how we started as "marginal providers" to an integral part of the health care delivery system today. And you know this is a very turbulent changing health world. Just earlier...last week I guess, we heard that the number of uninsured had once again increased by another million people and that

the division between those who have, and those who have not, had grown even further. And so we need people like Tom. And I'll tell you that his bold leadership and his strategic focus have enabled our health centers to meet challenges, to strengthen our resources, and to move forward an aggressive agenda for growth and development. He's recognized as one of America's most ardent spokesmen and advocate for the health center model of care. We're very happy to have you, Tom. Welcome to the Bay Area. Welcome to Alameda County. Please come on up.

**TOM VAN COVERDEN**  
**President and CEO of the National Association of Community Health Centers (NACHC)**

Well, thank you. It's my pleasure to be here... I started working for the United States Congress in 1962 and was there as a staff member for the House Ways and Means Committee when we wrote the Medicare and Medicaid and the Community Health Center program. You know, it was a glorious day in a glorious age for so many of us when people seemed to think bigger and believe bigger and could do more, whether it was providing health insurance for everybody, and they knew these were the first two steps, or things like the Peace Corps—that Americans have so much they can give and offer other parts of the world. Today, I have a number of foreign countries coming into our National Association saying, "Can you help us build a community health center program for our country?" Africa, East Asia, the former Soviet-bloc countries. And I said, "I just wish to God we could." We have so many young, talented people who you are developing each and every day. The problem is we can't even meet our own expansion needs and demands here. But what a tribute that is to you, not only within this country but around the world. People have figured out that somehow or another—whether it's cultural competence, whether it's dealing with more languages, whether it's how you really help the diabetic, or get the mom in early for testing or hypertensive—somehow or another, you guys have figured out how to do that.

Last week I was with Senator Kennedy. He said, "Tom, when this program was created, we as United States senators spent 3 days arguing about whether or not there should be a community board, 51% of the community involved. A lot of people didn't believe in it, and for a lot of us, it was a leap of faith. How could common people from the street govern a health care organization? It just wasn't supposed to be." And he said, "Didn't we fool them all?"

...So you look back at those people who didn't believe the early fights, the number of people that opposed this, that said it can't work—and here we stand today. It's no mistake that we were rated #1 in the entire 3,500 programs of the Department of Health and Human Services as the most effective. Nobody gave you that badge; you earned it.



So when I say to somebody, “If you want to judge us, let’s judge us fairly—that we can help the nation, deal with the problems of cultural competence, how to get the right kind of care in the right way to the people who most need it. But we can also help you save on the health care costs.” The health center program alone—with some pretty reliable economists looking at it—saves Medicaid now \$3 billion a year.

—TOM VAN COVERDEN

And it’s no mistake that the national Institute of Medicine, when looking at both cultural competency, patient satisfaction and management of chronic care—specifically diabetes, hypertension, infant mortality—it’s no mistake that you received the #1 rating. You earned it. And talking with my friends from the Tides Foundation...the great partnerships that again you have both at the state and local level. Nobody gave you facilities. You built them and sweat for them, brick by brick by brick. Many of you—and I’ve been out here—started in trailers, in ghettos, in barrios. And you’ve worked your way up to where you are now. Maybe we’re still not all the way with the information technology that we have but we’ve come a long way, a long, long way. And nobody gave that to you, my friends, that’s something you’ve earned.

As I look at the papers and the tremendous innovative things you’ve done here in Alameda County, I think once again, it’s innovation and a model for the nation. But my friends, make no mistake about it, the election coming up in front of us is going to be a very, very rough election. This is nonpartisan. Last week, I was with the president doing two health centers. And with the challenger, Senator John Kerry, I couldn’t do today (I was committed here), but who also wanted to go to health centers. But what does that say when both presidential candidates want to go to a community health center and launch their health care agenda? That my friend, nobody gave you—that you’ve earned.

We’ll be talking about it over the next week...more at our national meeting. But let me just tell you while we’re talking here about expansions, and your models and neo-models is right minded. And we are going to be fighting for stuff like this every step of the way. It’s what scares the daylights out of me—the size of those deficits which are unsustainable. And I don’t care who gets elected. They’re going to be facing some very, very tough choices. Three-quarters of the federal budget—I can give you billions and trillions number if it means anything. But better than 75% is off the table. Interest on debt—which is mounting to better than \$200 billion dollars a year because of what we have

to borrow to finance the interest—you can’t renege on that. You’re not going to cut back on defense, and you’re not going to cut back on homeland security; you can’t cut Social Security, and in the short term, they’re not going to cut Medicare. Guess what, my friends? That slice of the pie that we’re looking at is all of the rest of America, including funding for things like health centers, the CHIP [Children’s Health Insurance Program] program, HIV/AIDS, and perhaps prime target of all: Medicaid. Medi-Cal, here in California. This will be a big, big issue and at least a number of think tanks in Washington are talking about totally restructuring the program.

I don’t know who’s going to win the election; I don’t know who’s going to win the House or the Senate. But when you look at American public policy and how it’s made, the first 120 days of any new administration are the days when major policy initiatives are proposed. There are a significant number of people who feel that the Medicaid program is a drag on the economy: ‘It costs too much money. There’s no end in sight as to how much it will cost, and somehow or another we’ve got to cap that spending.’ Some proposals call for utilizing waivers (known as, under Social Security, 1115) to just totally give states total autonomy and flexibility and say, ‘You run it. The federal government is stepping back.’

There are other programs which look at consolidating that and other direct federal discretionary programs to roll that money to make it more attractive to the States and say, ‘You can insure more people. We’re not going to tell you exactly what or how to do it, but go ahead and do it.’ And there are still other proposals, which just call for simple funding cuts but leave the existing programs in place. On the papers...our guy—many of you know Dan Hawkins—has done [an analysis], for an example: a 10% cut in Medicaid—which translates roughly into about 250,000 to 300,000 dollars less income for the average health center. If you eliminate the PPS [Prospective Payment System] payment (or known as the FQHC payment) the average health center would lose about a million dollars in funding.

The point I want to close with is just simply this: I hope that I didn't depress people as much as to say, we need to know that there is a big ball game coming up in front of us. We can't wait until January 1st to engage in it. The meeting you're having here today could not be more important if you tried. You couldn't have scheduled this at a better time. The issues are that big and the federal budget cannot be balanced on the backs of the poor alone. There has to be equity between the tax cut propositions and when we're looking at things like Medicaid.

Both candidates are talking about ways in which they can increase or expand insurance coverage—President Bush as you know, through tax credits. I'm looking at some of your numbers and there's assuming you have any tax credits that is due you, but tax credits as well to small businesses to try and help them get more affordable insurance coverage. John Kerry, at this point... Senator Kerry has said he wants to expand the Medicaid program, the CHIP program and look for some other alternatives. My point is that there is going to be an awful lot at stake in this election. You'll figure out sort of which is the right way to vote but the thing is to get as many other people engaged in some of these issues because so very much is at stake.

The good news: we have an incredible track record to run on. I think we have to make a case to policymakers at all levels that you can cut stupidly or you can look at ways to do this smartly. And I think, it is what you have shown is, that you can provide access to a lot more people without it costing tons and tons of money. And the patients are happy with the care they're getting. There's less drain...when I meet with the members of Congress, they said, "FQHC payment is an overpayment, it's a fat payment." And one reason that's becoming more and more of an issue is because you have hospitals and doctors who are saying 'we want that payment level too.' Well you have to do the same things in order to earn that. But everybody—and I hope when you're talking to newspapers or policymakers, federal, state, state and local—studies that have been done show that health centers, through effective health care, reduce costs, total health costs by 30%. You have all the documentation. We've provided the studies, and we've done it with CPCA [California Primary Care Association] and AAPCHO [Association of Asian Pacific Community Health Organizations] and others. The data in the document: none of these are our studies. So when I say to somebody, "If you want to judge us, let's judge us fairly—that we can help the nation, deal with the problems of cultural competence, how to get the right kind of care in the right way to the people who most need it. But we can also help you save on the health care costs." The health center program alone—with some pretty reliable economists looking at it—saves Medicaid now 3 billion dollars a year. That's not chump change. And we do it by reducing the hospital lengths of stay in the admissions by doing good preventive

and primary care.

So I think back to some of the proposals you'll be discussing in advance in here. The good news is we have one heck of a great story to tell. And we ought to be telling it long and loud and so that people can hear it—not just policymakers, but people in the news media. And everyone of you in this room, I assure you, you're as much of an expert as the experts that they put in front of the TV cameras. Don't be afraid to say, "I need to be a part of that, I can be on that news show. I can do this and talk about that." You need to believe in that and have confidence in it. And as a national movement, we will be doing the same in Washington—whether it's dealing with the issues related to immigration, insurance and expansion of insurance coverage to all people residing in this country, and taking on the budget battles. But NACHC will not be able to do it unless we have a massive education and mobilization of the grassroots: the very thing that made us who we are today some 30 years ago, when people would've laughed us off the stage. It was community and consumers coming together with very dedicated providers who said, "We can make a difference and we can do things differently." We're up against very powerful interests. You know that as well as I do. But if we speak and if we can get people involved, when I go to some health centers, I say, "When was the last time [you saw] your Congressman and Senator or maybe in this case, your legislator," it's disappointing to me that only 10% of the people raise their hands. There is no better salesman of your program than you are to visit any one of your programs. I've done it. Nothing is a stronger selling point than that. We've got to do better than a 10% solution.

And likewise, when it comes time to reign in phone calls, signing letters, signing petitions—every time I've been at a health center, again so many of the staff and boards say "What can we do to be a part of this? How can we make our voice heard?" Merrie, I know you and our Hawai'iian delegation are going to be doing some grassroots tactics where at each health center, you have appointed a federal relations, a state relations, and a local relations to make sure that your voices are heard and that everyone's playing in it. I have patients coming up right, left and sideways and [they] said, "I didn't think there was anybody fighting for us, not with the big guys. Is there something I can sign? Can I throw a dollar in a fish bowl? Is there something I can do?" So I think that's the genius of what we're doing and who we're working for. We have better than 15 million people and probably twice that number of people of good will who share our concern and are willing to join in this fight. But we're going to have to lead it, and be there to do it. And so with that, I wish you well on this meeting. Know that I'll be with you every step of the way, as well as our organization. What you do is second-to-nothing in this nation and we shall overcome. Thank you. ■

## BUILDING COMMUNITY CAPACITY: HARD HEADS, SOFT HEARTS



Dr. David Hayes-Bautista (left) and Jose Joél García (right).

We're activists. But we're activists that are bringing together the art, the science, and the spirit, the spirit of our movement. —JOSE JOÉL GARCÍA

**Donn Ginoza, JD**

Vice President, Board of Directors for Asian Health Services

**David Hayes-Bautista, PhD**

Director of UCLA's Center for the Study of Latino Health and Culture and Professor at UCLA's David Geffen School of Medicine

**Jose Joél García, JD**

CEO of Tiburcio Vasquez Health Center and Board Chair of the Alameda Health Consortium

**Sylvia Drew Ivie, JD**

Executive Director of T.H.E. Clinic, Inc.

**Kaui Clark, MFA**

Member of the Board of Directors, Waianae Coast Comprehensive Health Center

**DONN GINOZA, JD**

**Vice President**

**Board of Directors for Asian Health Services**

Good afternoon and welcome. My name is Donn Ginoza and I've been a long time board member of Asian Health Services. And it's just a great privilege and honor to serve on the board and to work with Sherry and all the staff. The theme of the initial panel discussion is, as the title reads, Building Community Capacity: Hard Heads and Soft Hearts. And as Sherry indicated, what we'd like to do is give you an overview of the history of the community clinics—how they've developed, what their struggles involve. And to try to convey the idea this really has been a grassroots movement and that the movement itself has grown out of grassroots organizing, notions of empowering people to advocate on behalf of their own interests.

**DAVID HAYES-BAUTISTA, PhD**  
**Director of UCLA's Center for the Study of**  
**Latino Health and Culture and Professor at**  
**UCLA's David Geffen School of Medicine**

Thank you. Exactly two years ago, I had lunch at a meeting of the California Primary Care Association with my compadre, Joel Garcia, with Judy Gong, who's way in the back. Stand up, Judy, so you can see the unindicted co-conspirator here and with Patricia Aguilera. And we go all the way back to the early days of La Clínica de La Raza. We're just having lunch, getting together here, and we all have kids. So as parents, we're complaining about our kids and the way they're not growing up the way we'd like them to be. And certain experiences we have that we take for granted, they don't have. For example, when we say César Chavez, we think of farm workers. They think of the boxer, César Chavez—the boxer, you know? When we talk about the war in Vietnam, they have no difference between WWI or WWII, Vietnam—it's all the same. My daughter told me she knows the difference between WWII and Vietnam. I asked, "What's the difference, mi hija?" "WWII is in black and white and Vietnam is in color." "And by the way," I said, "Who won in Vietnam?" "(Gasps) We lost? They didn't tell me that part in school."

Anyway, we have experiences. We have history. But the younger generation often doesn't get that. And we started to talk about the need to start to pass on some of our experience—I hate to say wisdom, but at least experience—and we probably made every mistake in the book, to the next generation. At that point, then Patricia Aguilera said, "Well, you know, this all sounds like something that Tides Foundation ought to do." And before I know it, I got a call from the Tides Foundation and we were asked to put together a tentative video treatment of the history of the community clinic movement in California. So this is just a short one. This is sort of a workout session as we're getting our methodology down, but I'd like to share the short—it's an 18-minute video—with you. And then Joel and I would like to share some more of our thoughts about this with you. Can you roll this? Such a Hollywood term, roll 'em! I am at UCLA.

VIDEO PRESENTATION FOLLOWS. THE VIDEO IS ENTITLED, "COMMUNITY CLINIC INITIATIVE" AND IS A PRODUCTION OF THE TIDES FOUNDATION.

**JOSE JOÉL GARCÍA, JD**  
**CEO of Tiburcio Vasquez Health Center and**  
**Board Chair of the Alameda Health Consortium**

I want to thank David for that beautiful video. It tells our story, doesn't it? And I don't mean that because I'm in it but because we're in it and I take pride in being in it because this is my life. And this has been the lives of, I see, so many friends out here. I see so many people who've been students, who've been my teachers, who've been collaborators on so many things and it's really common for us to get together at a table, just like this conference and say, "Well, what about...? What do we think of doing this?" And then you say, "Well, it could—maybe, maybe not." And the next thing you know, somebody's doing something. Somebody's calling somebody, somebody's looking for somebody to support it, and then somebody to organize it. We do the work and we're here. We're present. And that's exactly what happened with this video...

And I'm very glad that Mr. Van Coverden was here. And I echo your words that we need to face the future, but we have to do it based on the foundation that we have, and the prayers that we share when we confer, when we have council, when we get together like this. These are very, very important things to define where we're going. And as David was saying many times, and this is true with my children—as I

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—JOSE JOÉL GARCÍA

share and I'm thinking about my grandchildren already—that I want them to see this video and I want this to be the first of many videos that tells our story because we've been so busy doing it. We haven't been telling the world exactly why we've been doing what we're doing. We're just doing it all the time. We're activists. But we're activists that are bringing together the art, the science, and the spirit, the spirit of our movement.

I was touched by the closing. All the other words and everything was touching as well, but the face of the woman—that's one of our patients, this woman who closed the video, pregnant woman. We've given prenatal services, comprehensive prenatal services to thousands of women who have had healthy births, thousands of children who were born healthy. And to see her face and see the warmth and the glow of being in our facility and being able to have that health—that tells the story. How many of you had board members that let's say you helped save their lives in a way, and in some cases literally you did. We have board members like that: early diagnosis of cancer and treatment, mammography that was done. And we're constantly being given gifts. People come and do our landscaping because "You helped us when nobody else would help us." That is



really what our movement is all about. And I thank the Tides Foundation for beginning again to have us tell the story. I want all of you who've been with the movement already to slow down a little bit about telling your story. To those of you who are new to it: it's your story, you know? Build it! You know, correct it when it's not what it should be!

When this whole thing started, for me it was like, "You guys can't do it, you're crazy!" I was the legal person they brought in and said "Research and law tells us what we have to do to get it started. So you're crazy, you know? Don't do it." Good for them, they didn't listen to their lawyer, you know? But they captured their lawyer. They captured the law student, they captured the person.

And what I thought, when we finally got into it, is that I did not want whatever we did to be a flash in the pan. Whatever we do—it has to have roots. It has to be here for the long time, the long term for the generations to come. So we're no longer marginal, we are mainstream, we are the system for many millions of people in this country. That's how far we've come. So while I was younger, I dreamt, I prayed, I hoped. And now that I'm older, I said, "You know what I need to do? I didn't dream big enough. I need to dream bigger!" And I need to face those roller coasters and those challenges that are thrown our way through this movement for so many years.

This has been 30 years of constant struggle and we can tell you everything that we've had to overcome: Prop. 13, Proposition 187, Ward Connerly, on and on and on. Most are unique Californian experiences. And maybe a little different in other states, but they've struggled through similar things. So my message—and I hope this video and our presence, my presence here—is to tell you whatever age you are, dream big! Don't let anybody get in the way of your dreams because the health of your community is at stake. The lives of our community are at stake. We don't have the things we need to have.

And I'll close with this as an anniversary wish to Asian Health Services. Three years ago, La Clínica de La Raza and my compadre here, we had an anniversary and I was given 30 seconds to talk about 30 years and so I boiled it down to one thing for each generation and one thing for this generation, and our generation is "peace." When will we have peace? Justice! When will we have justice? And healing. When will we have healing?

To Asian Health Services, to Sherry, thank you so much for doing this. And you're an inspiration always to us. You did a beautiful job last week as Jane said, but that is what it takes. We need to be continuing to heal our community through justice, and we always do it through urgent peace. Thank you!



The social justice element of community clinics cannot be realized unless we realize that getting social justice has to be done in the context of a business that works. —SYLVIA DREW IVIE

**SYLVIA DREW IVIE, JD**  
Executive Director of T.H.E. Clinic, Inc.

Hi again, I'm Sylvia Drew Ivie and Sherry asked me to talk with you for a few moments about T.H.E. Clinic and the history of T.H.E. Clinic and community clinics coming out of a Civil Rights context. T.H.E. stands for "To Help Everyone." It was founded 30 years ago and this is our 30th anniversary also.

And we are a little United Nations. T.H.E. is in the Crenshaw District of Los Angeles. It's a majority Black community but many of our surrounding neighbors are Japanese Americans who bought their homes coming out of internment. So the very beginning of our clinic—we were Black and Asian as soon as we opened our doors. We were founded by 8 women who had started in the Women's Movement trying to get more health services for women, family planning services. But this splintered group broke off, saying, "You know, we're really interested in helping women but we see the plight of the women who are poor as different from the plight of women as their gender."

So they came into the Crenshaw area and fought against local physician societies that didn't want them to be there, which happened to be Black and started the clinic. And one of those 8 women, a Unitarian white accountant from Iowa, was the first director. One of the second women of the 8 was a Jewish nurse from the Bay Area, Marilyn Norwood, who was one of our first nursing directors and is still our nursing director 30 years later. And they stayed on until the clinic got going. And then our second director was Irene Hirano, a Japanese American woman who was there

13 years and is now the director of the Japanese American National Museum in L.A.

So I'm the third director and I've been there 17 years and our clinic is still primarily focused on services for women. Eighty percent of the patients are women but we're now a primary care 330 clinic serving men, women and children and very much interested in social justice, social advocacy because of who we are and because of the needs of our community for a social justice arm that goes hand in glove with the effort to get health care to people. I was thinking about one of our patients (while I was watching this wonderful movie) who came in for a pap. An African American woman medical assistant took her in, [the patient] got undressed, waited for the nurse—the nurse was Marilyn Norwood, one of the founders. And when Mrs. Norwood came in, she said, “How are you today? What are you here for?”

She said, “I'm sorry, I've changed my mind.”

And Ms. Norwood said, “All right, but what had you come here for before you changed your mind?”

She said, “I came in for a pap, but I'm not having it.”

Ms. Norwood said, “All right, you don't have to have it. We're not here to force you to do anything. Would you mind talking with Pat. She works here. We could get your clothes back on and we'll just walk you around the corridor to see Pat.”

“All right. If it won't take long.”

Pat's a psychologist. We don't introduce Pat by her profession. She's just our co-worker. Well it turned out that this patient's mother and grandmother had died of cervical cancer. Both of them had been treated in small southern towns where they were ridiculed by the personnel because they used home remedies rather than getting modern Western care. And because of the humiliation that they suffered, this woman was terrified to get a pap. She was afraid we were going to mistreat her, ridicule her, make her feel ignorant. And so she couldn't go forward with the examination. After 6 weeks of counseling and health education on what a pap is, how you get it, how preventable cervical cancer is, she was ready to have her examination and it was normal.

But what happened to our patient after that experience was that she became an advocate for what we do in community clinics. It was transformational. It wasn't just a little cervical cancer examination, it was a transformational experience about ownership of information, ownership of her own destiny, learning and dealing with the past. Because part of her counseling was grief counseling for her mother, for her grandmother, learning where other community resources were. So when we get involved in our patients' lives, we are doing so much more than providing whatever the health services are that are being provided. And that's why it's always fresh no matter how long we're at it. It's fresh every single day because there's another opportunity to transform lives. And as we transform lives,

we transform and empower our communities. That's why community clinics work, not just because we save money, not just because it's preventative, not just because it makes health care available to people who hadn't had it, it's because we take the whole person, and we transform the whole life.

I was a Civil Rights lawyer before I came into the community clinic world and I was introduced to the difference between Civil Rights and health care access, when I was excited to find—you know how awful lawyers can be—I was excited to find, a situation in a little rural town in Mississippi where the only physician in this rural area had white and colored waiting rooms for his patients. And I said, “Oh I've just been waiting for this, I'm so happy, I'm so happy! I'd found somebody to go and get.”

So we lined up the people in the community and filed our lawsuit. Came the day of trial, and none of our people showed up. Not one of them. I said, “What happened?” Well, what happened was, they made a judgment call that they'd rather be in a segregated waiting room and have access to their physician than have a lawsuit and have no physician, thank you very much. It was a very important lesson for me about making your priorities fit with your patients. Not what I want, but what did they want? What did they need? And that's why our community members on our boards are so important in guiding us and keeping us on the right path.

Last thing I want to say is that the social justice element of community clinics cannot be realized unless we realize that getting social justice has to be done in the context of a business that works. So, so many of us old people who've been at it for a long time have, have learned the painful lesson that you're not going to be able to transform your patients' lives if your business end of the program is not working. And again, that's where the leadership of your boards is so important in keeping that going.

A friend and colleague who I worked with at the National Health Law Program many years ago, told me before this meeting that he thinks one of the things that would be most helpful to boards is to hire an executive director sort of person for our boards. And the job of that

That's why community clinics work, not just because we save money, not just because it's preventative, not just because it makes health care available to people who hadn't had it. It's because we take the whole person, and we transform the whole life. —SYLVIA DREW IVIE

person would not be to compete with the executive director, but to make the board of directors run in the way it's supposed to run so that at your October meeting, you have your peer review of one another. At your December meeting, you have other things that are on the list of things that board of directors [do] so that it's not haphazard. So that the board keeps its feet to the fire in doing all the things it's supposed to do to have a really good and functioning board. I just want to leave with that. It's not really a sexy idea but I really think it's a good idea. About how we can improve the effectiveness of our boards and give them the support they need and doing the things that they have to do to run our agencies well. So Sherry, congratulations on your 30 years. Thank you for having us to tell our little piece of the story. [Good luck] to all of you and your programs.

**KAUILA CLARK, MFA**  
**Member of the Board of Directors**  
**Waianae Coast Comprehensive Health Center**

Mahalo. Good afternoon. The Waianae Coast Comprehensive Health Center is the oldest comprehensive health center in Hawai'i. We are celebrating our 32nd year...historically, Waianae is kind of a radical, resistant community to a lot of Western ideas. And that all came about when in 1820 the missionaries came to Hawai'i. The last holdouts to Christianity and the Western way of life took their canoes and went to the Waianae coast. Now that attitude still prevails among the young people. Anything that comes from Honolulu, we don't want because we have our own way and we'll do it our own way. And so at our health center, one of the basic premises that was developed from the beginning was that we needed a place of healing. And that place of healing had to be where you came and you felt the healing process start when you talked to anyone.

So, if you've ever been to our website, or if you get information on our healing center it has a very good view of the Waianae coast, the coastal area, also the Valley of Luualalei. We have 25,000 clients with 125,000 visits a year. We are the largest health center in our community.

We have advocated, with any agency that comes in to do us the privilege of serving us, to say that we want a part

of that [research]. We just negotiated through our research committee with the University of Hawai'i. They want to do some surveys, and run some tests and all this and we said, "That's fine, but we want you to train our community members to do it." But they said, "Oh, no, we have our own people." And we said, "No, the agreement has to be that you cultivate the talent in the community to participate in the studies, and the data belongs to the community." We've had more PhDs and Masters people come into our community, survey the community, write their dissertations, talk about the disparities, and then get a degree and then go on to [developing] treatments that really could be afforded to the community but never come back. So we have learned very well that we work in partnerships and that partnership means that any conclusions that are devised comes back to benefit the community.

We are a community with a majority of a population of Hawai'ians. We have five homesteads. Now, if any of you don't know or understand the history of Hawai'i, we were overthrown. Our kingdom was overthrown in 1893 by the United States. So it's very interesting to see what is happening in Iraq because the same thing came to Hawai'i. We were a peaceful country and they came in and they overthrew our people. So that war's been going on for 111 years or something so you know, if you want to see some of the attitudes that were developed against the United States with good reason, come and study Hawai'i.

The Comprehensive Center provides innovative programs and our board of directors, talking about community capacity, insists that most of our board members come from the community. We do have appointed members that help us in making decisions, especially in finance, and legal things and business things because the community people are all service at heart...

Our board is aging, so we're looking for younger people (audience laughter). I've been on the board...Merrie recruited me to the board in 1989 and she said, "we just want you for a year," and I've been on that board ever since. And to let you know, Merrie is our warrior trainer. She's the one that gears the board member up, sets an expectation, give trainings, so that people can fill that expectation. But more than that, open up horizons, open up parameters, look at definitions, how are we being served.

Because of the redefinition of things and pushing community agenda, we developed a Native Hawai'ian Healing Center, which is traditional Native Hawai'ian practices. If any of you know, our ED, Executive Director, Rich Bettini... and when he got the first three-month report that we had served over 12,000 people he said, "Wow, there's something here." The community has really responded to what we have done and tried to address community needs.

From that we got into complimentary medicine. And if any of you've been to our center, we just built a certified kitchen, so we can get into dietary and preventive measures.

And we said, "The agreement has to be that you cultivate the talent in the community to participate in the studies, and the data belongs to the community." —KAUILA CLARK

We have learned from our traditional healing program that healing is done by the person and the traditional healers are simply there to enhance that process. So if we can adopt that for mainstream medicine, there is an accountability that takes place where people are responsible for their health.

—KAUILA CLARK



We have \$35,000 of exercise equipment donated by the Honolulu Club that we're going to put under our kitchen so that they know that as soon as they eat, they got to go downstairs. We have a partnership with YMCA where we have a walking path to YMCA, where we can use their swimming pool when we can get there and walk back. We're devising a whole pathway system where people can walk on the premises to exercise.

We have gone into electronic medical records and we have been garnering information we had not expected before, because most of the data that we had collected was required by insurance companies. What we found out on the BMI (Body Mass Index) form was that one of our cultural groups is, 100% of them are grossly obese. We would not get that in just the facts we get from insurance companies. For the Hawai'ian population, 30% are obese. So we know from those statistics and data that we have a problem with chronic diseases that would be onset very, very soon.

So in a way it prepares us. But more than that, we as a community need to look for ways so that we don't get into those areas of chronic diseases. What can we do in terms of prevention? We're always trying to expand the understanding of what is health, and for the Board of Directors the definition has been: healthy economy, healthy lifestyles, healthy families...

If we want to improve our health statistics there has to be a personal responsibility that's charged to everyone in the community. Now, we have learned from our traditional healing program that healing is done by the person and the traditional healers are simply there to enhance that process. So if we can adopt that for mainstream medicine, there is an accountability that takes place where people are responsible for their health. We have a lot of people who feel that they are victimized because of the overthrow of the system that presently exists. That victimization does not allow them to assume responsibility for a lot of their own health. So it is a whole process of educating the community and then bringing them on to the health center understanding.

One of the bad things that we have at the health

center—we have a reputation that people only go to the health center to die. And that's because of the newspaper. Because if there's any accident in the community, the death certificates are issued at the health center. So they think that they run up to the health center and they die. So they don't want to go there. So there's a whole education to the people that "no, this is the process that is used in order to issue death certificates." That you really go there to heal, and healing becomes central to the whole community as we address that. And as Merrie trains the board members to understand those things and to really be committed to that whole idea of community empowerment, that's the last bastion of democracy where you have a voice, where you can speak up, and you can bring about change. Health seems to be the opportunity that allows us the hope of a better tomorrow. So through that advocacy with the community and really charging the community with the responsibility of health we have been able to bring about change.

It was difficult for a time because the doctors were saying, "You know we have gone through all these years [of education] and this board member hasn't even barely graduated from high school. Why would they tell us anything because we're educated?" At that time we were pretty dominated by the medical staff that we had on—how things would be done, and then our kupuna, our elders would come in and say, "You know, I don't like that doctor. He comes in there and he doesn't say anything to me. Puts that cold thing on my body. I don't like him. I don't like to be served by him." So part of the training to the doctors was milder bedside manners, to get to know the family, to get to know the person, to get to know their likes and dislikes. And to start off with what Sherry was saying, "talk story." It's a technique that's used to build trust and confidence between people. So that talk story becomes significant in the way we serve that patient. And you know, maybe, 'how's your grandchildren,' is the first question, and then you go to into [other things]. So there's an introduction, rather than just this very cold approach to medicine, from a

Western perspective. So we're trying to allow our medical staff to become community.

I think 67% of our staff, whole staff there, come from the community. It's a double-edged sword. One is that they come in and see people that they know working at the center and they feel at ease. The other part is they don't want them to know why they're at the health center. So they want to kind of shy away. But you know that's the give and take of community and you have to maintain your confidentiality as much as possible. The point in that is: you have to allow the community to know that this is a community only, community governed system, and that becomes very important.

I don't want to pick on anybody, but our board member Lyle, who's one of our new board members...he works at the Lili'uokalani Children's Center. And the kind of things he has learned about the health center and the health center movement...we were just talking last night, he said, "the application of that [work with the health center] to all the other things that I do has enriched my life." And so to Lyle, I'll say, you're doing well, keep on, just follow what Merrie says, eat when you can, sleep when you can, because it's never going to be on the schedule.

Another thing that we have to honor, being that we come from the native Hawai'ian community, are values and traditions that really come out of the culture. Food is very, very important as ceremonial life. We do ceremonies. We open with prayer. We close with prayer. We do ceremonies that are appropriate to the community. We are expanding...

We want the community to know that they own the center, and so the activities that are structured are activities that we want them to come in [for] and it be there at least. We kind of anticipated the next year of activities and now we're kind of saying, "don't be too activity conscious" because the facility is filling up real fast!

But what now? What we're looking at is different parts of the campus being developed for different purposes. One

of the exciting things (to show the international nature of our campus and are welcome to anyone regardless of ethnicity, religion, or nationality), is that we just got a bodhi tree, from the original bodhi tree from India. And we planted it on our campus and we've designated that area for yoga and for meditation. So we try to be inclusive. It was part of the Hawai'ian tradition to include people and so that extension of inclusion is something that we offer to all people. Because we are all ohana, or family within the community.

I would like to thank you for the opportunity to share. If you have any questions, Joe Lapilio Aipoalani is the president of our board, and if you have any questions, Merrie Aipoalani is the one over there that is laughing. Mahalo.

**DONN GINOZA, JD**  
**Vice President of the Board of Directors**  
**for Asian Health Services**

Thank you very much. As one of the host agencies, I'm going to present something I think is unique about Asian Health Services. And when I was thinking about what to contribute and thinking about the theme, "Building Community Capacity," I didn't think very long because of the general membership meetings that we have that are [held] annually for [the last] 30 years. And today I'm going to present a video clip to give an idea of what one of these meetings is like. The idea is essentially to have a get-together of all of our patients. It's an opportunity for us to explain to them what some of the pressing issues of the day are. It's an opportunity for us to get input from them as to what services they would like to see the clinic provide. And, it's also an opportunity for us to—keeping with the theme here—to empower them to become advocates. When our patients become advocates, we *as an organization* become much more effective as an advocate. I think the video clip here will help you realize in what way that happens.



When our patients  
become advocates,  
*we as an organization*  
become much more  
effective as an advocate.

—DONN GINOZA

But first, I would like to give you a little description and history, and background, of our annual membership meeting. I have some competence as a community lawyer in the setting up of a community organization. And in California, when you want to establish a non-profit organization you must prepare a set of articles of incorporation and bylaws. These articles of incorporation are something you need to file with the Secretary of State in California in order to ensure that you get your charitable status, your 501c3 status. And as a community lawyer, I used to help organizations draft these articles of incorporation and one of the first things you have to ask your community groups [is], “Do you want to be known as what is a membership corporation or a non-membership corporation?” And the difference is simple but it’s fairly fundamental.

A membership corporation is one where all the members have voting rights and they elect the board of directors, and a non-membership public benefit corporation is one where the board of directors votes for itself. So there’s a nominated slate, and a sitting board of directors elects the incoming board members. So it’s kind of a self-perpetuating type of board and you might say somewhat anti-democratic.

Well anyway, when we started we were a membership corporation and so the general membership meeting was a necessity. We had to have it every year in order to vote in our new board of directors. So we began this thirty years ago. And, as I’m told by the historian in the organization, at our first general membership meeting we had one member show up. Obviously that wasn’t going well, right? The staff realized that they needed to figure out ways to get people to come and to participate and luckily over the years, we’ve grown in our general membership meeting. It typically has 300, 400, 500 people who attend. We have programs, we have break-out sessions, we have speakers come.

VIDEO CLIP PRESENTATION FOLLOWS.

On the discussion of health care policies affecting our patients—we’ve discussed universal health insurance, Prop 187, we addressed the federal welfare reform changes in the late 90s during the Clinton administration. We’ve had many noble speakers including Tom Perez of the Office of Civil Rights. He’s discussed the implementation of the Title VI requirements for language and cultural accessibility. It’s been a forum for getting feedback from patients.

We had one patient who came to the meetings on a regular basis and would complain about our not having dental services and he made a statement, “How can we have health, when we don’t have good teeth?” It was a really simple but really profound statement of connection between good eating, good nutrition, and health. And it actually became sort of a slogan for our campaign when we were raising money to start our dental clinics. So having patients there is a way of empowering not only the patients themselves, but our organization. And as the clip showed, it’s an

opportunity for patients to directly address governmental decision-makers. We’ve been very successful in drawing large numbers of people, and the idea is: if you bring the people, the politicians will come and that’s something that’s worthwhile. Seems like these people kind of line up and they’re very eager to attend.

The success of our meetings has really rested on our ability to translate to all languages, to really allow all the communities to participate. Our use of the simultaneous translation headsets is an example of putting your money where your mouth is. You know, we’re always advocating for the best in terms of translation and accessibility. So we ourselves have to be an example of how to do that.

And finally, one of the lessons learned is that it does take a significant amount of staff work ahead of time, in terms of doing your outreach work, in terms of reaching the community and letting them know this event is taking place. But it’s something that reaps great rewards.

## Questions and Answers Session

AUDIENCE QUESTION (FROM VIVIAN HUANG): *You talked a lot about the community health center movement. I just wanted to get your thoughts on the future. What’s your vision for the next 30 years?*

JOEL GARCIA: There are a lot of issues we’re facing that we have to confront and deal with, not least of which is the structural 10 billion dollar deficit that we have going and the national picture. We’re as strong as we’ve ever been to respond, to possibly turn a bad situation into good. And better than that—maybe come up with an answer no one has ever even thought of. And I think we can do that by developing further leadership and by developing a broader, common-shared principle [like the one developed] by our colleagues from Hawai’i on what community health really is and what the communities really need.

To set up our own institution—I would like to see is community health center university in California. A comprehensive university that has people that you know do the cultural competency that we’ve gotten in 30 years. Give the degrees that they deserve that they haven’t gotten yet. Become the teachers themselves. There are physicians that come in actually...the schools actually taught them about community work. They come in and they know we can teach them. The public health schools, the business schools and all that give us the people with the degrees but [who] also understand the community from the beginning, that we don’t have to reeducate them to come in and do the professional service. So there’s a lot of things that we’re capable of doing with partners that we have in the foundation world and also in academia for that matter that is healthy, that understands these different parts. So let’s bring all these people together.



Maria Altamirano

**KAUILA CLARK:** I think a lot of the future of health care is going to be personal responsibility, and prevention is going to have to play a big part in order to cut cost. And we may have to change our educational institutions. I agree. You know we might have “DC,” a doctor of coaching lifestyles. We might have “DI,” doctor of information. We might have “DA,” doctor of advice. That will help people make decisions on their health care rather than going through the chronic disease stuff and coming with recommendations. Give it back to the people. So that they can dictate their health care plan and their involvement—and I think that’s got to be the future. Because the cost is just getting so far out of hand that we’re going to have to design [a system of care] from community and be community advocates as to how our health care is given, provided, and how we receive our health care.

**SYLVIA DREW IVIE:** The other end of that future is that the clinics will, in the next phase of our lives, have to get out of their individual silos and be working in joint collaboration not only with other clinics, but with hospitals and working in regional partnership with other services needed by our patients. We’re really building connection for our patients and getting better at it. If we don’t move in doing this together, the patients will just never have a continuity of care that makes their care on a satin pillow in some ways when they’re in our doors, but then we just kick them out the door and they’re left on their own. So it doesn’t work unless we’re connected up to the rest of the system and we’re getting better at doing that.

**DONN GINOZA:** I think that within the next 10 years, there’s going to be a major transformation in terms of the leadership within our organizations. The long time executive directors that we’ve had, people who are firmly rooted in the history of the civil rights movement...we need to find

some way that the new people that come in understand that tradition. And of course you know the circumstances have changed. You don’t so much try to teach people the history of this, but adapt to the present circumstances that make everyone around you aware of how racial disparity still exists. How do they...why do they exist? And we have a very, very pluralistic society now. We have large self-sustaining immigrant communities, but we still have isolation in terms of the racial demographics in this country, and that contributes to continued disparities that contribute to racial intolerance. And this is a constant struggle. And we need to be thinking about how we can pass this legacy [of the civil rights movement] on.

**AUDIENCE QUESTION (FROM MARIA ALTAMIRANO):** *I think you already touch on this and I think every panelist speaker here spoke about it. And that’s the issue or topic of succession. What advice would you give people like myself? Because I’m going to face similar situations like you faced in the beginning. What advice would you give me and others here on what we should expect and what we should not do?*

**JOEL GARCÍA:** I think we should expect what the rest of the world expects—human rights. And I think that a lot of the dialogue we have in this country is in isolation to what is actually the foundational principles throughout the world. Actually it’s ironic because right across the Bay there you go over to United Nations Plaza, that’s where the United Nations team convene, where they have the Universal Declarations of Human Rights. It gives us an ethical disconnect. I think somehow to focus some of that [connection] in our youth and let them know that there are [these rights]...and we practice them...even if it’s in isolation and even in communities as we’ve grown up with these movements and so forth, they’re the same things. Civil Rights is about *human rights*. It’s a broadening of construct.

It isn't about one [group]... we can all [argue about] which group has had the worst of experiences. We can argue about that but then what's the solution in common for us then? I know that's very idealistic.

But I think [that is] the basic point. And I did struggle with this when I was in academia. I taught health policy and law and especially around Proposition 187...this one time when I went across country and talked to people and said, "Don't let what happened in California happen in your state. Don't let this poison about having immigrants hysteria and these negative scapegoating kinds of things happen." To be honest, I got a jolt of reality that the people had no idea what I was talking about. They've never heard of the Universal Declaration of Human Rights... It's not a political issue. It's not discussed.

KAUILA CLARK: I think that as individuals we need to take our passion and compassion and direct it to the masses—influence the masses, educate, inform. Because I think that if people are cognizant of what is happening then they will join in and they will stand together. But as long as there are information systems that people cannot access to be a part of it, then we're in trouble. So from a very personal point of view, I think the individual work that you do—it's great that we're getting people passionate about health care, and the movement about health care, and the services that are provided in reaching all people—can be a personal responsibility that you take on in your little circle, however little or big it may be, to try to influence others to your passion.

SYLVIA DREW IVIE: Just a word. I think that you have champi-

ons in your clinics like our patient, and you can identify people whose lives have been transformed. We have a patient who smoked Pall Mall cigarettes for 40 years. We asked him to go through our anti-smoking program. We invited him to go through it. He went through it and was successful. And he is just so unbelievably satisfied with the change that he's brought about in his life, and he's a community leader of young people. So by his change, he now takes that change to young people whose lives he touches. I think we move organically through people that we're touching and work with them. And this is something boards can do. Asking the staff leadership to bring success stories. Let us ask them to help us take these stories to the community and really rally others to have that kind of success. I think the more organically your advocacy is linked to what you do the more successful you'll be. The further away it is from what you do the harder it is for you to do it. So try to keep your politics and your health care linked together.

DONN GINOZA: Yes, and I think the one thing that we're lucky to have is the field that we're working in and there's just so many uplifting stories that we experience day-to-day working in our clinics. That gives me a great deal of confidence that just the services we provide itself will be spiritually self-fulfilling. That we'll always draw people to this kind of work, and it's not that hard to pass on the torch when we have all these wonderful stories to tell about. And it also again explains why we need to be as inclusive as possible. We need to establish mechanisms to grow leadership within our own organizations. ■



## BUILDING COMMUNITY LEADERSHIP

*Roundtable Discussions with Community Board Members and Leaders*



Top: Board Members share experiences.  
Bottom: Participants meet with each other.

CONFERENCE PARTICIPANTS BROKE DOWN INTO ROUNDTABLE DISCUSSION GROUPS. THE FOLLOWING ARE COMMENTS, THEMES, AND RECOMMENDATIONS THAT AROSE FROM THE DISCUSSIONS.

## **MULTIPLE ROLES OF BOARD MEMBERS**

**Representing users in their health needs and overall community development.** For example, at one community health center in Hawai'i, the board is involved in land condemnations and resale issues in community. In addition, boards need to be a representative of the community. In one clinic, haoles [white people] were making decisions and not Native Hawai'ians. Board members brought more Native Hawai'ian people to serve on the board of directors.

**Providing access and legitimacy in the community.** It takes time to develop board members into advocates but it is worthwhile—they become the best advocates. It takes a change in political consciousness for consumers to realize that they can contribute or become an effective advocate. For example, in one Korean community, Korean women were not getting Pap tests. The clinic in that community got Korean women to be advocates and they worked through the churches to get more women to get their Pap tests. In another example, board members went to Mexico to observe traditional medical practices. Consumer board members got excited and are now motivated and active, and are particularly focused on care.

**Listening to community concerns.** Good listeners who can listen to personal stories of patients are needed on the clinic boards. Sensitivity and starting where the community is at is crucial. To access communities, you must look at existing community systems you can tap into. For example cock-fighting is popular with some parts of the Filipino community and is one place to access people. One clinic is also trying to tap into the "ice" [crystal methamphetamine] community to get and share information. In addition, some community members are actually afraid of clinics.

**Building relationships and community outreach.** The board builds collaborations with major traditional leaders and other health care providers. Boards help connect with other health center systems, clinics, and clinic associations. Board members also play an important role as part of the community outreach. For example, one clinic has few employees, and they are all working in rural areas that have little transportation.

**Policy and planning.** Share patient stories with elected officials on the local, state, and national levels. Consumers need to have a voice in Washington, DC. Advocacy committees on boards are identifying and developing policy. Board members work with staff to organize clinic tours and legislative staff visits to the clinics where elected officials, board members, and patients can gather and talk.

**Offering professional guidance.** For example, the health center boards include lawyers, bankers, certified public accountants, and legislators.

## **BOARD RECRUITMENT, TRAINING, RETENTION**

**Addressing retention/attrition.** It is difficult getting the required 51% community board because most consumers have a lot of things on their plates. Board members need to have clear roles. For example, a written job description stating the time commitment required is useful.

**Support trainings for consumer board members.** Trainings have to be convenient to consumer board members. In particular, board members need trainings on reading a financial statement. Right now, board members use existing resources such as the National Association of Community Health Centers' "boot camp" conferences. One clinic also invites outside speakers to present and does video conferencing with outside experts.

**Pass knowledge on to the next generation.** Encourage each other and communicate with younger leaders.

**Adapt to changes in the patient composition.** For example, at one health center, 75% patients are Latino and there is still no representation from the Latino community.

**Address language barriers for consumer board members.** Language is important barrier to participation for some consumer board members.

**Move members of community advisory committees onto roles as members of the board.** Some of the former volunteers from the community are now on the board of directors. For example, at one clinic, housewives who were working as volunteers doing outreach, and immunizations in the schools are now potential board members.

**Giving board members choices of activities to maximize talents.** One clinic conducted a retreat to tap into common values among board members so each member felt that they had something to contribute. Each member presented to the rest of the board to develop the confidence and knowledge of what she or he as an individual can contribute.

**Bring business leaders in as partners.**

## **SETTING AND MONITORING STRATEGIC AND OPERATIONAL GOALS FOR THE HEALTH CENTER**

### **Sustaining and maintaining funding for community health centers.**

Clinics are born from concern from the community, and a majority of projects are started out of need. For example, our adult day care program was created based on need without a worry about funding. But we have to address changes and shifts in funding, such as Medicaid. In addition, if a clinic has status as Native Hawaiʻian health center, that can affect FQHC and other federal grants.

**Strategic Planning.** We do long and short-term needs assessments and planning in order to prioritize issues. We use our retreats to plan.

**Clarifying roles between board members and staff.** Generally the board sets objectives, and the staff executes, but there can be a fine line between board involvement and micromanagement.

**Evaluating performance.** One board advocated benchmarking procedures in their health center and now those benchmarks are being incorporated into new evaluations of the health centers. ■

## DINNER AND CULTURAL PERFORMANCE HONORING COMMUNITY BOARD MEMBERS



Top: Annie Ong, Connie Chang and Vera Leo play Taiko drums.  
Bottom: Sherry Hirota and Kauila Clark conclude the evening with board members.



Top: Red Willow Lodge Dancers.

Bottom: Conference participants tour the Asian Health Services' dental clinic, where staff showcase their paperless system.

## WELCOME AND OPENING REMARKS



Health care for the American Indian people was a form of cultural war when I was growing up. We were told to disregard our traditions and our medicine people.

—MARTIN WAUKAZOO

**Lyle Kaloi**

Member of the Board of Directors  
Waianae Coast Comprehensive Health Center

**Martin Waukazoo**

CEO, Native American Health Centers

**Sam S. Shekar, MD, MPH**

Associate Administrator, Bureau of Primary Health Care,  
Health Resources and Services Administration, and  
Assistant U.S. Surgeon General

**LYLE KALOI**

**Member of the Board of Directors  
Waianae Coast Comprehensive Health Center**

Good morning everyone. Can I ask everyone to please stand? Let us bow our heads and our hearts before our Creator. Divine Creator, we come before thee this morning to ask your blessing upon all of us who have gathered here near and afar. We come here to ask you for your wisdom, your guidance, your love for your people. We ask that you will bless the speakers that will share their thoughts to inspire and to lead other people in caring for each other. We ask you to sanctify this room, this building, this ground which you have given us. And we acknowledge all of those ancestors who have gone before us and those who will come our way. And, we ask this in the many names that we call you by. Amen.

**MARTIN WAUKAZOO**  
**CEO, Native American Health Centers**

Last night we had the opportunity to pause in our life and reflect on where we came from, what we're about, and how community health centers got started. It's about a movement, a community health center movement, back in the late 60s and the 70s. You know a movement is about making history. Organization is just about rearranging history. Community health centers: we are a movement about taking back health for our community. For too many decades, our communities—those people that we serve, those families and relatives in our communities—were disconnected from the health care delivery system. For too many years, our patients and our communities were treated as objects and not participants—that had to change.

If you were young in the 60s and the 70s, if you were young and an American Indian, you were dissatisfied. If you were young and an African-American in the 60s and 70s, you were dissatisfied. If you were young and Asian-American in the 60s and 70s, you were dissatisfied. The 60s and 70s were a remarkable time for our country. It was a time that our community took back the education, took back our children, took back the health care and assumed that responsibility. Urban Indian people were migrated, relocated from reservations throughout this country. Oakland, San Francisco, and San Jose were three of eight relocation centers. Thousands of Indian people moved from reservations to urban areas...

The urban Indian population throughout this country and 60% of all American Indians live in urban areas. 60% of all Indians live in urban areas, yet only half of 1% of all the Indian Health Service [IHS] fund is earmarked for urban Indians. Am I complaining? No. That is the way it should be because the relationship between Indian people and the federal government is between tribes and not individuals. When the Bureau of Indian Affairs offered enticement for Indian people to relocate to urban areas, they offered financial enticements, promises of education and better, and the golden state. Unemployment on the reservation is 90%, dropout rate 80%. Our ancestors wanted something better for us.

We were a young community when we moved out to Oakland, San Francisco, Minneapolis, Chicago, Denver, but we were also an active community that would not stay by and watch our people die of alcoholism and disease. Health care for the American Indian people was a form of cultural war when I was growing up. We were told to disregard our traditions and our medicine people. In fact it wasn't until the 50s and 60s that we were allowed to openly practice some of our traditional ways and ceremony. We've come a long way in 30 years, but we have a long way to go.

Today we are on the verge of looking at building a new facility. It's not that simple to go to IHS and ask them for capital or construction money. They shut the door on us:

I asked, "How do you say 'leader' in Navajo?" and she said the Navajo word for "spokesman." And I said, "What are the actual words?" and she said that literally that's the interpretation: "He-Who-Stands-With-Us."

—MARTIN WAUKAZOO

"You are an urban Indian. We only serve reservation Indians." When we get the little crumbs and the little handout from the Indian Health Service for diabetes, our community suffers. Virtually every one of our patients is at risk for diabetes.

Over the last 30 years...what I am most proud of that I've accomplished, every night I count my blessings and say prayer of what I am most proud of in our community is that our two doctors, Dr. John Pakula and Dr. Barbara Ramsey came to our clinic when they were 29 and 30 years old. They are still with us today. They didn't set out to make the Native American Health Center a career. Dr. Pakula was our "rent-a-doc" for about a month. He was traveling after graduating out of Colorado and did his work out of Colorado and was here on vacation, and happened to need to pick up some traveling money. And he came into our clinic and worked for a month. That was 22 years ago. Dr. Ramsey was working at Kaiser and making some good money, and we offered her something that she couldn't turn down...a \$30,000 salary! But, more importantly an opportunity to be a part of something that's going to help and heal the community.

We talked about integration of traditional health and cultural values. You know the message is out there, e-mail, internet—all those communications has nothing over the Indian Grapevine. When our community learned and heard that Dr. Pakula was in ceremony in a meeting in the Sundance, in the sun lodge in a Native American church, and that he participated—that spread throughout the community just like that. Likewise with Dr. Ramsey. Sitting down with community and praying with community and participating in the ceremony—that spread in the community.

Florence Nightchase, an elder who was 68 years old at the time, came up to me one day at my office on Julian Street. She asked, she said, "Hey Marty, Richard's coming out, the medicine person. But I'm afraid to tell Dr. Pakula, because I don't know what he will say. Richard's coming out to do a healing ceremony." And I said, "No Florence you go and you talk to Dr. Pakula, and you tell him what you're doing." And to her surprise, Dr. Pakula says, "I want to meet Richard. We could work together." You know that healing not only took place outside her body, but inside. And that's where our community needs to heal, is within. For too long our community have had the disease of jeal-



ousy and envy, anger, resentment. And those of you who are board members know that. All that political stuff that goes on. Those diseases of the heart...

It's a remarkable journey. We've always faced the challenges head on. We never went to the valleys. I take it from the buffalos—you know a buffalo will not go down into the valley during a blizzard, during a storm. He will not seek lower ground. That buffalo will go up to the highest point...that buffalo will go up to the mountain top and look at that wind and that blizzard coming down and face north head on, even though it's painful sometimes. Even though at times it would be much easier to go to lower ground where it's warm, get out of the wind, get out of the blizzard. But no. The buffalo would go up to the higher ground and face it, face the north and face that blizzard head on and stand there throughout the night. The reason the buffalo does that is because of its people. If you went to the valley to seek lower ground, you would be covered up and your people would never live again. You will lose your tribe, you will lose your community.

My father passed away a few years ago. He taught me much about who I am. I live with the name Waukazoo...you know I can't pronounce half the Hawai'ians names but I can pronounce Waukazoo. Live with the name Waukazoo. I know the prejudices and the discrimination and the teasing growing up in South Dakota with a name like Waukazoo, but I am very thankful that he never changed it to Walker, he never changed it to Walk, I still have the Waukazoo. And, Waukazoo in our language means "lights in a distance..."

But what he taught me was that no individual or no family can heal without community, leadership. I've always stayed away from that word—people would always want to introduce me as some type of leader. I'm not a leader. I kind of get embarrassed about being referred to as a leader. It kind of makes me uncomfortable. I had the opportunity to go down about 15 years ago when I was going through that leadership word and went to a Navajo reservation.

My wife is a Navajo. They had a clan meeting...all the extended family came together in late July. There must have been over 200 to 300 Navajos there all speaking their language. I didn't understand a word and this man got up and stood up and to me he looked like he was about 6'6", 6'7", and actually he was about 5'3". But he held himself. He had a bolo tie, the turquoise, the hat. And he got up and scolded some of the family members, some of the clans for all the in-fighting that was going on. I was very impressed with this man and I asked my wife, I leaned over and said "Helen, who is that?" and she said, "Why that's Sam George." And I said, "What is he?" and she said, "He's our leader." I said, "How do you say that in Navajo?" and she told me the Navajo word. As she said it in Navajo, she said "spokesman." And, I said, "no what are the actual words?" and she said that literally that's the interpretation: "He-Who-Stands-With-Us." A big jump from "leader" to "He-Who-Stands-With-Us." That sent chills throughout my

body because that's who I wanted to be. That's what I want to be: someone who stands with community. Because when you have that title, then you treat it with lots of care. It's very precious. It's a responsibility.

The most important people in our community are those people who don't have a voice that can advocate, that have pain and suffering. The clinics need to understand that the most important person in our clinic is not the physicians. Because the healing does not always take place in the back room and the exam room. It can take place with the janitors and the maintenance person who can offer a kind word, encouragement for a homeless person (and I hate that word and I despise that word homeless because there is no such thing in our culture as homeless. In the Navajo language, there is no word for germ, so how can we communicate better health to our community).

The Community Health Center Network have offered me a home, offered the Native American Health Center a home. I will be forever thankful for the Alameda Health Consortium for all that they have done for the Native American community in Bay Area. Yes, we have a long way to go but we are not afraid about what's in the future. We'll face it head-on, like that buffalo. The challenges in the deficit in Sacramento and Washington, DC and in the County are just challenges. We've overcome so many things over the last 30 years, that's a minor challenge. Together we can make a difference. We can improve the health of our communities...the diabetes, alcoholism, violence in our community. Under the public health system in the Indian Health Service when I was growing up, we weren't allowed...we were not allowed to practice our ways, our culture, and our traditions. There would be no medicine man available to us because they said we couldn't have them as part of the healing, as part of the family. Things have changed in the last 30 years.

I just want to close with a couple of words. You know we're in the newspapers almost on a daily basis and we have to overcome some of these misconceptions. Casinos are on the pages of daily newspapers: "They are putting up casinos, Indian people are putting up casinos everywhere." Only about 5% of all Indian people benefit from the casinos. Don't ever believe all people are sharing in that wealth. Our communities that we serve are not benefiting. If they do it, that's their choice. But I am very proud of the Navajo people, my adopted tribe. I'm very proud of the Navajo people because the elders said no to the casinos on three occasions because it will destroy their language, their culture, their traditions. The elders said no so they are not building casinos on the Navajo reservations...

I want to thank everyone here today for listening to me. It was an honor. I appreciate all the friends and the relatives I made the last couple of days. I want to thank everyone and thank these two ladies here, my sisters, who I've been with for 30 years. We talk about our children now and we talk about our grandchildren now. But the youth in our community need to step forward, we need to prepare to pass on that baton.



We are all over the United States. We now have 900+ grantees in the United States and about 3,700 individual health clinics. —SAM S. SHEKAR

**SAM S. SHEKAR, MD, MPH**  
**Associate Administrator, Bureau of Primary Health**  
**Care, Health Resources and Services Administration,**  
**and Assistant U.S. Surgeon General**

Good morning, buenos dias. And in the spirit of this conference and the spirit of my heritage, namaste.

Well, that title says, “Eliminating Health Disparities in Health Centers,” and that’s true, but here is something else that is true: let’s change that word “in” to “through.” And, why do I say that? Because as we go from movement to mainstream, as the health centers continue to grow, we are finding more and more and more evidence published by us, and more importantly published by those who are not connected to us, who just look at the data, look at the research and make the fact: *that when you put out a health center in a community you are reducing health disparities.* This is what I like to call “the walk.” And, you have heard the phrase “talk the talk, walk the walk,” health centers “walk that walk.” You want to increase access to care, you want to provide high quality health care, you want to reduce disparities? We got an answer for you, it’s called American health centers, and through the rest of the speech, I’m going to hopefully have you see that, understand that, embrace that, and go forth and conquer everyone else out there who doesn’t know that and have them know that as well. Because remember this, if you don’t remember anything else from the speech, this is the most important thing: health care for the poor does *not* have to mean poor health care. And, thanks to your work and our work, thanks to

America’s health centers, it doesn’t.

Where are we? We are all over the United States. We now have 900+ grantees in the United States and about 3,700 individual health clinics. That’s a huge number, in fact it’s such a huge number that it’s serving, as of last year, the end of last year, nearly 12 million and it’s going to 13 million very shortly. 50 million patient encounters, and you can see that even as we are growing, we are not forgetting our past, we are not forgetting where we started. Of almost 90% of the people who are below certain level of poverty, nearly 40% are uninsured, almost 2/3 are members of ethnic and racial minorities.

We’re very excited about where things are going. Jane mentioned the tremendous support from both the administration and Congress, from both sides of the aisle for the health centers. And, that is coming because they see it at the community level, they see the result and they want to embrace it and support it...

There are 176 new access points, 150 EMCs [Expanded Medical Capacity sites], and so forth and so on. I don’t want you to focus on the numbers, I want you to focus on the pattern, and the pattern is this: the country is starting to believe in health centers and they are starting to vote with it, with their dollars. And that’s what you are seeing.

Well, who are we? Who are the centers’ patients that we’re serving (see fig. 1)? And, this is very interesting because the math has changed. The pie chart has changed over the years. Currently, the single largest group with the health center world is Hispanic/Latinos at 35.4%, African Americans 24%, Caucasians 36%, Asian/Pacific Islanders

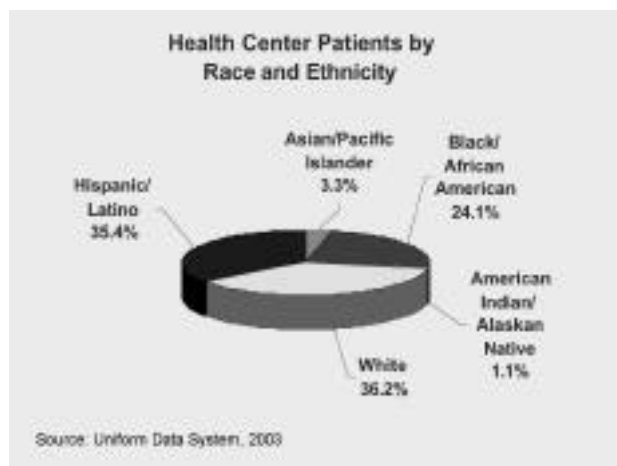


Fig. 1

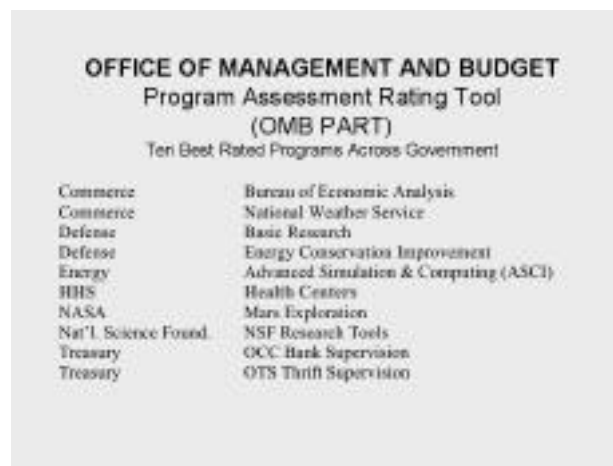


Fig. 2

3.3%, Native Americans 1.1%. So this is just a way of showing you where the pie chart is now, and whom we see. And, as you very well know, that differs by region.

Even as we continue to grow in leaps and bounds and continue to serve, we're keeping our eyes on the prize, as they say. We are focusing on those who are poor, we're focusing on those who are uninsured, we're focusing on those who are racial and ethnic minorities, significantly over that what you see in the rest of the United States.

Now our hearts are in the right place as are our heads. This is a slide that depicts a recent (at this point about a

year old) Office of Management and Budget survey that shows where they view health centers in terms of efficacy, effectiveness relative to other programs—not just 2 or 3 other programs, not just 4 or 5 other programs within the department of health, but 256 federal programs across the entirety of the departments. Transportation, Commerce, State, Justice, whatever, you name

it (see fig. 2). And what you see here is that health centers are in that list of not just being good but being great. One of the top ten across the entire federal government for effectiveness at what it sets out to do. And, when you look at that list (and I know many of you have heard me say this before), if you look at those underneath and around it, it's obvious that it is as important to this country as shooting for Mars, and especially for those of you maybe here from East of the Mississippi, perhaps a little better than being able to predict the weather.

Take a look at funding (see fig. 3). This is important. I don't know if any Medi-Cal folks are in the audience or folks from the State, if they are I was remiss in introducing you.

And what you see here is that health centers are in that list of not just being good but being great. One of the top ten across the entire federal government for effectiveness at what it sets out to do. —SAM S.SHEKAR

But, the point is this: we clearly are a multi-factorial program—cross pollination. I think Jane talked about it earlier. Well this is cross pollination of funding. The health center program that we run, the part that we give you, is about a quarter of your total funding, and you see that Medicaid has enormous impact. So in this state, Medi-Cal has enormous impact. What decisions happen in Medi-Cal have enormous impact on what happens in the health center world. And, in addition, we have a bunch of support from all sorts of areas, including state, local and others, and I think that the foundation funding would end up going in

there. You have other third parties, SCHIP, and even Medicare. So you really have to know, the folks who run the health centers are not just sitting there waiting to receive a check from Uncle Sam, cash it in and they're all set. That's only the beginning and then they have to really get to work.

One of the most important things you can do for people with health care needs is give them health care. And you can't give them health care unless you give them access. So are we giving them the access they need? Looking at uninsured patients, health centers are far more likely to provide an uninsured patient 4 or more visits a year to a health provider than their colleagues who are not seen in the health centers—clearly, walking the walk of giving that access to the uninsured. In fact, not only are we exceeding what you see, of those not seen in health centers, we've actually already exceeded the Healthy People 2010 goal.

If you expect people would have difficulty with their health, you would expect that they would have greater access to health care (see fig. 4). Right? It would make sense.

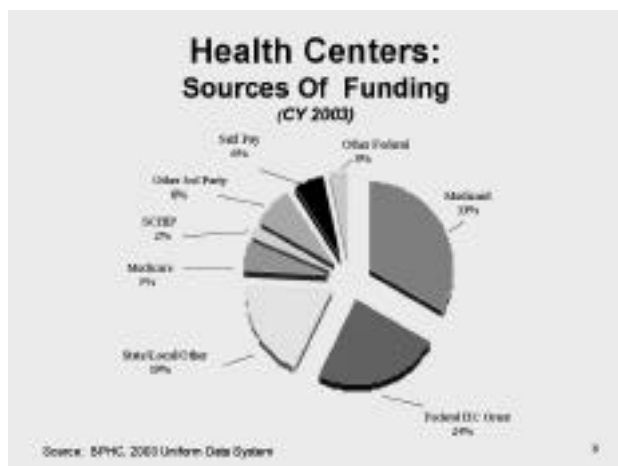


Fig. 3

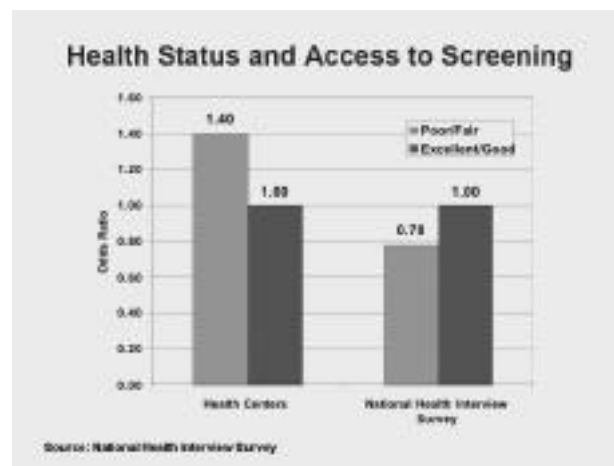


Fig. 4

Wouldn't it make sense? Well, that does make sense in the health centers. What's amazing is that it doesn't make sense, unfortunately, in the rest of the country. Patients who are in poor or fair health who are seen in the health centers are more likely to be seen and to get access to more screening services through health centers, than if they were not seen in health centers. The National Health Interview Survey is a national survey run by CDC which looks at all sorts of folks in a statistically drawn format to make comparisons about health. And, what you can see is paradoxically those people who have excellent or good health in the rest of the country are more likely to get the access to screening than those of poor health. So, if anything, our American health system is working against cross purposes. So we should focus where the issues are, where the needs are. That's what health centers do. And, again walking the walk, we don't just talk about it, we're doing it, you're doing it.

This is really sad. At a time that we are having all this money spent on health care in the United States, a majority of Americans are considered to have at least one pre-disease or borderline condition. And all of you know somebody (if not yourselves) that has this: diabetes, hypertension, cholesterol. Sound familiar? I'm sure it does. There is someone today that has someone they know who has one of these. A majority of Americans are now considered to have at least one of these conditions. So the country as a whole is sicker. And this is being reflected in our health centers and the growth across our system. And the three biggies are hypertension, asthma, and mental health. These are increasing in our health center system, and

Looking at uninsured patients, health centers are far more likely to provide an uninsured patient 4 or more visits a year to a health provider than their colleagues who are not seen in the health centers—clearly, walking the walk of giving that access to the uninsured. —SAM S.SHEKAR

you can see that year by year as it goes forward.

A recent *Washington Post* article citing a story in *Health Affairs* said that there were a lot of conditions, a lot of diseases, but really what it came down to is that 15 [diseases] accounted for about over 56% of the cost of the health care system and the cost of the rise in treating people (see fig. 5). And of those 15 [diseases], there were 5 that accounted for most of that percentage. So if you could get a handle on those 5, you could make some serious impact on health care and on improving health care in the U.S. And, what are those 5? You could name them yourself: diabetes, pulmonary conditions, mental disorders, cancer, hypertension. Sound familiar? And in this article, many of the 15 maladies, especially the 5, could be prevented or managed by simple, affordable steps you can see and do in the health centers.

In fact if you look at our Collaboratives, our Health Disparities Collaboratives, which has the goal of improving the health care quality for all, you can see that we have Collaboratives directly targeted to these 5 major conditions (see fig. 6). And, just to put it all together, you can see the range of Health Disparity Collaboratives that we have at the NACHC meeting coming up—Dr. Calvo will be focusing on [quality improvement]. We have an absolute goal to move towards everybody being part of it. And you can see where we are lining up in terms of both current Collaboratives, as well as our pilots, some of which are new that we are talking about at this meeting.

At the same time that we multiply our level of folks in these Collaboratives—15,000 to 135,000—at the same



This study will show you that our centers have almost a 4-fold lower hospitalization rate, 33% lower in patient cost, lower days of hospitalization, and, here's the kicker, and an average total annual cost per diabetic patient that was 5 times lower than providers within the state for the same reimbursement stream, Medicaid managed care. Higher quality, more cost effectiveness. —SAM S.SHEKAR

time we increase that number by enormous leaps and bounds, we decreased our HbA1c level in diabetes one whole percentage, which translates as you well know into significant reductions in morbidity and mortality in disease conditions. So therefore, at the same time we are growing by leaps and bounds, [we have made improvements] in a population that you would expect to have cases significantly worse than others. Therefore what have we done? We've accomplished a miracle and don't underestimate that. That is huge, and the world needs to know about this. Again walking the walk. People wanting to reduce disparities, increase access to care? We got an answer. It's right there, right in front of all of us.

Two percent of the national health care budget is spent on prevention and core primary care activities. Yet we spent so much [on medicine], and 50% of the deaths in the United States are due to preventable conditions. There is a real mismatch here. And yet are we leaders in prevention, in public health? Diet, activity, smoking, STDs, in terms of counseling issues, health centers are significantly increasing their access to these services for uninsured, let alone insured, in the United States through the health centers as compared to their colleagues elsewhere.

And this is where we go from process to outcome. I think cancer is a pretty serious outcome. I know you do too. We're not talking about minor things here. And take a look at these pap test results [AS SHOWN IN PRESENTATION SLIDE]. Health centers are far more likely to provide pap test on a regular schedule to women than other health care delivery agents in the system. This applies even when you are looking in Medicaid. Within Medi-Cal, you're more likely to have the patients, the women, getting their pap test on time in health centers. Looking within the insured, looking within the African American population, and looking within the Latino population. And all of this for the most part is either meeting or exceeding already the Healthy People 2010 goals for the entire nation.

This is data that you put together and that we've drawn from the [National] Health Interview Survey and

matched [them] (see fig. 7). This is real world, this is real life. These are the results you are making. And you are making a huge difference on the leading causes of death and disabilities in the U.S.

Low birth weight (see fig. 8). For the first time since 1958, the infant mortality rate in the United States has gone up. First time since 1958. And here we are in a country that spends far more on health care than any other country on earth, and many combined. And as the total U.S. rate for low birth weight (which is an antecedent to infant mortality rates) goes up, what's happening to the health center rate? It's going down. It's going down, when you would think—looking in our population and the folks we treat in the communities we work with—that it may be the leader for the increase. In fact, it is helping to pull the national average down. Which is good.

Not only are we reducing the impact of low birth rates among those we care for, we're actually decreasing differences among those that we treat. We're actually equalizing care, we're actually making things equitable. What you can see is that our low birth weight rate in the health centers are lower comparably than those in either U.S. general, or African American general, across this sample survey. Okay, so what? If you look at the difference between the African American rate and the U.S. rate, it's 5.6. But for the health centers it's only 3.7. So in addition to lowering the overall level we're decreasing the disparity. Again, walk the walk. If you want to reduce disparities, if you want to eliminate disparities, we say invest in health centers and we say we got the proof for it.

Okay, quick thing on reimbursements, because I think this is important to know and certainly in California you're very focused on what's going on with Medi-Cal. Medicaid has significantly increased its share of our program. It started off being about 15% of our program. It's now close to... actually here it says 35.5%. And our health center funding from the Bureau of Primary Health Care was about 50%—it's now down to less than a quarter. This is not bad news. What this means is that you are increasing your diversity,

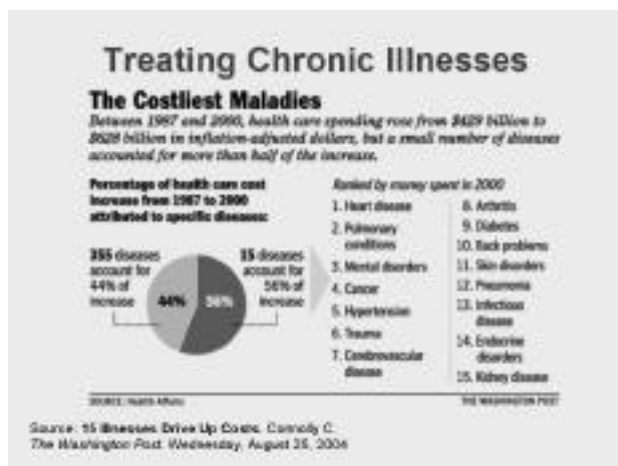


Fig. 5

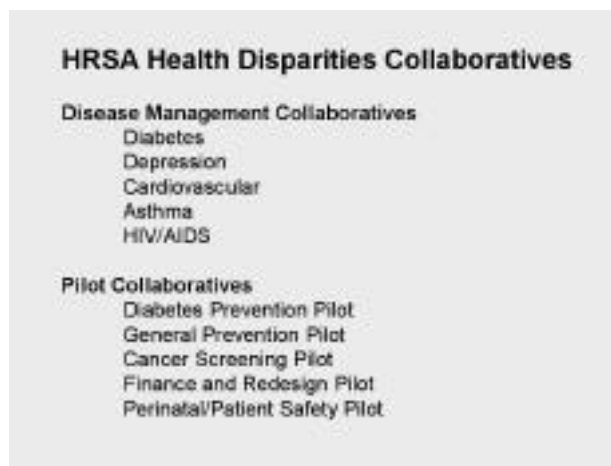


Fig. 6

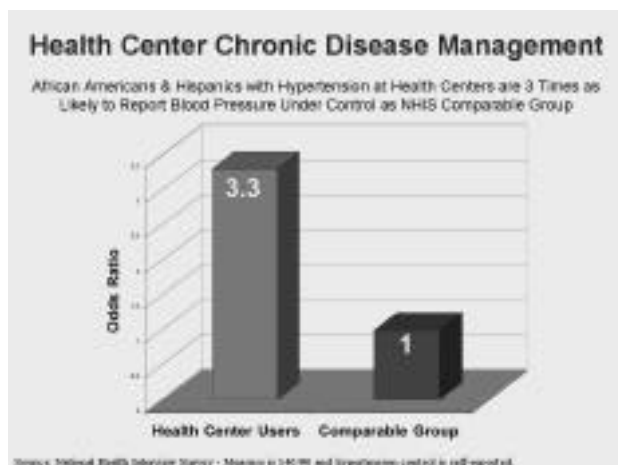


Fig. 7



Fig. 8

you're increasing your ability to have funding from a variety of streams.

The end result of this is moving in the track of tying what I've just talked about—the quality focus into the reimbursement focus through information that you've seen before, and that we're talking about here. The cost of treating a health center Medicaid patient is 30-34% less than the cost for those who've received their care elsewhere—26-40% lower for prescription cost, 20% for asthmatic sufferers, and so on, and so on. And when you compare those who are being seen in the health centers versus those who are not [seen in] health centers, Medicaid patients are 22% less likely to be hospitalized for potentially avoidable conditions. And, even when you take out the ER visits in the middle of the night, it's still 11% less. So, if you're sitting there and you're looking at issues from a funding perspective, you can put the one and one together, and it spells out two. It's very simple. You get better quality care, you get

better cost effectiveness. It's straightforward.

Lee Partridge did this study (see fig. 9) in 1999 looking at HEDIS data and she compared the performance of over 167 health care plans, which I know are big in California, health care plans that enroll Medicaid beneficiaries. And as you can see, and you may not be able to see what they are comparing on, but I will read some of them off for you: childhood immunization, adolescent well care, check-ups after delivery, eye exams for persons with diabetes, children's access to care in the pre-school years, etc, etc. Through those variables, they compare these health care plans for quality performance. And what they found is that 9 health plans that prominently feature health centers in them performed significantly better than those health plans that did not have health centers in them at all. So, even in the health plan perspective we certainly are delivering that quality...

What we are trying to move towards now, is tying



Fig. 9

quality with reimbursements together, because we can be the engine of this train, not the caboose, but we need to move in that direction. And I will be saying a lot more about that at the NACHC meeting on Sunday. But, this study will show you that our centers have almost a 4-fold lower hospitalization rate, 33% lower in patient cost, lower days of hospitalization, and, here's the kicker, and an average total annual cost per diabetic patient that was 5 times lower than providers within the state for the same reimbursement stream, Medicaid managed care. Higher quality, more cost effectiveness.

Putting it all together, we estimate in working closely with the National Association of Community Health Centers, we estimate that we potentially across the board have saved a minimum of \$600 million a year for outpatient care alone, and in further extrapolation, perhaps as much as \$3 billion in total care, including avoidable hospitalization and reduced specialty referral. Why do I keep talking about reimbursement? I'll say more at the speech on Sunday, but one thing is clear: the next big train coming down the pike—certainly IT is coming, no question—but a real big one is quality being used as a reimbursement tool. The concept of value based purchasing. And you're starting to see this from Medicare, from Medicaid, from Aetna, from the U.S. health care. You're starting to see value-based purchasing being utilized as a way to discriminate between providers. You have great quality? We'll give

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—SAM S.SHEKAR

you incentive payments. You have low quality? We won't give you the payments, and we may even take you out of our plans. And that's where things are starting to move, and we want to make sure that you all, as community leaders, continue to have that strong focus of support and quality and cost effectiveness in moving forward. Because we do not want you to slip into the caboose of that train. We want you up front.

So to conclude, you have always been a leader within your communities, and you will continue to be, and we will work with you to continue to make that happen. As you continue to expand in these communities and continue to make these strides in quality and cost effectiveness, it's becoming more and more clear through the great works of Sherry, Jane, and all of you out here that health centers are now increasingly not just a destination of chance for those who need care, but a destination of choice for all who want care.

"Cost effective primary and preventive care is possible, if providers are willing to bring care directly to the streets and shelters." That was a recent quote in a *New England of Medicine* article. And guess what, this is something that they are prescribing for the rest of the health care system and that's what you've been doing since the 60s, since the 70s, since the 80s, since the 90s, and today. Thank you for helping us all build a healthier and more equitable American health care system through American health centers. Thank you very much. ■

*Presentation of Community Voices Policy Paper:*

## **"COVERING ALL RESIDENTS: THE CASE FOR IMMIGRANT COVERAGE IN HEALTH REFORM"**

*with a Blue Ribbon Response Panel*



Top: Luella J. Penserga

Bottom, from left to right: Tanya Broder, Dr. Ninez Ponce, Patricia Ford

### **Luella J. Penserga, MPH**

Project Director, Community Voices Project

### **Sandra Hernández, MD**

CEO of The San Francisco Foundation and Member of the Institute of Medicine's Committee on the Consequences of Uninsurance

### **Patricia Ford**

Chair-Elect for the National Coalition on Black Civic Participation

### **Tanya Broder, JD**

Staff Attorney and Policy Analyst of the National Immigration Law Center

### **Ninez Ponce, PhD**

Associate Professor at UCLA's Department of Health Services and Faculty Associate with the UCLA Center for Health Policy Research

### **LUELLA J. PENSERGA, MPH**

**Project Director, Community Voices Project**

Good morning. I'm going to quickly sum up the major points that we have in our Community Voices white paper, which is included in all of your conference packets. We welcome feedback, it's still in draft form.

I know we're among friends and Alameda County is quite a progressive county, so I wanted to put in context and remind ourselves what is going on nationally and how differently people in different areas think about immigration. Samuel Huntington for example, is a Harvard professor, and a political scientist. And he believes:immigrants are a threat to the American work ethic, the English language, the legal system, and social institutions and values, American social institutions and values. He's not a Republican. He's against the war, and he's said that he's voting for Kerry.





Fig. 10



Fig. 11

So this is just a reminder that immigration is not a partisan issue. This is still a controversy. And while we are surrounded by friends, we still have a lot of work to do.

The Center for Immigration Studies also came out with a report. Also as a reminder that people who are arguing against immigrant access to health coverage often blame immigrants for the costs of the uninsured in this country. This center has put forth in the last couple of weeks that immigrant families are responsible for a lot of the government costs in health and social services.

Immigrant rights advocates responded that with most of the families in the study, the parents were immigrants but the kids were U.S. born citizens. Therefore the U.S. born citizens—the kids—were actually costing more than the parents. In fact the money is really going towards U.S. citizens. Yet you'll see later on that about 1/3 of U.S. born kids who have immigrant parents are still not taking advantage of health coverage that they are eligible for. So while they may be using a lot of the resources, they are eligible. They do deserve these resources and in fact are not even really using up all of what's really deserving to them.

About 22% of the people in the U.S. who are uninsured are immigrants. Immigrants are not the cause of the growth of the uninsured. The Kaiser Family Foundation has come out conclusively around that statement that they are not the reason behind the growth of the uninsured, any more than any other social group is single adults, certain groups of color. They are not a cause in the growth, they are a percentage.

After federal welfare reform, the cost of covering

recent legal immigrants shifted to states. Welfare reform really impacted all of the local communities. Suddenly all of the immigrants who had recently arrived here who had not yet been in the U.S. for 5 years were ineligible for benefits. State funds in certain states that had high immigrant populations—due to all of your advocacy—were set aside to cover immigrants that were made ineligible by federal welfare reform. So you see a shift of the costs down to the states from the federal government. State-only funds, as we all know, are vulnerable to our budgetary cycles.

And the cost of covering the undocumented—because welfare reform did not affect the undocumented as much as the recent legal immigrants—the cost of the undocumented still has and is really borne by the local communities who are committed to serving those populations.

One of the major issues as many of you know with immigrant families is dealing with the fact

that families have mixed status. So some people call them immigrant families, some people call them mixed status families—what this means is that the legal system breaks up families, and makes it very difficult for families to access coverage. Children Now came out with a recent study, earlier this summer, that 47% of children in California live in immigrant families (see fig. 10). Quite a high number. Approximately 1/3 of children in the U.S., as I said, who are U.S. born, who are eligible for benefits, are not taking advantage of this for different reasons. We are also seeing that if one family member has coverage, then it makes it more likely that other family members will get coverage. Conversely, if there is one family member, or certain family members who are unable to get coverage, it makes it

They [immigrants] are not the reason behind the growth of the uninsured, any more than any other social group—single adults, certain groups of color. They are not a cause in the growth, they are a percentage.

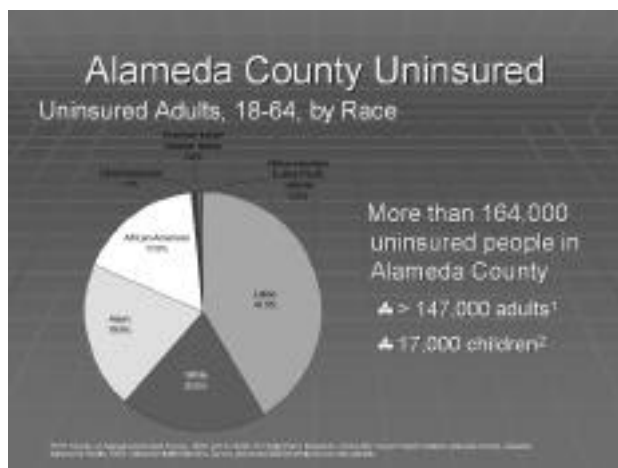


Fig. 12

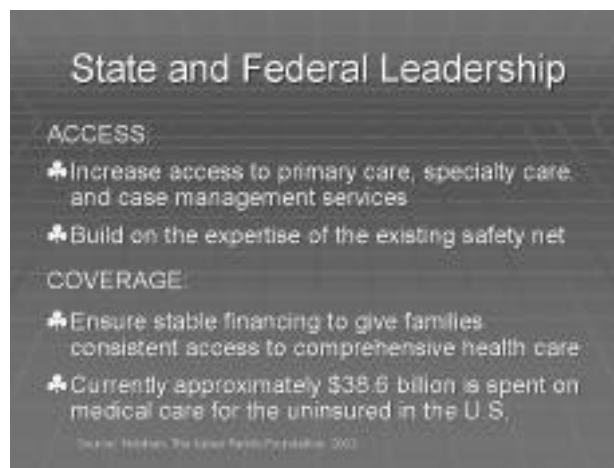


Fig. 13

more difficult for the whole family to come in. And you can imagine the dilemma that a parent must face who has 3 kids—2 are U.S. born and are eligible, but one is not. And that points to some of the reason why 1/3 are still not taking advantage of benefits.

Families with mixed immigration status are reluctant to apply for health coverage. Of course there's also an ongoing fear. All of the media battles that are going on around immigration are causing a lot of fear about accessing benefits and applying for benefits. Screening for immigrant status, of course adds to the administrative complexity, so there's a trade off—it's always cheaper in the short run, to deny people benefits. But there is an added expense of implementing those screening procedures. So checking for immigration status does make it more complex and more burdensome. And there has been an outcry in the health care field. I know some of you are aware about the policies that have been proposed about screening for undocumented in hospitals. There's been a really strong outcry from health care providers such as yourselves against that type of thing, because of the administrative burden, because of the moral dilemmas.

Not only are we seeing movement around addressing issues of the uninsured in California, but we are seeing movement around making sure that those proposals are inclusive of all people, of all residents, in each of the counties that are making movement. Ten large California counties are covering children, regardless of immigration status. (audience applause) These are large counties. These large counties represent 67% of our population here in California. That's 22 million residents that that represents.

**Ten large California counties are covering children, regardless of immigration status. These large counties represent 67% of our population here in California. That's 22 million residents that that represents.**

Other states are also offering coverage to all children, regardless of immigration status. In Alameda County—and people can correct me if I'm wrong—but my understanding is that Alameda County is the only county, local community, that has extended coverage to adults to both parents and adults who are eligible, regardless of immigration status. And our paper talks more about that. Kaiser Permanente, and I know there are folks from Kaiser in the room, has a child health program—again it is open, regardless of immigration status.

Just real quickly, we all know some of the ingredients that it takes to put all these coverage programs together (see fig. 11). It doesn't happen overnight. The political commitment, networks of strong established providers, the safety net, the strong presence of community health centers, private foundation support. The California Endowment has been critical to making sure that these new coverage programs do exist, that they don't use barriers based on immigration status. Also the presence of tobacco related funds is really interesting. Who would have thought that health coverage for kids would be dependent on people smoking? So it's really a perverse relationship with our tobacco funds. There is a lot of instability with that because of course as smoking goes down, we have decreased amount of money for coverage. And of course the absence of state and federal funding for coverage is an ingredient.

This is based on the County of Alameda Uninsured Survey which Dr. Ponce actually spearheaded (see fig. 12). We have more than 164,000 uninsured people in Alameda County. Most of them are adults. And as I was saying, the

Latino population is disproportionately represented among the uninsured.

Like I said, political commitment is one of the key ingredients to being able to put together these coverage programs for immigrants and uninsured communities. Alameda Alliance for Health is our local health plan here in Alameda County that provides coverage for primarily Medicaid and SCHIP eligible residents. This gap coverage product focused on people who are not normally eligible for public programs. It was heavily subsidized. Alameda Alliance for Health—again demonstrating its commitment, it's own progressiveness—put forth \$20 million of its own health plan reserves towards covering the uninsured in Alameda County. Eligibility requirements—again, targeting people who are not eligible for other federal programs, targeting people who are below 300% of the federal poverty level. And also another requirement was having another child enrolled in another Alliance program, Medicaid (called Medi-Cal in California) and SCHIP (called Healthy Families in California) or Alliance Family Care. This is getting at family-based coverage, this strategy of family based coverage.

Now after 4 years of seeing what has happened in Alliance Family Care, and having many discussions around this, the University of Michigan did an evaluation of Alliance Family Care. They saw that use of preventative services increased after enrollment. So health coverage does make a difference. Also, community clinics are efficient vehicles for health coverage enrollment. There was no formal marketing strategy for Alliance Family Care. At the height of Alliance Family Care there were 7,400 people enrolled and there was no formal marketing strategy.

Immigrant families are a healthy addition to the risk pool. We did not find that there was any type of adverse selection. There wasn't a mass of really needy, sick folks coming in. There was an appropriate mix of people coming in to apply. I think it was about 1/3 who had never had insurance before enrolling in Alliance Family Care. We found that they were using their benefits appropriately, and they were willing to pay their premiums over time. There was only about a 2% disenrollment rate in Alliance Family Care. So that shows how quickly people do understand the value of health insurance. Some of the ideas that were tossed around at the beginning of Alliance Family Care were discredited with the data from the University of Michigan.

Local communities are committed to expanding health coverage. But as you know, the long term sustainability of these programs were really put to the test, especially in the last couple of years with our state budgetary problems, the

Immigrant families are a healthy addition to the risk pool. We did not find that there was any type of adverse selection.

reduction in revenues hitting all levels, from government to foundations to local communities. Enrollment in Family Care has been reduced in order to continue its viability. And we know that local communities cannot continue to cover the uninsured on their own. Even when Alliance Family Care was at its height, we still had a high number of uninsured left in the county. So Alliance Family Care was not the answer, but we did learn a lot about starting new coverage programs.

State and federal leadership is still needed (see fig. 13). Dr. Shekar talked a lot about access and the importance of community health centers. We're very pleased that the Bush Administration is putting more money towards community health centers and that the administration has this new initiative. But we still need health coverage. We need to have a two-pronged approach. We need access—but not just access to emergency rooms, which is the way most uninsured get access to health care, but we need access to primary care services, access to specialty care services, and case management services.

We need coverage to ensure there's stable financing to support this type of access. And we know that there is approximately \$38.6 billion spent on medical care for the uninsured in the U.S. currently. So money is being spent on emergency room services, expanding safety net services. We can maybe look at that type of money that is being spent and use it more efficiently for coverage up front.

Recommendations that we have in our paper include: developing targeted state coverage expansions that cover all children and families. So even if we're using an incremental approach, even if we're just starting with kids, let's cover all of them, including immigrant kids, undocumented kids. Build on local coverage programs—simplifying the health coverage enrollment process to maximize federal funding, for example, with Medi-Cal and Healthy Families. So again, trying to draw in more support for local coverage efforts. And more long term goal – restoring Medicaid and SCHIP benefits to recent immigrant families. And this is something that has been reintroduced to Congress over the last 3 years. So we have a lot of work to be done. I'll close with that, and I look forward to hearing the panelists.



**SANDRA HERNÁNDEZ, MD**  
**CEO of The San Francisco Foundation and**  
**Member of the Institute of Medicine's Committee**  
**on the Consequences of Uninsurance**

Great. Thank you Jane and Sherry. Congratulations Sherry on your 30th year anniversary. It's an amazing 3 decades of service that you've provided. It's great to be here and to remember where health care and community really interface in community health centers.

This particular topic about covering not just the uninsured, but the subpopulation of the uninsured that are immigrant regardless of what generation, mixed families, etc. is really a bold topic to undertake. It is a political hot potato. When the Institute of Medicine (IOM) did its work to look at the consequences of the uninsured, we spent the first day dancing around the issue of undocumented folks and how we were going to approach that in our data and in our objective scientific reports. And after about a day of dancing around it, it came up on the table that we really needed to talk about it head on.

And as the report that Luella and others wrote suggest, there isn't a lot of data, but as you can see, a minority of the uninsured are immigrants in this country. And so it's important that as we debate how to cover all Americans, all people living in this country, that we not forget that as other people have tried to suggest, it isn't that the immigrant population produces such an enormous burden on the health care system.

Kaiser looked at this in San Francisco, when we were looking at trying to cover everybody there, to do some actuarial data analysis. And I think one of the most powerful pieces in this particular report that Luella just presented is the fact that these are, generally speaking, younger, healthier adults. And I say adults because as these local projects have shown, it's much easier to get funding and support for

The actuarial finding is that there is not enormous undue risk, or for that matter, a tremendous amount of pent-up demand, with the exception of for preventive services. That is a really powerful message that has not permeated the health care reform debate in the way that I think it needs to...

—DR. SANDRA HERNÁNDEZ

children than it is for parents, regardless of their age, their actuarial status, their immigrant status or the like. And so I think it is really important where these counties and localities have tried to take this on: that the actuarial finding is that there is not enormous undue risk, or for that matter, a tremendous amount of pent-up demand, with the exception of for preventive services. That is a really powerful message that has not permeated the health care reform debate in the way that I think it needs to...

So I think the actuarial data is really important in this, and you see the data on most of the local projects that have done really well. And this is true by the way across the country. The IOM looked at localities and states that had tried to go to universal. And in fact [we] came here and got testimony from the Alameda Alliance [for Health] about what had been done here in Alameda as one of the case examples. And all across the country, states that had great leadership on this and have much less immigrants than we have in California, uniformly have all come to the same conclusion, which is: it can be done, but it cannot be sustained without a federal financing stream to get it done.

And I who have done a lot of work in local projects, have been convinced that all of these projects—I mean Alameda Alliance which started with 7,400 and is down to 2,000 enrollees—that all of this really is going to require federal leadership and as Martin has said, “standing with us on the issue of universality in the country.”

The state deficit has shown us what happens to fabulous local programs when Prop. 10 dollars decrease, and SCHIP gets squeezed and Healthy Families doesn't get expanded. That happened in Tennessee, that happened in Oregon. Every state that's taken leadership has run into the same problem: you can't sustain it without federal funding. So ultimately I think that is where the public policy agenda needs to focus.

The actuarial data is very important. And politically

another aspect that we really don't talk about is the importance of educating communities of color in the political process about the importance of having everybody in the health care system. This is a real issue in the Latino communities, in Asian communities, all across the country. There is sense of "if-more-people-come-in-my-health-care-is-more-vulnerable." And we saw this in San Francisco with retirees who said "yeah, we think the uninsured is a problem, but we don't want them in a city-purchased system because we're afraid that that will drive [up] costs and reduce benefits and that will in effect push us out." I think that we in this country need a notion that everybody can come in and that there are plenty of resources to do that, and there doesn't need to be a silent and invisible population such as the immigrant population.

The other thing that was really clear to me in the IOM discussions is that this ties really closely to INS policy. And certainly in the war on terrorism post 9-11, the INS policies are taking very draconian measures. I think it's really important that health policy advocates and analysts and wonks and researchers understand that we will not get to this immigrant issue in the insurance system if we do not pay attention to what's happening in INS policy. And that's a place that those 2 advocacy groups really need to come together. We have great civil rights organizations that are taking on the INS stuff together. But this issue is something that's going to get buried much deeper if the INS policies aren't something that we pay more attention to as people who care about health care and universal coverage. So that was my general reaction to it.

I also think that we cannot do incremental reform by just talking about children. It was really clear...there was a whole body of literature that was cited in I think the 5th report of the IOM. It was entitled *Families Matter*. And essentially the findings there are that even if kids are insured, if parents remain uninsured, children don't get access (preventative care and appropriate utilization of services) because you still have a parents-are-out-kids-are-in situation.

And despite this phenomenal data from HRSA—which I was just ecstatic to see your data on what health centers have done in closing disparities—the fact of the matter, we still know—and that was what the Healthy Families expansion was about—that if you don't cover parents, even if you cover kids, we have a badly fragmented family structure. And ultimately health care disparities don't get closed nearly as quickly as we know they can be otherwise.

So I think we need to stop what's comfortable, which is always talking about kids as what's important (as kids are and grandkids are, as Martin was talking about this morning). We have to start talking about the working poor adults, who are trying to make a living. Affordability really

We really don't talk about is the importance of educating communities of color in the political process about the importance of having everybody in the health care system... we in this country need a notion that everybody can come in and that there are plenty of resources to do that, and there doesn't need to be a silent and invisible population such as the immigrant population.

—DR. SANDRA HERNÁNDEZ

does matter. That's an important finding in all of this data in all of the counties. There is still a myth out there that even if you make it really affordable, low income families really don't want health insurance. That is clearly not true. There is an affordability hit, and when it is affordable, people will come in.

And the last point which wasn't in the paper, and I'm increasingly convinced we need to have it, is that we really need to have a social marketing campaign on the issue of affordability and insurance for those who are eligible for programs now and who are not enrolled. When we had application assisters for Healthy Families, we saw enrollment go up dramatically. As soon as we cut funding for application assistance, enrollment became tougher. I am convinced...I used to say at MRMIB meetings that if you think about health insurance costs in Healthy Families—what it costs to get eligible families into Healthy Families—it is about the cost of 3 Big Macs and 2 orders of fries a month. And if you think about the marketing machine that McDonalds has, and thinking about what we need to do in thinking about where you spend your next dollar—regardless of where you are in your income strata—we have a lot of work to do in social marketing, the notion that health care, and health insurance in particular, is going to close disparities more than any other avenue. And I think that's an area where the philanthropic sector can be of significant help.

I want to thank Bob, because really The [California] Endowment has done some subsidies of a lot of these projects across the state. It takes a lot of guts to do that because it's not clear where sustainability is going to come from. That's really important in the philanthropic sector, and yet we wouldn't have these local programs to show that kind of data if we didn't have that kind of leadership from people like you Bob. So I want to thank The Endowment in particular today.

**PATRICIA FORD**  
**Chair-Elect for the National Coalition**  
**on Black Civic Participation**

Let me give you a little bit of different background. And my take is a little bit different. Trust me, I had a lot of respect for you and the non-profit organizations before I switched over, which has only been a couple of months. After being on this other side, I have a great deal more respect for you and the work that you do. And how difficult it is with respect to convincing people and organizations who have resources about the necessity of the kind of work that you do, particularly in the health care field. But as I was listening to the speakers this morning, I thought back about almost 30 years and about what brought us together.

And in reading the white paper it brought back a lot of memories. If I remember correctly I think how I got to know Ralph and Sherry and later Jane was around Proposition 36. It was “No on Prop. 36.” And out of that campaign came the Vote Health coalition. And out of the Vote Health coalition, we all were thrown into leadership much quicker than we had anticipated. I became head of my local union, the Alameda Health Consortium grew, Floyd Huen became medical director of Highland Hospital and now the Medical Center of Alameda County and because of that community coalition and the work that we did, there came this issue of patient dumping.

I was born here in Oakland, California and never lived anywhere, not in Berkeley, Alameda, San Leandro, only in Oakland for 47 years before going to DC 8 years ago and I thought about how strange other people were in other states. Only to find that when I got in DC, how strange we were! But in a good way. Because we are blessed to have come up in a community that understands the necessity of coalitions. How that brought power in the patient dumping [issue], because of this coalition. We showed that patient dumping went across all economic barriers because those who had health care, whose children were in college, or did not have health care—they had to rely on the public hospital. And then they died en route to the public hospital.

We understand in the African American community about access to health care. Not just based on economics, but it's based on our ethnicity. —PATRICIA FORD

Because of the work of Ralph and Jane and Sherry and many of them there, this went on to be legislation that passed...

I want to talk a little about the significance of immigrants in access to health care, and also ethnic background. You know we understand in the African American community about access to health care. Not just based on economics, but it's based on our ethnicity. I have a great uncle, who during the Jim Crow days died of appendicitis. At 27, he left 3 kids and my great aunt. Because of his ethnicity, he was denied health care to the hospital. So we do have that experience as well, and you need to understand that we have that connection, and you have to—and I'm trying to say this in the right way, with respect with us in the African American community—you need to understand history.

We're very...we're not as informed as we should be, I should say, around immigrant rights. I know in SEIU, my major issue outside was social justice. And that's because I came from here and understanding the significance of that. We have to educate African Americans in, and I say African Americans—because, in the African American community, we consider immigrants [as one group], no matter what your ethnicity. You can be from Africa or the Caribbean—and there was this thing: ‘no, they think they're better than we are? So why should we be supportive of them?’ And you have to find that commonality.

And I remember an African American conference that we had, and insisting that they have a workshop on immigration. And you know, it only took once. And for every year since then, when the African American caucus gets together for their bi-annual conference, they have a workshop on immigration, once they got educated about it.

Coming out of SEIU, the Service Employees International Union...I was born and raised actually in SEIU. I spent my whole 31 years of struggle in the labor movement because of this, and I'm sure you know we've been on the forefront of health care and access for everybody. We've been on the forefront and have changed the attitude of organized labor with respect to immigrant rights. That was very important, that was SEIU.

I want to say to you that labor can have resources, and



From left to right: Ellen Zweban, Violet Lundberg, Martin Waukazoo.

Now for the African American community, we are now not going to be the largest minority anymore. That's a big change for us. But it will be still a struggling for justice. We know how this system works. We've had 400 years in this system. —PATRICIA FORD



Moanikeala Akaka

remember that we have to keep reminding ourselves of that, that we have certain resources. We don't have a lot of resources—people think that labor has a lot of money. Our members, particularly in SEIU are largely immigrant, low-wage workers. Fifty-six percent of them are women, low-wage workers, most of them women of color. So it's not like we have a lot of money, we have a lot of members that make us have a lot of money. We have the skills of organizing, mobilizing communities. We bring that to you. We have the skills of having resources in SEIU on issues of health care that should not be overlooked and should be partnered with, particularly on the national level. I wanted to offer that. I want to remind us that there will always be the forces out there who will always try to divide us. Nothing could be worse than to divide ourselves on health care.

Now for the African American community, we are now not going to be the largest minority anymore. That's a big change for us. But it will be still a struggling for justice. We know how this system works. We've had 400 years in this system. And having to say, 'now don't let this divide us, between our Asian and Latino brothers and sisters, they're not the issue.' The issue is not about ethnicity or race. And we need to make sure that we keep instilling that in our children and each generation. Because we should not assume that that will not happen again. There are still those forces out there that to stay in power, to stay in control, we have to be divided as a community. As one of the pies showed, one of the presentations—we have to keep reminding ourselves and referring to ourselves as a majority.

I was one of the original people on the Alameda Alliance for Health. And I was really proud when I read in the white paper, about your Alliance Family Care. And was a little disappointed when I read a little further that it was being cut back. And it shows just how much our struggle needs to happen. But it also shows just how much on point you are. And I'm going to share this information with people as I go across the country because I think that's the way we keep in the forefront. This white paper was very, very good.

And last but not least, I just want to take a little bit of

time to say a few things. One is, is that we're so blessed here to have the particular leadership of Ron Dellums, and in particular John George who was all of our mentors. He taught us—I'm getting teary-eyed—he taught us, the significance of working together. Alameda hasn't always been your friend. They tried to split us up—labor against the community. I remember being in the room with people from the [Alameda] Health Consortium and them telling us, "We're not going to let them do that, let's talk about what you have." And John brought all of us together. He taught us that we were put here to serve the community. I am just so thankful that we have that.

Now I did not stand for re-election, and this is my last comment, as the executive vice president of SEIU. I decided that my social justice program wasn't done, the political program that I'm working on in Washington, DC. And to bridge that gap. Because I think there's been some distance in the responsibility between organized labor to the social justice aspect of this program. Those members who are not being served are our members' children. It's for that reason that labor needs to pay attention to what goes on in the communities. I am hoping that in my new position as the chair of the coalition on National Black Civic Participation, that this is not just about Black folk, but about bridging that social justice community with the labor community. Because I have those experiences in educating the labor movement on their responsibility not only in health, but also with our children. Because when you think in terms of mental health and counseling and children, you have to think in terms of the juvenile system and how our children are involved there, and how our ethnicity and our culture plays into that, and how this country can think it's more important to incarcerate our children than to educate them. We cannot ignore *that* health care, because it is a form of health care, under the title of mental health. So thank you so much for inviting me back home, my family thanks you for inviting me back home, it is always a pleasure, and it is just so great to be among friends and old colleagues. It's nice to see you Ralph.

**TANYA BRODER, JD**  
**Staff Attorney and Policy Analyst of**  
**the National Immigration Law Center**

I appreciate the debate on access to care for everyone, and in particular for immigrants. I also appreciate the voice of labor that has really amplified in the last couple of years to look out for everyone who's working in this country and contributing dollars—yes! I want to put a special tribute out there, and I want to put out a pitch for the voice of health care providers and for health care workers in the debate on immigration today. There's no more sane voice and there's no more effective voice right now that could change the way we talk about public policy. In California, more than half of the low income families, more than half of the uninsured workers, most of us, we are a majority-minority, we are a different country. California is a different state.

There are immigrant families. There's no way to talk about public health policy without talking about immigrants and that means every immigrant. There's no way to talk about a family by saying, this is an undocumented family, this is a citizen over here. We live all together. Almost every family has a range, we have to stop segregating ourselves. Public health policy demands it. And when Dr. Hernandez talked about health care providers shaping immigration policy, it wasn't a stretch. I can't believe the kind of mountains that have been moved by this community here. Not just fighting back in the face of the largest budget deficit in the country, but we have preserved the programs that were developed and created here. Health care providers changed the "public charge" policy. And that was very much—thanks to the leadership here at La Clínica de la Raza and Asian Health Services—who noticed what was happening with their clients and made noise about it. People talked about, we heard even...INS changed its policy. From the immigration perspective, it was unprecedented in over a hundred years. And without that kind of clarification, it was thanks to you guys, and thanks to the people who you know about that made

change. Sadly, even that wonderful guidance even now continues to haunt families who hesitate even bringing their kids in. And not too long ago, we heard about a woman who didn't bring her child in who, as it turned out, had appendicitis. She was crying in the waiting room, saying she didn't know she could bring her kid in for health care. She was afraid. And her child who had had a bad stomachache died not long ago because of the INS policies and the fear they create.

We've made huge progress here. We've pushed back. We've got new programs, that provide gateways for immigrants regardless of status. The CHDP [Child Health and Disability Prevention Program] gateway is something we can build on, the breast and cervical cancer program, we've done a lot of things. We're not in the same place as we were 10 years ago with Prop 187, thanks to the alliances and labor and health care. And the composition of our legislature, certainly in California and elsewhere, has deepened the commitment to these programs and these communities.

But where are we now, post 9-11, fiscal crises? We're still playing defense in this game. So what do we have? We have our own representative Rorbacher who's trying to convert emergency room providers into immigration enforcement agents. We've got the Center for Medicaid and Medicare Services looking at policies for providers to ask individuals questions of their emergency patients about their immigration status.

Who's the sane voice in pushing back all of these policies? Guess. It's the health care providers. The CEO with the southern accent, of a Texas hospital who said not only does it make full public health sense to provide care regardless of status, they refused to ask these sorts of questions. But the people and their patients coming into their clinics are contributing billions of dollars. Their workers are contributing billions of dollars to our economy, getting very little in return.

Health care providers are in the position to make these kinds of statements boldly and without apology. And I really hope that we can work together to try and turn back...the press that was generated by health care providers



Dr. Alice Chen and Laura Hogan.

I can't believe the kind of mountains that have been moved by this community here. Not just fighting back in the face of the largest budget deficit in the country, but we have preserved the programs that were developed and created here. Health care providers changed the "public charge" policy.

—TANYABRODER



I wouldn't dignify the debate on immigrants of doing the costs and benefits, or the net benefits of immigrants. 'Are they putting more into the economy, or are they using more?' I mean, what population group have we done that to?

—NINEZ PONCE

and hospitals who refused to ask those types of questions and intimidate people and threatened their health, generated a little space. So now the Centers for Medicare and Medicaid Services are re-considering their policy, their proposed guidance on asking questions about people's immigration status. We have a breathing moment. And it's because of the voice of health care providers.

I'm hoping that as California re-organizes its health care systems and talks about streamlining and simplifying, we can find a way of incorporating immigrant families into these systems. As we do so, we have to be very careful about on the ground needs and experiences of immigrant families. Because people can easily get swept up. Systems that simplify might well ignore the needs of immigrant families. We're going to have to look carefully at those. We'll keep pushing for more federal funding, for Medicaid and CHIP, for immigrants who were cut out, and lay the political groundwork so we can look at full Medicaid restoration. We can't do that until we change the debate and the policies that have changed these scary policies.

I have one more pitch, and I hope we discuss it a little bit, on messaging. Because a lot of these proposals that are out there, by Rorbacher...I don't know if you guys know about the pro-English lawsuit that was filed to challenge the language access guidance that HHS promulgated. The doctors in that lawsuit, and I don't know who they were, the doctors who held that lawsuit talked about their first amendment rights...to what? To oppose language access policies. And to speak English because English is being "suppressed." English is being suppressed in this country! It's laughable on some levels. A lot of these lawsuits, like the one filed in LA, they get dismissed. A lot of the proposals like Rorbacher was defeated resoundingly—331 to 88. But the public message, the kind of media that's generated by these proposals sows the kind of fear in communities that we need to combat. It really does damage, even where it has no merit. That's where we have to turn the tide. I hope that we can all follow the leadership of the Alameda Alliance for Health and work together to change the debate and to move toward sustainable coverage for all kids and parents.

#### **NINEZ PONCE, PhD**

**Associate Professor at UCLA's Department of Health Services and Faculty Associate with the UCLA Center for Health Policy Research**

I have 4 items to talk about in terms of the white paper to which I'm responding. And they're generally under the topics of: (1) Where's the government? (2) Is it all about money? (3) What about our future? And I'm going to end with the rational actor model – common sense.

So where's the government? This white paper did talk about some of the delays and the lumberings of TANF, reauthorization of TANF, the delays in actually putting money in Healthy Families, expansion of parent coverage and I think that could be stronger. In the context of a few years ago when I first got hijacked into working with Community Voices (laughs) by Sherry, I talked to some colleagues that worked on access and [it seemed] "isn't this cool, tobacco money, private foundations" and I thought, well that's cobbling things, that's not really public policy. So it doesn't follow a traditional public finance view of traditional tax revenue sources in what society considers in are social justice causes or entitlements for example. So there was actually perhaps a fear a while back that if we continued in that "third way," to paraphrase somebody from offshore, is that it would then maybe lessen some of the role of the public sector, federal government as well as the state. But clearly that's what's been sustainable – this local effort, and this forged effort of private foundation support...not just private foundation support, but private sector. For example, Santa Clara county earmarked—not just in the general revenues—earmarked Prop 10 monies. The other distinguishing factor is that it was funneled to local communities. The authorization was at the local community level. So that was the difference. It wasn't just the state. So local communities actually had power and authority to decide what to do with it. So thank you to the Supervisors of Alameda County.

And of course the most important ingredient—and you're the ones who fill it here—is the local community networks and advocates. And so this power of community in health that we're seeing now that's been talked about. And so in the paper it talks about "these are the three ingredients" and I would venture to say that you need to be stronger about it, that of course these were necessary. But they're not sufficient. And what's really missing, and you allude to it towards the end, is that "Where is the government?" Definitely there should be this cobbling, this fabric, this quilt, as Assistant General Shekar said, but it's got to be more up front. So that's "Where's the government."

The second is: Is it all about money? And it probably...who thinks it's all about money? [LOOKS INTO THE AUDIENCE AND LAUGHS.] Just one person! Only one person thinks it's all about money...okay. First of all, I wouldn't dignify the debate on immigrants of doing the costs and/or

net benefits of immigrants. 'Are they putting more into the economy, or are they using more?' I mean, what population group have we done that to? Did we actually say, with Irish coming in, did they put in more than they use? So we've never really done that. We've never really done that in health care. With drug companies, are they really making more money? Are we subsidizing more? I don't think we should even dignify the debate of this cost-benefits of immigrants because in liberal and classical economics it's a wash, it's a transfer. So the employers get benefit, obviously they are benefiting. So the labor market is there. It's there. So it's a transfer.

I think the cost of the uninsured is still really important. So getting that right, getting the hands on that is right...there was a study that came out from the UCLA Center for Health Policy Research that estimated it to be about \$10 billion, the cost of the uninsured. Some say it might be less. So say \$5 to \$10 billion, the cost of the uninsured in California. And then, looking at the white paper I was just adding...and I'm an economist, not an accountant, so I round up a lot (my dad's an accountant. He accuses me of not balancing my checkbook). Because \$20 million was put in by [health plan] reserves, and then the Endowment, and then Prop 10 money. So say about \$25 million. And there's 58 counties in California. Now not all of them have immigrants. I think Alpine county doesn't have immigrants (laughs). So there's 58 counties, and let's say 45 counties [have immigrants]. So if you multiply \$25 million by 40 counties, that gets at \$1 billion. \$1 billion is still less than \$10 billion. If you want to be conservative, it's still less than \$5 billion. So cost of covering the uninsured, compared to costs of not covering them, it still seems to be—if it's all about saving money—it still seems to have a savings if you cover them. Ok so that's really quick.

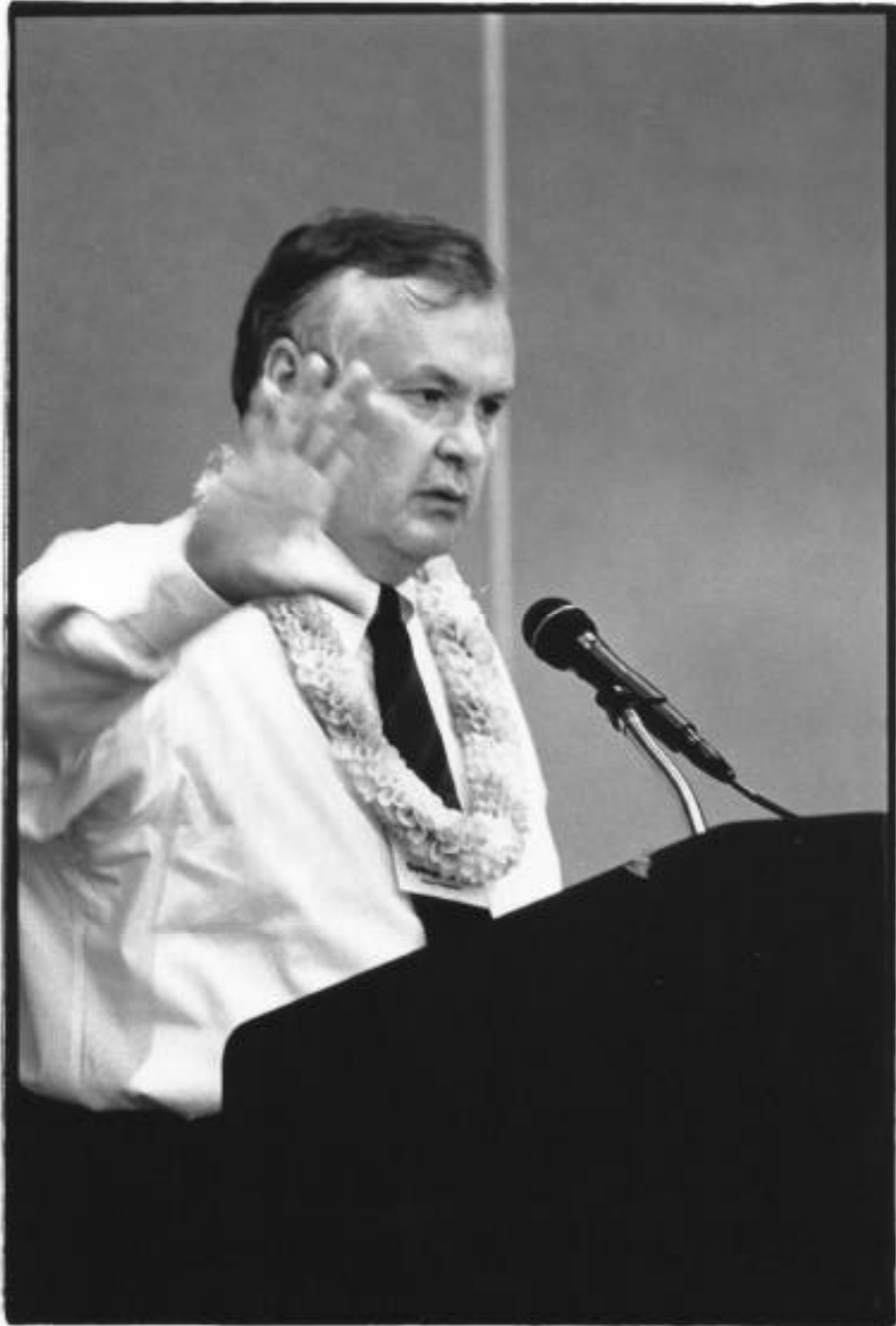
So point three: our future. So our future is now. And because we have a high discount rate here in America. So

our future here is...half the kids born here have a foreign-born mom, right? So that was close to 47% of kids who are in immigrant families. I think that what people don't know, and I got this from the Public Policy Institute of California is that 9 of the 10 new labor entrants in this economy are immigrants. And they came in the 1990s. They came early. So most of the people coming in are re-fueling, re-invigorating our economy. It's new immigrant labor. And why is that? It's so expensive here that most of the domestic labor that came here from the reservations, they came from the midwest and the south, they came during that late gold rush...economic opportunity. Well it got really too expensive and they left. So the domestic migration that filled these jobs, particularly low-wage jobs, left and went to the other states. And what filled it? International labor. So again, it's a transfer. It's a flow. Is it a net benefit? Should we even ask that question? I think it really depends on where you stand politically. So international migrants filled that. And also California is mostly an agricultural economy, people forget, and a service economy. So with those two, who fills that? Immigrants. And that's what makes California work. So something more of the labor market consequences should be put in the paper as well.

And last as my fourth point: the commonsense rational actor model in health economics. The role of personal health insurance—and this is Kenneth Arrow's contribution—it's to protect the individual from financial hardship or ruin, in case some unforeseen catastrophic cost happens. It's really not for everyday things. It's so that you make sure that with some unforeseen catastrophic thing happens, you are not ruined by it. And your family is not ruined by it. I posit that if public insurance, if we could see that it could protect the state from catastrophic ruin, which is sort of what we're facing right now, then it becomes less of a hurdle to convince legislators that this is the case. And again I bring back: \$1 billion, or \$5 or \$10 billion? ■

## KEYNOTE SPEAKER

*George C. Halvorson, Chairman and CEO, Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals*



Thank you. It's a great pleasure to be here. You do absolutely magnificent work. The difference you make in the communities you're in is absolutely essential to the health, to the happiness, and to the functioning to the thousands and tens of thousands and hundreds of thousands of people. Without you there would be a big hole in the fabric of health care in America. You, in some ways, have enviable jobs because when you go home, you know you've made a difference in people's lives and you've made a difference that wouldn't be there if it wasn't for your clinics. So I have immense respect for the community clinics, I have immense respect for what you do, and immense respect for the agenda that you have in front of you. And I also have a strong sense of what a challenge that agenda is bringing us. We're in an environment where there are 40 million uninsured Americans. And that is an embarrassing number. It's almost a criminal number. Because we spend so much on health care in this country, more than any other nation in the world by far, and to spend that much money and to have 40 million Americans uninsured, is a crime.

What makes me a little nervous, is that as we look into the future, it's hard to see the number of uninsured Americans going down, and as health care costs go up, and as more employers decide—and sometimes they have to do it to remain in business—but as more employers decide that they need to shift those costs somehow, they're putting in place \$500, \$1000, \$2000, \$3000 deductibles. And if you think about the impact of a \$3000 family deductible on a single mother with two kids who's working and has to make decisions about the care that her kids receive, that is the functional equivalent of being uninsured. We are in danger in this country of creating another 20 million underinsured Americans in addition to the 40 million uninsured Americans which will put more pressure on community clinics because a lot of those underinsured people will be looking for places to go for their care and the logical place for many of those in that population to go is to you.

Now I understand entirely that employers in many cases have to move in these directions. I would rather see somebody have a \$500 deductible, a \$1000 deductible, than no coverage at all. When you're looking at the tradeoffs, a lot of small employers are giving up coverage all together. And that's really bad. A lot of other ones are moving toward deductible plans rather than give plans altogether. That's better. The best alternative, for many, is increasingly unaffordable.

In one of the last books that I wrote, *Epidemic of Care*, one of the chapters talks about the things that can be done to deal with the uninsured. And basically, if you separate

Because we spend so much on health care in this country, more than any other nation in the world by far, to spend that much money and to have 40 million Americans uninsured is a crime.

the uninsured into the basic categories, there's this one subset of the uninsured that are basically very healthy and feel immortal and don't bother to get coverage. There's another set of people who are in transition, who are uninsured for a very short time, and they are going to be insured in the not very long time. There are other sets of people who are uninsured because they have medical conditions that don't let them get insurance in some states. And then there's a significant subset of the population who are uninsured because they don't have any coverage available to them from their employer, and a certain subset of that population is not going to be able to afford coverage even if it's subsidized coverage. Health care reform that relies on subsidized coverage is still going to be unaffordable for a sizable population, regardless. So one of the things that I wrote in the book was that we need to strengthen the safety net of this country relative to community clinics. We need to strengthen that safety net, and there's a certain segment of the population—if you're an undocumented, non-citizen, living in LA—a tax rebate plan is not going to make insurance affordable. There is a subset of the population for whom that is probably a very workable plan. That's a small number of people who have relatively high incomes who can afford to make those kind of payments. For most of the population—a big portion of the population—it's not a viable alternative.

I think our version of universal coverage probably ought to have at its core, a safety net that takes care of all people regardless of their insurance status, regardless of their immigration status, and basically creates a sense of entitlement to basic care for the population, these populations in these settings. So you're at the cutting edge of that, you're at the front lines, you're the people who are doing the heavy lifting, you're the people who are seeing those populations. And seeing those populations in ways that are extremely culturally competent. And the old standard used to be culturally sensitive. That's a good first step. Culturally sensitive gets you part way. Culturally competent gets you a long way. And to have clinics that focus, and to have care delivery sites that focus on particular populations, understanding the needs of those populations, the cultures of those populations, and the situations that that population finds itself in and that particular environment is critically important. Because if those kinds of avenues, and those kinds of access to care don't exist, and people are faced with going into a system that is hard to understand, hard to access, it creates a system that is unaffordable.

Part of the challenge is also to find a way to improve the population health management available through the community clinics. And that's an agenda [item] that needs

to be done by American medicine across the board. This country does an amazingly bad job of providing population health care. The recent RAND study...I don't know how many of you saw the study that just came out from the RAND Foundation a short while ago...but the recent RAND study showed that of all the diabetics in America, barely a third received adequate care. Of the patients who had a heart attack, barely half received adequate care. The system is expensive, but it's also inconsistent. It doesn't deliver all that it should deliver. It takes over 5 years by the time a medical procedure has been proven to be the best medical procedure until half the doctors in a given specialty use that procedure. Any other place in industry, you see a 6 month turn-a-round. Something new comes out, everybody studies it, everybody reverse-engineers their own process. There's a learning curve in the rest of industry that is extremely fast. And in health care, it is a very, very slow process. The Institute of Medicine talked about the fact that it takes 17 years for non-procedural best practices to become the norm in a given specialty. Now think about it. 17 years between the time that a piece of science is proven to be effective and people get it. So we need a system to disseminate information about best practice, current best care to the physicians in a medical exam room.

We need to get away from a paper medical record where there's a silo piece of information about each patient...you've got 5 doctors, 5 medical records at 5 different sites and they don't talk to each other. We need to move away from that to one where there is a single electronic medical record for each patient and all the information about each patient is there and that information is available to each patient and to the patient's doctor so that they can make the right decision about drugs and follow up care and so the physicians and caregivers after the fact can know whether or not the care was actually even followed up on. If you look at the cancellation rates, or the number of people who do not refill their prescriptions, those numbers tend to be very, very high. And if you're projecting working with a population, trying to manage the health of that population, you need to know that, you need to know which patients didn't fill their prescriptions, and make that part of the caregiving process. And physicians in an information dependent profession where best practice, best science depends on information about the patient and their care, physicians are too often operating in a void.

Kaiser Permanente has made a huge commitment to

If you're looking to make a difference on the health care costs, really identify the people who are migrating into that very high risk category and do an intervention to keep them from getting there.

go forward and work on an automated medical record that has medical best practices imbedded in it. One of the things that we're looking at doing is creating some pilot programs to extend that model to community clinics. So we're going to be talking to some community clinics about setting up some pilots. Because a community clinic population would benefit immensely from that kind of a tool. And I think they would benefit from that kind of a tool, because people are on Medi-Cal, on Medicaid, off Medicaid. The patient moves in and out of an electronic...or record-keeping system. And longitudinal data that would follow the person forward, regardless of their current insurance status will be a lot of use to the caregiver, and will be a lot of use to improving the care of the patient. So we know we need to do it in our own clinics and our own care setting, and we need to extend it and figure out the best ways it can be extended into community clinic environments. [APPLAUSE.] So we'll be working with you...

As I look forward to where we're going in this country on health care, it's absolutely impossible to predict what's going to happen in Washington relative to health care policy. I don't think it's very likely that if either party wins, we're going to end up with a coherent health care policy. I think the tasks involved in creating a coherent health care policy exceed the potential of our political system at this point and time. So if we're not going to have a coherent health care policy, we're going to end up with a health care budget... What I'm really worried about is that we're going into a time of increased deficit, increasing pressure in Congress. We're going to end up with the government deciding to do more cost-shifting, and less subsidy of some of the critical programs that we need to have. So I think we're going to have to work together to keep the funding flow as healthy and strong as we can out of Washington as well. I think there needs to be a very aggressive agenda reminding all the members of Congress and working with our labor partners to keep that agenda in front of members of Congress at all times. But members of Congress of all parties need to understand and appreciate how essential it is that we have the kind of infrastructure and support system in place to support the populations that we have in this country who so desperately need that care: the people who are uninsured, the people who are underinsured, and the people who are insured and need a care setting that is sensitive to their particular culture and particular needs, the particular language needs. I think we need to do that on an ongoing, constant, never-stopping sort of basis. So we're not going to have a coasting time, but I think the pressures on all of us are going to get worse before they get better. So I know that's on your agenda already and you're talking about that but I would just strongly, strongly encourage that that go to the top of the priority list. Because as I'm talking to people in Washington, and I talked to someone this morning, they're all saying, 'We have to cut this budget, we have to cut these expenses, we have to cut back on

We need to move away from [the paper medical record] to one where there is a single electronic medical record for each patient and all the information about each patient is there and that information is available to each patient and to the patient's doctor...



George Halvorson, Yvette Radford, and Alameda County Supervisor Alice Lai-Bitker.

the amount of money that's going out.' The days of the surplus and trying to figure out what to do with the surplus are over. What we have is a very large deficit. And the likelihood of getting good support for these programs, unless we work really hard to get them, is pretty low. So on that happy note I'll end and open for questions. [LAUGHS.] Are there questions?

AUDIENCE QUESTION: *I'm just thinking that neither party is really going to bring reform. What are some of the ways you think reform will happen in this country?*

HALVORSON: Right now, I think neither party will bring reform, just because I haven't heard anyone with a clear, overall agenda for reform. President Bush is talking about health savings accounts as his number one...you know every time he gives a talk he talks health savings accounts. Health savings accounts are a good model if you're making good income, and you've got enough money to set aside in the health savings account and then you've got catastrophic coverage, and you have front end cash flow. A health savings account, if you don't have enough money to create a health savings account, is just a \$1000 deductible with no front end coverage. Senator Kerry on the other hand, is talking about a catastrophic, back-end risk pool sharing model.

When you look at where health costs are, 1% of the people are almost 30% of the cost; 5% of the people are almost 70% of the cost. There's a very disproportionate sharing of cost. 20% of the people are 0% of costs in any given year. 70% are only 10% of the cost. There's a very steep curve on the cost side.

And if you're looking to make a difference on the health care costs, it's to really identify the people who are migrating into that very high risk category and do an intervention to keep them from getting there. So if they have a first heart attack, you stop them from having a second heart attack. If they haven't had the first attack, you stop it. If they're diabetics, you have an intervention that prevents the complication of diabetes. There's a great opportunity there.

And that opportunity by the way is very much supported by the electronic medical record because it helps to identify who those people are and where the high leverage interventions are. So that's kind of the opportunity: to have best practice, best care, best intervention, to stop people from getting to that category. And then, when people do get to that category, then do what works. So use the stints that work and do the technology. This country doesn't do a good job in figuring out what technology works best. And so we have a lot of very expensive technology happening that's not always in the best interest of the patient. And then we've got a lot of people migrating into those high risk categories. So there is an opportunity there. If you look at it analytically, there's a couple of opportunities. I think the catastrophic – the reason I mention that – I think just having a purely catastrophic pool over there will just take everybody off the hook on the high cost care, and that's where all the dollars are so if you just shift all the dollars into that high cost pool, and then give everybody a free pass on the use of that money, I think the system isn't going to reform itself that much.

I'm actually more fond of one candidate than the other but I'm not that fond of either agenda at that level. But I think the second part of the question is that when there's an increasing number of underinsured Americans, I think when a lot of people have very high deductibles and they're paying out of pocket for all of the care, and discover that an office visit costs \$90, not a \$15 co-pay, and the prescription drugs cost \$80 and not a \$10 co-pay, I think people are going to have a whole different level of both enlightenment and energy about health care costs, and I think that's going to translate into having a more actionable and political agenda in the future, and I think the result of that will be by the next presidential election, people are going to be forced to come up with practical plans. And I think there's going to be a lot more energy in that direction. So I think we're more likely in the out years to see an agenda. And I think our leaders won't get us there until our followers demand it. And I think people will start to see something. But right now, people are unhappy, but not demanding.

SHERRY HIROTA: *George, when you came out in the San Francisco Chronicle interview and said that there is enough money in the system to have universal coverage, and that should include immigrants, and that could include immigrants, that resonated with communities, underserved communities, poor communities throughout the country. There is a need for political will, and your leadership and vision helps give us that inspiration. We are 3,500 community clinic sites throughout the country, all of which are representing communities that are willing to be that voice and connect up with you. How can we make that partnership for a better public policy stronger?*

GEORGE HALVORSON: That's a wonderful thought. I don't have an immediate answer but I'll think about it because the fact that the community clinics are in city after city, site after site, and have constituencies that are very committed and supported, I think if we can come up with a reasonable agenda, a reasonable recommendation, it could create great leverage to get it in front of people that it needs to be in front of. So I think that's a very good idea.

The specifics of the plan – I don't know what that would be right now. But I do know that a plan that creates subsidized coverage...one of the things that we worked on where we were trying to get the state [Minnesota] to a high level of insured. And we managed to drop the level of uninsured from about 11% to less than 6%, the lowest in the country. Hawai'i was number one when we started the process, and Hawai'i was number two when we finished the process, partly because Hawai'i has had some slips actually.

What we did there is we created a mandated issue, guaranteed coverage for low income people and we subsidized it. And by subsidizing it we made it affordable. So it was a sliding scale subsidy. And people could take a voucher and they could go anywhere they wanted to go in the system. They could go to a community clinic and they would take the voucher, they could go to a health plan and the health plan would take the voucher, and so Minnesota created a subsidized voucher for low-income working people in addition to making sure all the kids who were eligible were covered under Minnesota care, and basically worked out a program that extended coverage.

And frankly, if California could afford it, that would be a marvelous program for California. Because there's a lot of people who really want coverage, and as health care costs go up, they want it even more and it's unaffordable. But if there's a subsidy...but then subsidies require a source of revenue...what we did in Minnesota for revenue is basically create an internal tax on health care. And what I said earlier about there's enough money in the system...we took some of the money out of the system by creating an internal tax on health care and apply that to the uninsured. So we basically subsidized health care from health care by recirculating the money. And one of the reasons we did that is that we didn't want health care to compete with roads

and streets and schools and all of the other things that it would otherwise compete with. We wanted a dedicated stream of revenue that would make care affordable for that population. Because the minute you get into fighting about how much the money goes here, the money goes there, the programs tend to get underfunded. And California has some great programs that are underfunded. Eligibility is capped, you can't get into the program. And the reason for the capping is that those funds have to compete with roads and streets and whatever. So I think there's a model. And that model could be done, that model combined with strong support for community clinics and creating a guaranteed availability of care for people in those communities could be a good model, I think it would work.

AUDIENCE QUESTION (FROM MOANIKEALA AKAKA): *I'm from Hawai'i, and the fact that these clinics started from Civil Rights movements...don't you think that we may have go back to those tactics, if necessary, to ensure that all of our people get the adequate medical care that we need? As the economic situation gets more and more dire, its going to be unfortunately more pressure that gets put on the immigrants as well as all poor people. So that's why there's even more reason why we have to work together. As she said, we have so many of our health clinics, but we also have our websites and the internet which makes it that we can be closer to one another as far as standing up and being counted is necessary. As I said yesterday, in a civilized society, people have adequate medical care. And yet this, one of the richest countries in the world, it's getting worse and worse, and we know it will get worse. What with 42 million people with no health care, it's only going to get worse, so it means we all have to stand up and be counted, and work together in order to get our constituents the health that they need. Mahalo. [APPLAUSE.]*

GEORGE HALVORSON: That internet point is a very good one. One of the things that could be done with this entire group—it would take an annual convention to maybe link people, or maybe a newsletter. But the opportunity to have a network of kindred spirits linked through the internet, getting information, getting activities together, coordinating promotions and various kinds of communications in a national way. I think there's great potential for that. I think Dean's presidential campaign created an electoral synergy for quite a long time using the internet to create the connectivity for a lot of people going in. It came out bad alternatively, because of the internet. Because of the news media.

ELLEN FRIEDMAN: *I'd like to make a personal plug because that already exists online. [www.communityclinics.org](http://www.communityclinics.org) is an online community of all the community clinics here in California. It's open to any community clinic throughout the country and it has discussions about these kinds of issues, public policy issues and people sharing information, questions that people have. So I would like to just offer that up to anybody who would be interested. ■*

## COMMUNITY HEALTH CENTERS ON THE LEADING EDGE



From left to right: Dr. Warren Taylor with Dr. Ahmed Calvo, Ellen Friedman.

**Raymond J. Baxter, PhD**

Senior Vice President of Community Benefit  
Kaiser Permanente

**Ralph Silber, MPH**

Executive Director of the Alameda Health Consortium  
and CEO of the Community Health Center Network

**Ahmed Calvo, MD, MPH, FAAFP**

Chief of the Clinical Quality Improvement Branch,  
Division of Clinical Quality, Bureau of Primary Health  
Care, Health Resources and Services Administration

**Warren Taylor, MD**

Northern California Region's Medical Director for  
Chronic Conditions Management, Kaiser Permanente

**Ellen Friedman, MBA**

Vice President of the Tides Foundation and Managing  
Director of the Community Clinics Initiative

**RAYMOND J. BAXTER, PhD**

**Senior Vice President of Community  
Benefit of Kaiser Permanente**

George loves policy if you even guessed that. So when you all started asking questions, about changing national health policy, he got so wrapped up in that that he forgot to talk about funding, which is the other side he was going to talk about. And what George had wanted to announce and what he asked me to announce now, is that in addition to the things he talked about, as a tangible representation of the community we have to working with the community clinics...since we are in Oakland, this is our hometown, our headquarters, that we are going to make a contribution of a million dollars to the Alameda Health Consortium to help address access needs. [APPLAUSE!!!!] Community Benefits at Kaiser Permanente is viewed as part of our mission to build healthy communities, not as a side business, but core to who we are. I better stop right here. I want you to understand this is a deep measure of respect for the work that all of you do here and we want to do something. This is money that we expect to go for access and direct services for the uninsured in this county and recent immigrants and we know that you will use it wisely so we'll be meeting with you to work out the details of how that can be used here. Thank you all very much.



**RALPH SILBER, MPH**

**Executive Director of the Alameda Health Consortium  
and CEO of the Community Health Center Network**

I'm not exactly sure how to follow that. Thank you. I say that from the bottom of my heart and I say thank you to Kaiser. We've been working with Kaiser for many, many years and it illustrates the similarities between the organizations. We're both non-profits and health care systems dedicated to improving the health of our communities, not just delivering medical services. So I really, really appreciate that kind of investment and I take it that in the spirit of the conversation in the last day and a half that it's really about the community clinics being a political and social movement as well as a health care delivery system and re-committing ourselves in light of that kind of investment, both to providing absolutely positively the best health care we can and equally importantly being part of the role of improving the overall health and well-being of the communities we serve and giving them the best ideals of our country of democracy and social justice. So we take that investment with a great sense of responsibility and humility.

The session that we're going to do I think flows really nicely from that. It's called "Community Clinics on the Cutting Edge" and as you've heard, starting with Dr. Shekar this morning, I think we're now in a position to have incredible proof both quantitative and qualitative that community health centers in California and around the country are actually providing maybe the highest quality care in the United States. And I think that the investment that the federal government, the foundations and that the people in our communities have made in our institutions give us the ability to work on what are incredible problems in our communities. I think everyone knows what the statistics are about diabetes, about heart disease that affects the communities that we serve. And I think today's panel is about how we can use the institutions that we have to address those problems.

For those of you who know anything about diabetes (which I've learned in the last few years) HbA1c is the basic blood test that's given for patients who have diabetes as a way of helping to manage their condition. On this graph (see fig. 14) at the bottom are the seven clinics that are members of our Community Health Center Network. And the HEDIS data, as those of you know, is a national database for HMOs. Eighty percent of diabetics in a national HMO sample had the HbA1c test, which is the basic tool for managing diabetes.

As you can see, I'm incredibly proud to say that our health centers had an average of 91%, fully 11% higher than the HMO average. The national average is actually an embarrassing 24%. So in spite of the fact as you all know that 91% of all of our patients are poor, about 75% of our patients are from communities of color and many of them don't speak English, many of them face enormous barriers

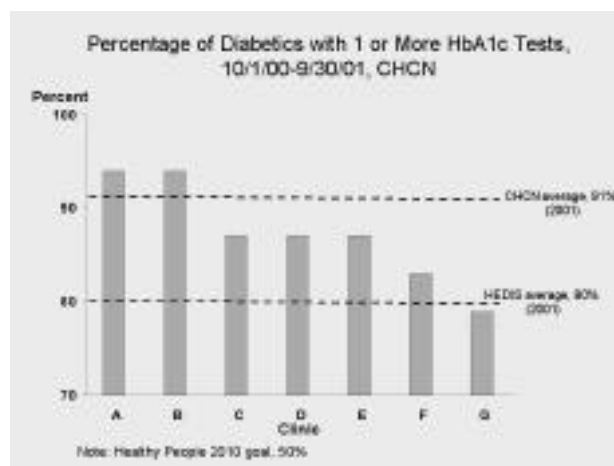


Fig. 14

I am incredibly proud to say that our health centers had an average of 91% [of patients tested for diabetes], fully 11% higher than the HMO average. —RALPH SILBER

not only to getting medical care but to taking care of the their health problems. I'm incredibly proud to share with you today these kinds of results.

All of the patients/communities of color in our system had this test at a rate in the 80s and 90s which is as I've said well above the national average. Very interestingly, all of our patients of color were more likely to get this test than our Caucasian patients were. And for those of you who know a little about statistics and the multivariate analysis, race and ethnicity was not a statistically significant factor in whether or not someone got this test. So in a nation where we now have voluminous research that says that people of color are less likely to get the health care they need even if they're insured, we had this incredibly startling result that in our system, race and ethnicity (as is should be in any just society) was not a factor in whether people got the test. Similarly, you have the interesting result when you look at insurance status, that our Medi-Cal and uninsured patients were in fact more likely to get the test than our commercial patients. And again in the multivariate analysis, insurance status was not a statistically significant factor. So for most of us in the room who have dedicated our lives to having a health care system that looks like this, at least in our health centers here in Alameda County, for our health centers, for diabetes, we can now prove that we have accomplished what we have set out to do and what most of us have dedicated our lives to. [APPLAUSE.]

**AHMED CALVO, MD, MPH, FFAFP**  
**Chief of the Clinical Quality Improvement Branch,**  
**Division of Clinical Quality, Bureau of Primary Health**  
**Care, Health Resources and Services Administration**

Well thank you very much for the invitation and the opportunity to participate today. Let me talk a little bit about what's going on with the Health Disparities Collaboratives, the first Health Disparities Collaboratives trying to bring this to concrete examples and practicalities. I subtitled this "Access Quality and Innovation at the Community Health Centers" because I think that's really what's coming together through this process. We have so much data in the Collaboratives that I can overwhelm any of you with sheer amount. And it's an important concept. Because we now have a full-blown, evidenced-based process. Just like I want to congratulate in regards to the article in diabetes just shared. We now have a similar process that over and over again are now being replicated with regard to different diseases and different processes. It's a critical point that we consider when I try to answer the questions that were posed to me as to what is happening at the community health centers and why they're on the leading edge.

There are 15 conditions as Sam referred to earlier that account for the 56% of the 200 billion rise in health care spending. As Sam mentioned, the Collaboratives address the first five point-blank from the point of view of cost and the importance of addressing those particular areas. In terms of looking at the health centers in particular, it's basically a rise in diagnoses by numbers by HRSA so we have clearly hypertension, diabetes and mental health to be concerned with at the local communities, not just from the general perspective of cost issues.

Therefore the Collaboratives are very important, because they have addressed diabetes, depression, cardiovascular, asthma, AIDS, as the disease – specific Collaboratives and then pilot Collaboratives with regards

to diabetes prevention, general prevention, cancer screening, the finance and redesign, and perinatal patient safety that's about to launch, starts December. We're now in the midst of converging the results and learning from all these Collaboratives into an integrated process. The reason is I can't see health centers throughout the country doing in 20 different Collaboratives having to populate the data registry of 20 different needs. So we need to go toward a single point of entry and make it...we have to consider what it feels like at the front office, at the back office staff level as well as each of the clinicians. So we need to clearly understand that and that's been a hot topic of discussion at least since I got there in the last few weeks.

Frequent questions that I get asked are: what are the HRSA Health Disparities Collaboratives? What is the model for improvement and how will it help us to make progress at HRSA? What makes the HRSA Health Disparities Collaboratives such an important opportunity? The Collaboratives (see fig. 15) is basically a full-court-press to facilitate transformation in the performance of organizations, based on what already works. In particular, it's designed to define, document, and disseminate good ideas, accelerate, improve results and build a clinical...true clinical leaders for change.

The Collaborative basically works as follows: a topic is selected, a planning group gets evolved, we bring experts from all over the country with regards to that particular disease. A separate process is developed to figure out which participant health centers will in fact be a part of that collaborative. The change concept is identified by the planning group.

They come together in what's called "learning session 1." They go sequentially through various learning sessions, and in between, there's an action period which is known as a PDSA action cycle. So the "Plan, Do, Study, Act" process is taught to the teams. The teams are sent in from all the health centers that are chosen for that particular cycle of



A question from G.G. Greenhouse (left); Mildred Thompson (right).

Our process includes transparency as a routine way of doing business at all levels of the Collaboratives, staying evidenced-based, and strengthening CQI as well as risk-management. —AHMED CALVO

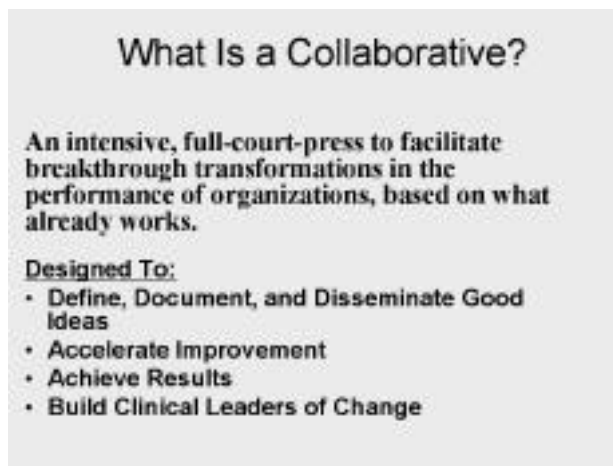


Fig. 15.



Fig. 16

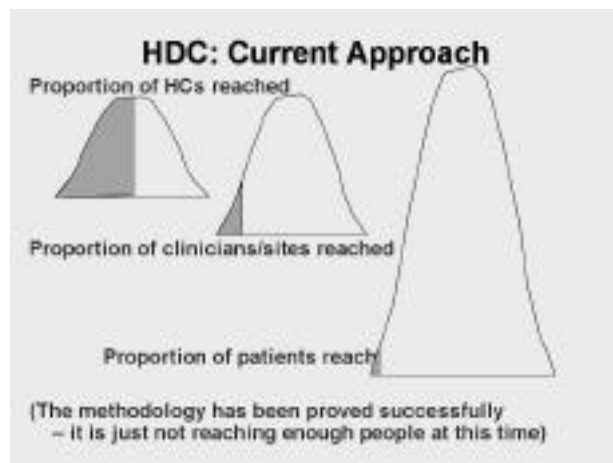


Fig. 17

the Collaborative and they come in from all over the country. This is organized through 5 clusters, 5 lead PCAs [Primary Care Associations] are engaged with HRSA with regards to coordination of this apparatus, which requires quite a bit of coordination. The bottom line though is that it has to address the local needs of the health center in terms of senior engagement of the management of the health center. A champion, on the clinical side of the health center has to be sent as part of the team and you go through a series of activities including conference calls, site visits, website support. All that stuff that was addressed earlier as being needed, we actually already have in the National Health Disparities Collaboratives.

Summary of results. Major sustained increases in process measure. Breakthrough increases in outcome measures. Almost all the teams know how to test and improve and are sharing with each other. That's a critical piece of the whole process. We know a lot more about high leverage changes that actually get results.

An abundance of knowledge has come out of this. Best practices are evolving continuously, teams are learning from each other in a real time basis. There is a synergistic flow of ideas, which is accelerating change at the local level and nationally. Teams are able to implement changes based on fact and not chance or guess, and they're cross-pollinating back-and-forth with each other constantly and therefore we have plenty to share and much more to learn.

The overarching strategy for this system-wide improvement process is an unrelenting focus on change, improvement, and results. In other words: we want real data. We want to stay evidenced-based. For that, the entire apparatus adds up to a quality improvement process, and in particular, part of the solution.

A bit of history is worthwhile here, namely that IHI, the Institute for Healthcare Improvement in Boston, started a process which engaged the Mayo clinic and other private clinics back in 1998. And they added 5 health centers because they felt that the health centers were already used to reporting and having an apparatus to monitor themselves. And in fact, they turned out to have wonderful, excellent results that's led to the fact that we have 497 health centers in the current process.

We've learned basically that the Collaboratives generate results faster, and they can generate results that improve primary and preventive care. And in particular can be accelerated by using state-based and national apparatus of infrastructure, including IT, leadership and other partnerships.

It used the Institute of Medicine *Quality [Crossing the Quality Chasm]* report's 6 aims of quality care: safe, effective, timely, efficient, family centered, and equitable delivery of care. It's created a tremendous amount of partnerships, and that's true within the different agencies at the [U.S. Dept. of] Health and Human services, as well as other foundations and local organizations and all the clinical net-

works, the migrant networks, the homeless networks, etc.

We use the planned care model, which basically focuses on the patient self care management, evidenced-based decision support, clinical based patient systems which frankly required that the whole project evolved a patient registry system IT component as well. Delivery system for patient and family goals, and dealing with the organizations for quality and all these community partnerships needed to be evolved simultaneously.

So what does it mean? A health center joins a Collaborative with a commitment to improve quality of care, a commitment to system change, to share information, and a shared national measure. In other words, the health center commits to opening up its process and not isolating itself. It's the critical piece of this whole set of activities.

That's what's happened systematically with 5 health centers back in '99—we systematically added more health centers, and more complexity by adding new diseases to each Collaborative (see fig. 16). We needed to do specific diseases first to designate the forms and tools to do this. But it was never meant to have this “diabetes collaborative only” or “cardiovascular collaborative only” or “cancer screening collaborative” only. We need to —and I'm moving now to our integrative analysis— move towards our next step.

Why are they unique?

Bottom line is that there's a 4-pronged strategy. It addresses senior leadership at the health centers. The CEO, the board members, have to be engaged in the process. It's one of the critical strengths of the health centers. 51% of the board has to be local.

The system implements a 3 way change of model — plan care learn model. I'll go over this at NACHC meeting a lot more in detail. Changes, practices and quality improvement and those partnerships are part of the outcome. We end up with a health center with national recognition for innovation, able to implement new clinical research very quickly, very effectively. Through our Diabetes Prevention Collaborative, we were able to take that 17-year Institute of Medicine finding and provide new base of expectations and apply it within a year. We can do it within the Collaboratives nationally, at the health centers in less than a year because of how they are set up to do this.

On a practical basis, what does it mean? It means a commitment by the leadership of the health center to use nationally accepted measures, and to be data-driven in it's CQI [Continuous Quality Improvement] operations and reporting structure, agree to core measures, agree to statis-

tically and evidenced-based approach. It uses a particular set of structure, which I won't go into detail here, but it basically boils down to a national apparatus, and a local apparatus via personal and IT-type communications.

Our process includes transparency as a routine way of doing business at all levels of the Collaboratives, staying evidenced-based, and strengthening CQI as well as risk-management. For example, the division of clinical quality, which I'm part of, basically deals with all the FDCA [Food, Drug and Cosmetic Act] coverage, all the issues around risk-management as well and that's why they all go together. Because we have on the one side the advancement of the quality improvement side of the grant, and then making sure that we don't have any loose ends.

We have strengthened federal partnerships. And evolved relationships with foundations and national experts, in particular process improvement such as IHI [Institute for Healthcare Improvement] and NICHQ

[National Initiative for Children's Healthcare Quality], as well as with [people with] disease expertise which I mentioned to you earlier. In particular, it's achieved a transformation within the nation's delivery system. That have been able to document this, not just for our clinicians and staff at the sites, but actually nationally and external to us. Particularly it's demonstrated the delivery of quality service. It's now an area that needs to be critically ana-

lyzed with regards to this one point of entry and being much more user friendly. I think the answer to that has to involve 21st century technology.

We've essentially created a learning change (see fig. 17). That despite only half the health centers going through and sending a team. This is our current situation: 50% of the health centers have gone through, a much smaller percentage of clinicians have been exposed, and much tinier percentage of patients have been addressed. We have a long way to go. Imagine if we were at 100%. We intend to in fact, reach every health center, every provider, and every patient. That is in fact what Dr. Duke said last week at the Health Disparities Collaborative, and I believe she might even repeat that at the NACHC meeting in the next few days.

We're getting very important attention from everyone else outside. Critical that it be able to be analyzed from the outside, including the Robert Wood Johnson Foundation and other agencies. I believe that this has created an apparatus that has been working on the national and local bases, and I will be happy to answer any questions in the future. Thank you very much for the opportunity to talk.

Best practices are evolving continuously, teams are learning from each other in a real time basis. There is a synergistic flow of ideas, which is accelerating change at the local level and nationally. —AHMED CALVO

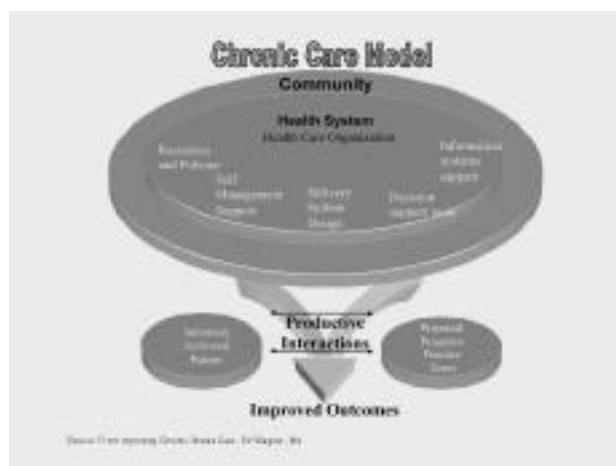


Fig. 18

Successful Transfer of Practices in KP  
Key Findings – Care Experience Council

There is a greater likelihood of successfully transferring a practice when:

Challenge	<ul style="list-style-type: none"> <li>Practice addressed a compelling problem and was aligned with regional and/or department goals</li> </ul>
Source Champion	<ul style="list-style-type: none"> <li>Recipient team visited source</li> <li>Willing to help throughout transfer</li> <li>High level of trust in source champion</li> </ul>
Lead Implementer	<ul style="list-style-type: none"> <li>Convinced of value of practice early on</li> <li>Perceived evidence of improvement at source site</li> </ul>
Management	<ul style="list-style-type: none"> <li>Provided behind the scenes support with logistics, systems, and removing barriers</li> </ul>
Implementation	<ul style="list-style-type: none"> <li>Strong physician champion</li> <li>Formed a steering committee</li> <li>Involvement of multiple stakeholders</li> </ul>

Fig. 19

## WARREN TAYLOR, MD

### Northern California Region's Medical Director for Chronic Conditions Management, Kaiser Permanente

Here's the problem. Everyone's aware of it in the United States and I don't need to articulate it for you but I think the bottom one is that: how do we create delivery systems in health care that really are sustainable businesses, that can adapt to the health care system today? Because quite frankly, Kaiser is only 2% of the health system in the United States. Not everyone's going to look like Kaiser. You in the community are a much larger portion of it but you're also not the only ones. So we're going to have to think very openly about how we engage the rest of the community outside of community clinics and outside of KP in the long run. And how we're going to create something that's going to give us something more predictable, and probably lower increases in health care costs if we're going to be able to sustain this over time.

So how are we alike? We're both engaged in the public health model. What's interesting is that when you hear Mr. Halvorson talk, you hear Robbie Pearl talk (who's our CEO) [of The Permanente Medical Group, TPMG], you hear most of the people in Kaiser – they talk just like a bunch of public health people. It's like you went to a community clinic or something. And I am a family physician. And I actually trained at UCSD. But we won't go there.

To make the story short, I think we do all share the same principles – that this is all about how we improve the health care of our nation. And I think that we all believe in prevention, the chronic condition management, and all those items that we all hold dear to our hearts. We also believe in integration, of using team approaches. It's not just about doctors, it's not just about patients, it's about that shared responsibility about how do you improve the health

care of our communities. What you're seeing in the disease management industry is a carve out. If you talk to a disease management company right now they want to ignore doctors and actually the health care professionals almost completely, because they can't get anywhere with them in the current fee-for-service systems. So again that's not really our vision and I don't think it's your vision either. The other thing I think is important is that we're all trying to do what's right for the whole population, not just the people who can afford health care. And again it's about diversity, it's about cultural competence. And in order to actually achieve the kinds of outcomes we envision, it does require us to take these things into account, not only in Kaiser, but obviously in the whole community and the whole nation. So again, I think we're all in the same line there.

We want patient-centered care. Interestingly enough, if you look at my organization, TPMG, the physician group, we're still very much a physician-centered organization. We talk about patient centered care. We have probably the leading expert on patient centered care, David Sobel, who's been talking about it for nearly 20 years. We're not quite there yet. But I think hand in hand with you, we're going to get there and we're going to develop the kinds of systems that really achieve that in the long run. We all share the "chronic care model" which is now called the "planned care model" but I still use the chronic care model moniker.

But to make a long story short, you're doing the same thing we're doing in terms of the Collaborative. There's really not much difference. We also know that we all share community resources. And I think this was pointed out previously. There are a lot of community resources. And if we ever get them coordinated and we use them in a coordinated manner we can do tremendous things in our communities. And last but not least I always like to remind the community that you are an integrated health care system.

Despite the fact that you don't feel that way as a community clinic, there are community hospitals, there are community clinics, there's actually all kinds of community services and when you think about it, most of what you're doing is publicly funded. So in a sense you are an integrated health care system, it just doesn't act like it. We at Kaiser have the advantage of actually being an integrated health care system although we don't often act like an integrated system either. But we have the advantage of actually being designed to be that way. So we can help each other in this process. Chronic care model you're all familiar with (see fig. 18).

First of all, sponsorship. You need something in terms of resources. It may be nothing but time, but again you need something there in terms of commitment and again infrastructure. Which is becoming clearer and clearer and it's really IT tools in many respects that you need more than anything else.

And I made this point before in some community clinics. What's the difference between complicated systems, and complex systems? And I'll give you the family practice, simple idiot's version. Complicated is when you build a rocket. It's very complex and it requires you to know a lot about math and this sort of thing. But the interesting thing about building a rocket—you can build it the same way each time, and it will turn out the same way generally. Complex systems are like raising children. You can do it the same way each time, and they will turn out completely differently—okay? So what we're doing here is raising children. Health care is raising children, not building rockets. And once we understand that in change management and you get that concept in your head—for family physicians you've got to be real basic, I'll tell you. And I have 2 kids, one teenager. I get it—it's complex.

We've also learned that there's some real basic implementation transfer kind of strategies that you all have to realize. And I think you already know this if you've done any type of implementation. This came out of the experience of the Care Experience Council—trying to transfer

best practices between centers. The first thing is: people have to perceive that the thing you're trying to change, that's it's really a challenge, that it's really important to them. If you go into a community and you say, gee we have a problem here and no one sees it as a problem, we're not going to get very far. That's the first thing (see fig. 19).

The second thing is that you have to have a champion on who's interested or has the passion around doing this. In addition you need someone who knows something about it who can share this with the other champions. So a lead implementer is very important. Then you have to have somebody in management behind you. What we found at Kaiser Permanente is that the only way you get anything done is that you have a clinical leader whose got the passion and the clinical expertise but they don't get much done. They can waive their hands and talk a lot about things. You've got to have manager connected to them. And when you have a good manager, and a good clinical leader, it's amazing what you can do in our organization. It's that dyad that's really important and I think you'll find the same thing to be true in what you do in community clinics. In addition, you need the sponsorship from your leadership.

And last thing is that when you do implementation, the most important thing is what we call "bus tickets." Get people together who know what they're doing. So if you have someone who's really interested in doing it—connected with sponsorship and a leader—have them talk with someone or meet with someone who's already done it. And that's a very important piece about the network. Interestingly enough, that networking can take place over the web, over the phone, or in person. It's awful nice to get together in person, but all of us want to go to Hawaii, but not necessarily Cleveland. So you got to keep that in mind.

So what else have we learned? A lot of these things we've already talked about, but I think it's really important in setting up incentives. We've found, in particularly with money, a two for one sale is a really big deal in our organization.



Dr. Warren Taylor and Dr. Sue Chan

Kaiser is one of the big gorillas in the room. But the other big gorilla in the room is the community clinics... If you can imagine, if we were all working the same way, on the same kind of systems doing the same kind of things, how that would drive health care in the state of California and I think be a model for the United States, and probably potentially in the world about how to do better health care. —DR. WARREN TAYLOR

If I go to you and say, gee I'll match this money if you come up with the other money, that's a great way to get some people to commit some resources. We've found that to be very effective. I think the other important thing is to make incentives and compensation. As you know, in Kaiser Permanente-Northern California, the quality goals that we have are part of our incentive package. If we achieve them we get more in our bonus and it's actually tied to our compensation. Turns out it's not very much money. But you'd be amazed at how competitive physicians are, particularly about how well they do. And if you're the last one in the group, it doesn't look good. So it doesn't really matter with the money sometimes, sometimes it's just the competition. So again, sometimes an incentive system, even if it's very small, can make a difference in the way people's behavior changes around something.

And last thing is the most important thing. And this is where we get back to the million dollars and Epic and those sorts of things is: information systems. As one of my colleagues said, it's very hard to do population management on 3.3 million members on 3 x 5 cards. You just can't do it. You've got to have IT systems to support this.

We learned too, that a lot has to do with case care managers. We've also learned you can use MAs, or clerks to do a lot for panel management and it's something we need to explore together. We're now building models and tools to do that with our own initiatives and we'd like to share those with you. Particularly the training and how to set those things up with the IT tools.

I just want to share with you a project that's gone on with the Care Management Institute. We actually looked at our diabetes implementation and kinds of systems across all the KPs. And we said to ourselves, if you break down the chronic care models into all of its components, try to go out and find out what really works to improve quality. We looked at all the quality measures we had at all the different KPs and clinics and asked questions by survey. Just to

find out what they were doing or how they thought they were doing on certain aspects.

So they went in and went through all this stuff, got a survey, validated it, did all the questionnaires. And here's what they found (see fig. 20). What's interesting is that out of those 20-odd some things, that are part of the chronic care model, 5 things fell out that show...these are the ones to distinguish the places that were doing the best job. And what's interesting about them – first one is financial incentives, which is something that we do. Second, which is heartening, is action plans. Specific action plans are extremely important to success. So self care, self management becomes a very important part. Last three are all tied to IT systems. Automated medical record, the next is an outreach system which allows you to outreach to people who doesn't traditionally see you in the traditional DOV [doctor office visit] to do follow up. And last but not least is provider alerts and reminders. So again, it's very IT dependent, or some kind of system dependent. Now this doesn't mean that the other things in the chronic care model or planned care model don't work. It just means that these fell out, in this particular analysis.

These findings actually have been shown in other studies. And I think it just gives you another concept of saying, 'Gee if I'm starting out here and I'm trying to make an improvement in the population management approach, what are some of the things that I might focus on?' This helps to guide you – again, provider education feedback, reminders, unblended reports for instance are very helpful, patient education reminders and financial incentives. And then improvement of patient self management skills. So it's this combination of IT support, provider support, and then patient support. We're going to use these findings to go forward and continue to improve our systems, but mainly to look at our computerized systems and see how we can make it work better in this kind of a process for population management.

When you think about getting a population under control, most of what we've focused on, even in the Collaboratives in some respects, is trying to get doctors to change their behavior. Turns out if you have a physician prescribe a drug to a patient, they only take it about half the time, unless you've done a lot of really good work, to get to improve the adherence. If a doctor tells a patient to change the lifestyle, they do it about 10 percent of the time. So we're actually not doing very well by having doctors be reminded. What you really have to do is build a system that's going to help the member or the patient or the client to actually be able to do this themselves. So we've sort of been missing out again with our physician-centric approach and we need to go more toward a patient centered approach.

So our next step is to focus on all these operational things we've learned as well as the IT things. We would like to share all this with you obviously and be a partner in that.

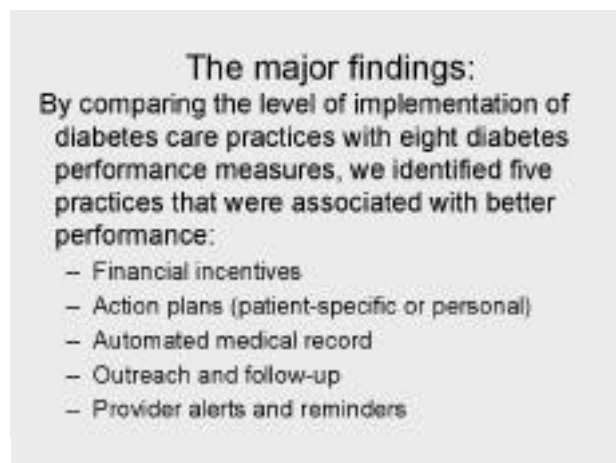


Fig. 20



The Community Clinics Initiative has enabled 90% of the clinics in the state of California to achieve a minimum level of technology capacity. —ELLEN FRIEDMAN

And I think the big thing for us is, if you think about the State of California, and I've said this before, Kaiser is one of the big gorillas in the room. But the other big gorilla in the room is the community clinics. Because if you look at the people who are covered in California, about 6 or 6.5 million are covered by Kaiser. Another 6 or 7 million are covered by community clinics. If you can imagine, if we were all working the same way, on the same kind of systems doing the same kind of things, how that would drive health care in the state of California and I think be a model for the United States, and probably potentially in the world about how to do better health care. That's the vision. And that's where we're all going. Thanks.

**ELLEN FRIEDMAN, MBA**  
**Vice President of the Tides Foundation and Managing Director of the Community Clinics Initiative**

I'll start by saying that my presentation is going to take a little bit of a different focus than Warren and Ahmed's because I'm not a clinician and I'm not representing a program that has looked at the improvement of clinical quality. What we have looked at, at the Community Clinics Initiative at Tides, is how to strengthen community health centers so that they can do these types of activities. And what kinds of organizations we need to have that can implement innovation and experimentation and deliver the kinds of clinical services that we've talked about today.

So very quickly...the Community Clinics Initiative is a partnership between the Tides Family of Organizations and The California Endowment. For the past 5 years, what we have done is that we have distributed... \$45 million directly to community health centers and their regional networks and statewide networks in the State of California. Our funding was originally to support community clinics to increase their use of technology tools. But over time, based on data—we have a lot of data too from our program evaluation—we've learned that we really need to look at the

question of infrastructure development. So our program has not only put hardware and software in clinics, it has acted to change the way clinics think about and approach, not only the use of technology tools, but their own long term sustainability. The program has enabled 90% of the clinics in the state of California to achieve a minimum level of technology capacity, and through our close examination of what worked and what didn't work, we now understand the factors that promote innovation and improvement in community health centers.

So what are some of those factors? We've heard a lot today about the important role of mission. This cannot be underestimated. Because those clinics that have a real clear sense and passionate-felt sense from the minute you walk into the door, of their mission and the roots of that mission and the application really make a difference in the way that they approach how they look at innovation and experimentation. This mission needs to be felt from the board to the front desk staff, and it really affects the way the clinics do their work in the community. Connected to that mission and having that mission felt by everyone in the organizations, is that the mission and the vision is a very broad one in the sense of social justice and access to health care. And this means that the clinics see their role as holistic community based institutions, that they are there not only to serve the needs of individual patients, but the community as a whole. And I think that it is this vision that has really put clinics in the lead in areas that we've heard about, such as prevention, culturally competent care, community outreach, and other activities that look at community improvement.

We for instance, recently funded the California Primary Care Association and Project Vote to do voter registration and education in community clinics. And we had a discussion on our online community, which I mentioned over lunch, the community clinics voice. We just posed the question: how many of you do voter registration and voter education activities in your clinics? And the stories we got back were fabulous. And through the work of Project Vote



in particular, 900,000 people have been registered in the state of California. [APPLAUSE.] And it's imperative that clinics are active actors in that attempt to register people to vote and to participate in activities that directly impact them. Flowing from the mission and vision is the creativity and resourcefulness that exists in clinics as organizations. When there's not a lot of financial margin, you figure out how to do things in creative and unique ways. And what we have found is that clinics who look at that and take that seriously are willing to take risks in ways that sometimes organizations are not willing to take. They get different kinds of people involved and call on different community partners to help them accomplish a project that needs to be done. And that goes to the next critical factor which is partnerships, strong partnerships, and partnerships which are created to advance advocacy, increase skill development, all kinds of different partnerships that clinics have, and how they value those partnerships determines how strong the network is that can implement the projects that they want to implement. And the last factor we see in clinics that are leaders in this area is the willingness to think and act outside the box.

One of my favorite examples in this area – it took place in the Northern Sierra region here in California. We funded the regional network to bring affordable, high speed connectivity to a network of clinics in a fairly isolated and large geographic region. And to make a very long and complicated story short, it was a very, very expensive proposition. And very few vendors were interested in bidding on the project. But when the regional network actually went out and organized the school district, the local government, and other safety net providers and had a real mass constituency, the vendor was finally interested because the project was big enough. But that could not have happened had those partnerships and those relationships been in existence and the vision that that's what the larger community needed was internet access in that way. And that was really important in getting the job done for everybody.

So what does a cutting edge clinic look like? Well we talked about partnerships, and now we're going to talk about collaboration. I think that collaboration is just one level deeper. And what we see is that the degree of collaboration both inside and outside of the clinic is critical in moving forward an innovative agenda. Here in Alameda County, we have a really fabulous example. One of the first

projects we funded was a group of 4 clinics that banded together to share an electronic practice management system. One of the clinics had a more developed and evolved system and was willing to dedicate staff and resources to this vision of a shared infrastructure model. This project, now in its fifth year, has really had dramatic results on all of the organizations involved. And I'd like to quote what one of the clinics said to us: "This project was not just about a change in computer systems, but it was about a change in the way that we work together, and in some cases, the way that we were organized." This is real collaboration. These are people who work together and talk together on a regular basis, and are changing the way each member of the collaboration contributes to making the whole project.

And this project has had an impact not only on the 4 clinics involved in achieving cost efficiencies and shared data, it contributed to the strength I think of the work that's being done in Alameda County in general. Because it's provided a daily example of how people can work together to get a shared vision done. Meeting community needs holistically is integrated into how community clinics think about their work. It doesn't see their work as a narrow silo of treating individuals but it sees those individuals within a larger community context.

A clinic we funded in southern California used an electronic practice management system. It enabled them to analyze the data that they had had on those cards that they didn't analyze. But when it was electronic, they did analyze it and they found high rates of lead in the blood of the children who came in, so they did further analysis and saw that those kids came from a particular neighborhood. And the clinic, because it had a strong and trusting community partnership, shared the data with local housing advocate groups and jointly they organized a lead abatement campaign that changed the way the housing conditions were.

Clinics recognized and strategically deployed the resources they have both at the individual clinic and at the regional and statewide level. This is really important due to a sense of lack of financial resources in the communities in which clinics work and the fragility often of funding and regulatory environments, clinics recognize the depth of the resources that they have. Today it's been underscored the importance of the data that clinics have. This is really, really important because to tell the story in the ways in which everybody's slides have shown today—Sam's slides, Ralph's and Ahmed's—the data has to be there. And we have to be able to analyze it and use it and then share it. And clinics have incredible data and they need to use it. Clinics are often the strongest community based organizations in the communities where they exist. They have meeting space, they own property, they are key community institutions. They have great technical resources, they're often a critical employer in the community. And they have networks and experience. And strong community organizations tend to be strong innovators. And our research has documented

Clinics have incredible data and they need to use it. Clinics are often the strongest community based organizations in the communities where they exist. —ELLEN FRIEDMAN

One of the clinics said, “This project was not just about a change in computer systems, but it was about a change in the way that we work together, and in some cases, the way that we were organized.” This is real collaboration. —ELLEN FRIEDMAN

that not only here in California but also across the country that there are key factors that make strong organizations. Some of them I’ve already talked about but some other ones include having interdisciplinary management teams where the clinical leader is an integral part of the management team, having strong financial systems, continuous attention to staff training and development and organization, a willingness to innovate—because not everybody is—and leadership that recognizes opportunities.

One key thing that I would like to emphasize is that in the national dialogue that’s currently taking place about health care information technologies clinics need to be in that dialogue. Clinics have learned enormous things about technology, implemented complex technology projects successfully, and clinics have lessons to share, especially about the challenges and what it takes to do something. Ralph has talked a little about the county-wide clinical data warehouse measures project. It’s an unbelievable project that every clinic in this county has participated in. They have worked together to set standards, share information, learn from one another, and create the supports that are necessary to improve practice. As anyone involved in that project will tell you, it has not been easy. It’s been really hard work. It’s a complex technological challenge, and from an organizational point of view, it’s really, really difficult. They have done it. They have a story to share, and they should be telling that story not only here in Alameda, but what they have learned needs to inform how the national health care technology agenda will be shaped.

There are lots of challenges too. Sam showed that mix of different funding sources but I think that what makes

that really a challenge is that those are really different funding sources, they have different requirements, they want data in different ways. They come in with different requirements, and not many of them actually support innovation. The prospective payment rates here in California are providing in some ways a disincentive to implementing technology systems because clinics are not reimbursed for those innovations.

We talked a lot about partnerships and collaborations but one of the things that we found through our program is that often clinics are very isolated. Well they will talk with other clinics but they are not in partnership with other health care providers or other community based organizations. That isolation needs to [be broken].

So that last one is what we call “dangerous watering holes,” “drinking at dangerous watering holes.” And what that means to say is that the world that we’re living in is changing really fast. Not just in technology but in many ways. This requires all of us to leave our comfort zones that we’ve been accustomed to, to engage with new partners, in new venues about new ways of working. And it requires us to have a clear sense of vision about what we need to do and change and improve the health of our communities. And we need to hold that vision when we interact with our partners who are non-traditional partners.

Last but not least, if I leave you with nothing, I want you to know how important it is for clinics to participate in this national conversation about technology. It’s really important to have information technology conferences. We have been the only representatives that we have seen there from the safety net population and we think it’s really important that clinics organize. I think it was Sherry who raised how we can influence that agenda. There’s going to be money there, there are going to be decisions and priorities made that clinics need to have a voice in and be key players. This requires relationships, building relationships, because they are transformative. They transform the way we work, the way we think about our work, and how we get our work done. So relationships with our clinics are important, relationships with other community organizations, and relationships between health care providers. And with this shared sense of vision and mission, clinics can really lead the way to transform health care. Thank you. ■

## RECAPTURING HEALTHY TRADITIONS: CULTURAL FACTORS IN ELIMINATING HEALTH DISPARITIES



Community competence comes out of a larger model  
around eliminating population disparities, and that  
larger model includes something that I call  
community development.

—ROBERT G. ROBINSON

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Good afternoon. I'm going to take you on a slight journey  
and talk about *Pathways to Freedom*, which has emerged as  
the state of the art cessation program for the African  
American community. I will take you on a little journey  
from its inception to its revision in 2003, and place it in the  
context in what I've called community competence, which  
I define as somewhat different than cultural competency.  
It's really one and the same, but there are advantages I feel  
to looking at it in terms of *community competence* rather  
than cultural competency.

And this is *Pathways to Freedom* as it existed in 1992. It was created because African Americans lead, and continue to lead the country in tobacco related disease. There were no culturally competent materials. *Pathways*...and this was originally developed in 1993. In addition, there were no, very few, African American researchers in tobacco control.

We needed a self help guide, because the community could not support technical, highly technical protocols. What I mean by that: there is no question that if you have counselors on line, telephone counselors on line, that that is going to increase the effectiveness of your program. But, we started from the premise that the Black community was poor and would be poor for the long duration. And therefore what we wanted to do was develop something that they can take in their hands and use it independent of whether or not they had resources. For in our view that was providing capacity and infrastructure that would resonate with the community as it was. We were trying to keep it real.

So, *community competence*... let me say very clearly, that even though I am making a distinction between community competence and cultural competency—what I have heard and what I believe you have heard from the other speakers—we are in fact doing community competence. We're calling it cultural competency because that's the term that has been given us. So I'm not going to go into, to explain something to you that we are not doing. But, I am going to offer perhaps a language and a way of looking at it that's maybe a little different.

There's a hidden agenda to this. Not *so* hidden because I don't keep it hidden. But community competence comes out of a larger model around eliminating population disparities, and that larger model includes something that I call community development, which is about capacity and infrastructure development. Again, something that this audience doesn't need to be told, because you inherently understand the importance of bricks and mortar in your community, and the ability to provide direct services. Trust me, where I come from, we don't understand necessarily the importance of enabling communities to provide services. What we understand is giving money to health departments and assuming that the community will be the beneficiary. So therefore, I talk about community development and I also talk about community competence. One of the reasons is to try and bring—at least in the level that I am working in—to try and bring community back into the lexicon of public health discussion. It does not get there, and when it does get there, it's not very well understood.

Our communities are much more complex than our cultural expression. And, if in fact we are going to deal coherently and comprehensively with disparities, we must have models that in fact reflect the complexity of our communities.

—ROBERT G. ROBINSON

The core constructs of community competence are: history, culture, context, and geography (see fig. 21). What else am I doing when I talk about history, culture, context, and geography? I am also talking about race and ethnicity. In fact, for me, race and ethnicity is synonymous with community. In fact, for me, talking about the *Latino* does not make any sense. Talking about the *Latino community* makes a lot of sense. Talking about a person being Black...well they can be Black, maybe they're not Black. Maybe their consciousness is off in the clouds. This is not important because it is not important at the individual level. It is most important and makes total sense at the community level.

Again, what makes us? What is the foundation of our power and purpose? What comprises us as a race and ethnic entity? Our history, our culture, our geography, our context. And what I am doing as well is trying to provide support to affirming the importance of race and ethnicity, because if you read the scientific literature, what you're getting is just an incredible debate as to whether race should even be considered an important scientific variable. So what do some people say? They say, "throw it out." It's a social thing, or it's a cultural thing, but they don't define it. They don't construct it as something positive but define it in the negative: race/ethnicity is *not* a biological thing.

Of course it's not a biological thing. We all understand that it's not about genetic determinism, but what we don't do in our science is we don't go beyond: "OK, if it's not biology, if it's social, what does that mean?" We don't construct it in a way that make sense, at least not in my view. So, what I am attempting to do here is, what I am saying is community and race and ethnicity is about our history, it's about our culture, it's about our context, and it's about our geography.

So history...how are you going to deal with African Americans if you don't consider the historical experience of slavery? Talk about Asian/Pacific Islanders...I'm not sure what the important historical experience of that community may be. It may be the fact that Chinese were piled this high when they were building the railroads across this country. The fact, the point I am making is: you cannot begin to understand a community or a race or ethnic community without to some degree considering what that historical experience was. Same thing with Hispanics, Latinos...last week somebody "celebrated," somebody "celebrated" the fact that that it was the anniversary when the United States won California from Mexico. Somebody celebrated that. My point is that it is important to understand that historical experience and what that might mean to the

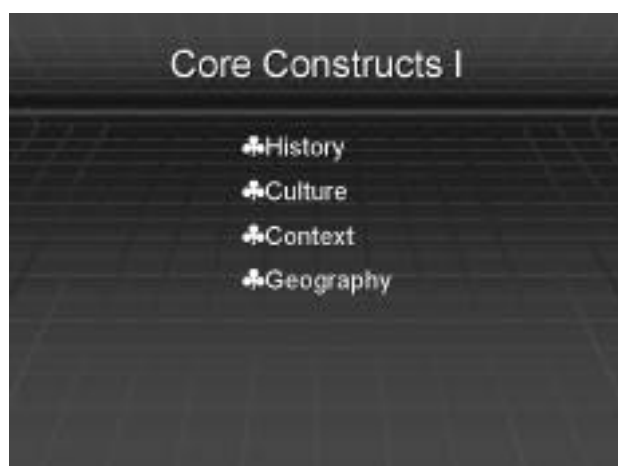


Fig. 21

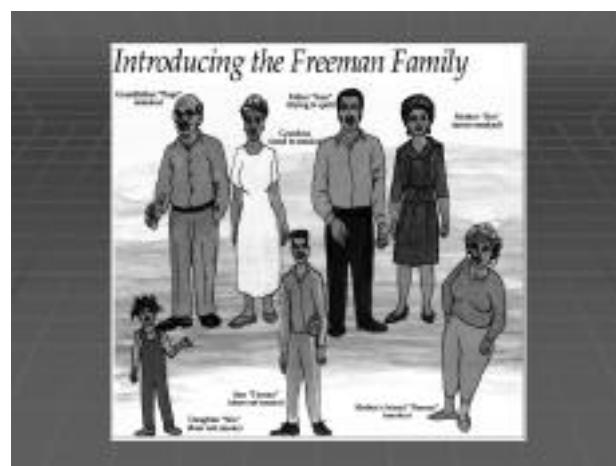


Fig. 22

Latino community. Santana, that wonderful guitarist, informed us that people did not cross the border, the border crossed people. Native Americans...how do you deal with Native Americans without in some way incorporating, resonating with, dealing with the historical experience of the near genocide of that community?

Culture reflects our spirituality, our family, the importance of elders, traditions. One of the problems I have with “cultural competency” is that it is devoid of our complexity. Everything gets dumped into culture. History will get dumped into culture...everything gets dumped into culture. It’s like we are the sum total of our culture. Our communities are much more complex than our cultural expression. And, if in fact we are going to deal coherently and comprehensively with disparities, we must have models that in fact reflect the complexity of our communities. We’re not going to get to our complexity through the singular notion of culture. Because culture is simply one component of who we are as community.

Context: racism, sexism, poverty, underemployment, lack of access. Context in the here and now, the reality, what we deal with. In Massachusetts, a door-to-door survey was done of the Cambodian people. And they, they did that survey and were having no success reaching the Cambodian people. And so they had to do a little homework. And, when people knocked on the door, they said, “We have a study.” Well, they did a little homework and they found out that in Cambodia when the Khmer Rouge came and appropriated people out of their homes, and took them into rural areas to decimate them, one of the things they told them was: “We are going on a study.” Now somebody knocks on your door and says “we have a

They found out that in Cambodia when the Khmer Rouge came and appropriated people out of their homes, and took them into rural areas to decimate them, one of the things they told them was: “We are going on a study.”

—ROBERT G. ROBINSON

study”...well obviously they had to change the language and the protocol. The point being: that’s not culture! That’s context...a language that simply confines you to a singular construct such as culture.

Geography. We’re different if we’re urban, rural, mountain, access to the sea. Vieques, Vieques is that island in Puerto Rico that the United States exploited to test bombs...humankind really has to figure out how to get to point A to point B without bombing. The people of Vieques in Puerto Rico are different from mainland Puerto Ricans. You’re not going to get that if all you’re thinking about is Puerto Rico. The example given yesterday...I recognize my limitations...I can’t even remember the name of the island let alone try to pronounce it...it’s the example in Hawai’i. That different island, that island...that’s geography differences. In other words, Hawai’ians are not the same. I mean they maybe are the same in terms of some kind of cultural base, but you’re going to

get to those unique differences by making explicit the issue of geography and how it allows you to deal with differentiation and complexity.

The second level of constructs is language (common usage, common knowledge, literacy level, read/design). When we think of literacy we usually think of 4th grade, 5th grade, 6th grade, but it’s also a question of how you design something. In *Pathways to Freedom* for example, the layout is: every two pages there is a concept, which means that I can look at those two pages and I get everything I’m supposed to get about that particular idea. If I turn a page, I don’t need to remember what I just read because I’m on a new idea. That’s a design issue. Salient imagery, positive imagery, multi-generational, and diversity. Okay, I’m going



Fig. 23



Fig. 24

to try and go through the rest of these slides fairly quickly.

So history...this is the first *Pathways to Freedom*. Introducing the Freeman family (see fig. 22). Freeman—you don't have to take slavery and hit people over the head. Freeman, the African American community understands where Freeman came from. For example, I think we all know Harold Freeman, past president of the American Cancer Society, and Chair of the President's Panel on Cancer. He explained his history, how his family got that name based on his great, great, great grandfather being free and naming himself Freeman. Yes, the African American community understands the history of the name Freeman.

*Pathways to Freedom* was the first cessation guide that explicitly used religion and prayer, and we didn't need a Constitutional Amendment to do it...on our guide (see fig. 23). That's the church. Context...the stress of being Black in white America makes us smoke more...that's context. Racism. Geography. Targeted marketing in neighborhoods. Positive imagery speaks for itself.

When we did this in 1992 there was a theory in health education that said you can't use scare tactics. So when we tried to put the black lung in it, I was a junior researcher at Fox Chase Cancer Center (I was old but I was junior, because U.C. Berkeley took a long time to graduate me. Bless them I needed all the help that I could get). I took this back to my collaborators at the Center, they were very senior. They said, "No we can't scare people." I went back 3 times and on the third time I came back. I remembered that I was principle investigator on the project and I could actually say what went into it. Salient imagery is exactly that—it's what is meaningful to the community...not necessarily what exists in theory, but what you know intuitively in terms of being responsive to your community.

Alright, this is a card table. It didn't work, but there was a card table, we like to play cards, African-Americans you know, we do Bid Whist. I mean...you know we stay up all night doing Bid Whist. So this was theoretically a card table without ashtrays. We were trying to be responsive.

But that's alright, we tried.

Multigenerational, it's the idea of bringing in not just parents but grandparents and children and making it reflect that image. We got good results, good results. No, no seriously...we got good results. My proudest moment as a scientist was *Pathways to Freedom* out performed traditional materials by 100%.

You've got to do focus groups. Freeman...[focus group participants said] "well that's Jewish. They weren't slaves, you know." We think we're trying to really get history into our guide. In spite of that, people went away thinking "why are they calling me Jewish." So we kept Freeman and explained it in the text. Culture...faith, prayer was certainly affirmed. Context...well, we did need to do NRT [Nicotine Replacement Therapy] in the new guide and issues of environmental tobacco smoke, which were not issues back in 1992.

The stress of being Black...that was seen as a cop out. People did not want to be considered victims of something, so we needed to reframe that. Again, I was, I had a bias. I like to make racism explicit, and I want to make it real, and I want to get it into what I do. And this was what I was trying to do. We had to soften it and reframe the message to be respectful of how people were receiving it. Next slide—positive imagery. Next slide—the one on the left, the first edition. It was seen as too confrontational, so we had to soften that (see fig. 24).

Noreen, which was the best friend...this is funny. She was sort of standing next to the husband [in *Pathways to Freedom*], and people told us, "What's Noreen... why is she standing so close to the husband? Who is Noreen?" So we had to keep Noreen, but we had to make her a relative. That was the only way we could keep Noreen. You've got to do focus groups, you've got to do focus groups!

Diversity, we added more faiths...Christian and Muslim, Islam... and we added the notion of spirituality. But diversity goes further than that. "We are not a 'Latino' community—we are Puerto Ricans, Cubans, etc, etc." "We



In the state of California, you have almost 40% of California's population speaking a language other than English at home.

—CARMELA CASTELLANO

are not an 'Asian' community—we are Chinese, Vietnamese, Cambodian, etc, etc.” The point being that disparity...if you look at aggregate data in terms of A/PI [Asian/Pacific Islander], you're not going to see disparities. But you will see them at the sub-community level. When the poverty statistics went up, it was said that the only community that it rose in was A/PI. And then the next statement was, 'the A/PI community was so small that it's an insignificant rise.' Well, let me tell you something, if you understand those poverty statistics for the A/PI community, you know that it's the Vietnamese, the Hmong, and the Cambodians who are actually at 40% poverty rate. It's significant for those distinct Asian communities.

We did gay, lesbian, bisexual, transgender imagery in this to add diversity into the new guide. Not heavy-handed, but it reflects the diversity of our community and we wanted it to be responsive of that community.

In 2001, for the first time in four decades African-American smoking rates went below that of white smoking rates. *Pathways to Freedom* was part of the disparity elimination. Thank you very much.

Community clinics incorporate the culture and language needed in health care, as part of the history of health centers being born out of the civil rights community.

—CARMELA CASTELLANO

#### **CARMELA CASTELLANO, ESQ.**

**CEO of the California Primary Care Association**

I am Carmela Castellano with the California Primary Care Association. Looking at the importance of culture and health...obviously it's key. It promotes understanding and communication, it allows the provider to obtain accurate medical information from the client, it facilitates treatment plans that are supported and followed by the patient and family, and it enhances the overall health care experience for the patient.

Another reason why culture, linguistic diversity and cultural, linguistic competence are so important is because we are in such a diverse society here in this country, with the federal statistic, a quarter of the U.S. population being people of color. And then in a state like California where you have a “majority minority” population, these issues are very critical and need to be addressed. And clearly when you look nationally, the United States' immigration brings diversity from around the world. We are a nation of immigrants (see fig. 25). In the year 2002, 32.5 million people



Fig. 25

were foreign born. When you have this level of diversity, it's important to know that states like California lead the trend in terms of immigration. But this is an issue clearly for the whole country, with the immigrant population spreading throughout our nation.

There is a significant immigrant population throughout California, and you can see in 1980 the percentage where there was more than 30% immigrants, or between 16-30%—quite small. And now we see from the 2000 statistics how much the immigrant population has grown throughout the state of California. So again, a very significant issue for our state.

In the state of California as well, you have almost 40% of California's population speaking a language other than English at home (see fig. 26). This is a very significant statistic for our state, in particular for the health care field and community health centers that serve the ethnic population. In our health centers we have very large numbers of non-English speaking populations, and their needs must be addressed.

What we have in our state is the fact that community clinics and health centers are clearly the safety net for diverse communities. And in terms of health center statistics in our state, you have a very large number being people of color, with the Hispanic/Latino population comprising over half of community clinic patients in California. And that's with over 3.1 million patients served in the state of California in 2002—of course a large number of low income, uninsured, and Medi-Cal [patients]. We are providing great care, share of care to the uninsured, with 18% of California's uninsured receiving their care at community health centers.

Now, one important role that community health clinics play—the national data and studies have supported this—is that community clinics reduce health disparities. And the data shows that states with the highest level of community health centers...their patients show the most

dramatic reductions in health disparities. The extent of community health centers' penetration into underserved communities was correlated with narrowing the gap in health disparities, between African-Americans and whites, specifically for total death rates and prenatal care, and between Latino and white for tuberculosis case rate and prenatal care. So community health centers are shown to actually reduce health disparities.

Another important piece...when you think about putting in a historical context, community clinics incorporate the culture and language needed in health care, as part of the history of health centers being born out of the civil rights community. Community health centers are governed by boards that ensure that the services are tailored to meet the needs of the community, and in fact health center boards are...half of the board members are actually patients of the health center and that helps ensure that the needs are met. Also, community health centers have a strong commitment of hiring from the community and utilizing promotoras and other community health workers in the work that they do, and that helps make their services culturally and linguistically appropriate.

I just want to point out some of the promising practices in providing culturally appropriate services that we've seen in the state of California. Establishing programs to have interpreters serve as cultural mediators, where they not only translate the language, but also have an understanding of the cultural beliefs between the provider and patient. We've seen programs where community clinics are very good at conducting cultural competence training for their staff, placing a high priority and value on the training issue. Our health centers in California also conduct cultural competent self-assessment to assess their own ability and then be able to improve upon them as needed. We've seen community health centers conduct patient satisfaction surveys in [different] languages which include specific questions around the cultural and linguistic needs of patients.

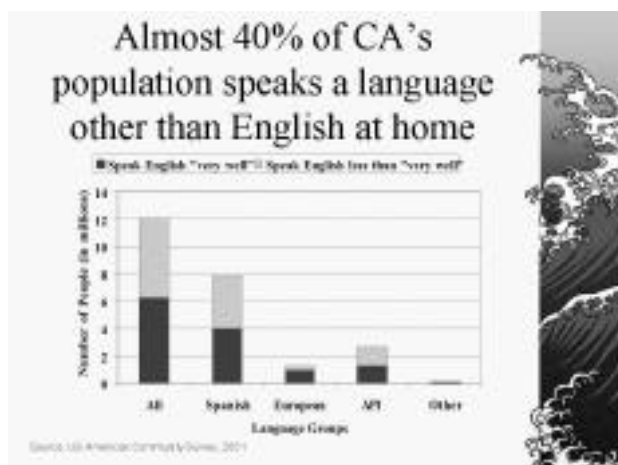


Fig. 26

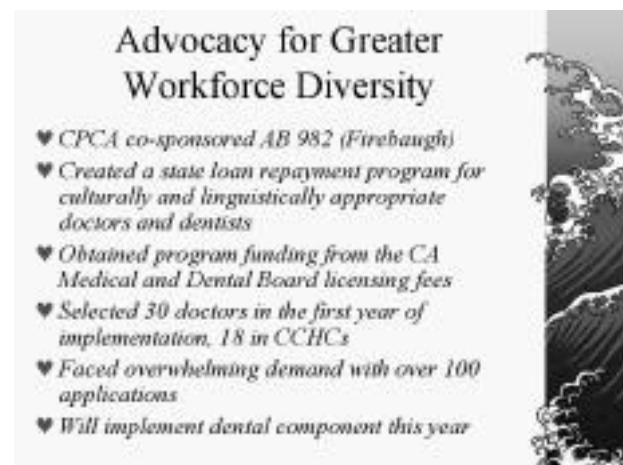


Fig. 27



And we've seen a health center host a weekly cultural clinic to teach staff about the cultural beliefs of patients and discuss the specific case needs.

Health centers have joined together to establish a network of interpreters that can be utilized by clinics and other health care providers in order to make it much more cost effective working together as a group. We've seen community health centers develop curriculum to train interpreters. We've seen the creation of evaluation of staffs' oral and written language proficiencies so that health centers can ensure that the translator actually speaks the language well enough. Of course a translation of vital documents is very common in the health center context, and also health centers monitor compliance with timely access to interpreters.

So these are some of the kinds of actual practices that we've seen and we have studied and documented this issue in the state of California because we find that our community health centers are truly leaders and innovators in the whole issue of cultural and linguistic competence. But another issue I want to talk about—besides the fact that community health centers are actually leaders in providing this kind of services and models—we're also leaders in advocacy in issues that support cultural and linguistic competence.

Just for example, going back a number of years...the whole issue of "public charge" was a major issue in our community in California and other parts of the country, where immigrants were being required to pay back the cost of Medi-Cal benefits that they had incurred in the past as a condition of being able to re-enter our country. And the fact that this was happening at airports and the border, put a real scare throughout the community and some of our health centers here in California experienced a lot of fear among the immigrant population. Actually, they dropped off in terms of people coming to the health centers, because this of whole issue of "public charge"—patients being deemed a "public charge" for having used services in the past.

And so the clinics mobilized around this issue. Actually Asian Health Services (and Sherry) is one of the leaders in our state. We looked at documenting the negative impact on clinics and patients of these "public charge" practices. We actually mobilized health care providers to educate policy makers about the detrimental impact that these practices were having on access to care. We advocated for clarification of the policy to be able to have it reversed and dispel the fears in the community. And we educated patients about the clarification of what constitutes a "public charge." Actually when the federal clarification came out, it made it possible for our patients to be able to receive their care at health centers without fear of being deemed a "public charge." That was a very important policy accomplishment that health centers played a direct role in at the federal and state level.

We've also played a big role in and a unique role in being supportive for providers of cultural and linguistic

competent services. In fact, California has really been a leader in promoting these policies both at the state and federal level, where back in the early '90s a coalition of multi-ethnic health care providers and advocacy organizations joined together to promote cultural and linguistic competence standards in our state's Medicaid program. And, organizations such as the California Rural Indian Health Board, Asian Health Services, La Clínica de La Raza, Alta Med Health Services, and others joined together to ensure that in the new Medicaid managed care model that there would be requirements on mainstream providers to provide cultural and linguistic competence. And we were after several years, ultimately successful about having these guidelines adopted in that program and that has served as a model for other states throughout the country to adopt similar kinds of standards and requirements.

Health centers have also been leaders in promoting at the federal level clarification of Title VI, the Office of Civil Rights guidance, which helped to clarify what the federal standard requirements are. And of course the Office of Minority Health Cultural and Linguistic Standards have received a lot of feedback and input from the health center community. And as providers, health centers have often been the leading provider organizations in support of these kind of standards.

Another place where we play an advocacy role in promoting cultural and linguistic competence is of course, advocacy in support of greater work force diversity (see fig. 27)—surely a concern for all of you who are running health centers. And our own primary care association, CPCA, sponsored a bill a few years ago that created a statewide loan repayment program specifically for culturally and linguistically appropriate doctors and dentists, recognizing that those doctors and dentists, studies have shown, are more likely to practice in a low-income diverse community. Through this legislation we obtained funding from the California Medical Board and the Dental Board Licensing Fees. We were able to get this through a budget crisis where there wasn't a lot of discretionary state funds, so we went after the licensing fees. And this actually supports loan repayment programs and already 30 doctors were selected the first year, and 18 were assigned to community health centers in the state of California. There was an overwhelming demand for this program with over 100 applications, so we think this will continue to be an important effort in our state and hopefully the dental component will be implemented this coming year.

So again, that's health centers at the lead in promoting a culturally competent, diverse workforce. Then finally, advocacy to reduce health disparities...our community health centers really mobilized around Proposition 54, which was a 2003 California ballot measure which sought to prohibit in our state, prohibit the state collection of race and ethnicity data. I'm sure those of you from other parts of the country heard about this very onerous initiative that



Sylvia Belcher (left) with Vivan Ahmad

Boy, there are some remarkable strategies in managed care on how to avoid high-risk patients. It was quite impressive. Then I thought about our mission as health centers: our mission is to go out and get the highest risk patients. And, I thought, how are we going to reconcile these two worlds? —RICHARD P. BETTINI

would have made it extremely difficult, to impossible, for us to track health disparities if we could not collect the data...among other devastating impacts.

And so of course, health centers needed to mobilize and strongly oppose this initiative and contribute to its defeat. We did everything from generate media coverage, educate the general public about the negative impact, we mobilized and educated health center patients around this important issue, and we secured opposition endorsement from other health care organizations. We had members of the steering committee that played a visible role in ultimately defeating this initiative. Those are some of the examples of some of the key policy initiatives that health centers have been drivers in California and throughout the country to promote cultural and linguistic competence.

And, our association is also involved in recognizing the importance of documenting and publishing the important work that health centers do in our state to promote cultural competence. And we produce publications such as a promising practices guide, we have a publication on expanding immigrants' access to health services, which documents a lot of the policy changes that we've secured in California that are beneficial to immigrants and we've shared that with other primary care associations throughout the country to help facilitate hopefully their role in securing similar measures in their state. So we think it's very important to get the word out about the important work happening in our state, and also to promote policy changes at the federal level, and throughout the country.

In conclusion, the key message in this presentation is really to recognize the critical role that community clinics and health centers are playing. Not only in practicing and being a model for cultural and linguistic competent services, but in promoting policies that will ultimately enhance these services. Thank you.

#### **KAUILA CLARK, MFA**

**Member of the Board of Directors of the  
Waianae Coast Comprehensive Health Center**

#### **RICHARD P. BETTINI, MPH, MA**

**CEO of the Waianae Coast Comprehensive  
Health Center**

KAUILA CLARK: Aloha. Mahalo. In listening to Dr. Robinson's presentation, it brought to mind that before I start our presentation on what we are doing in terms of cultural context, I should probably do a little talk about historical context and why we do what we do.

For those of you who are not familiar with Hawai'iian history, 90% of our population was lost in disease after Western contact, so it is very important for us to look at the health issues. Looking at contemporary issues...if you look at what's happening after 9-11, that was not the first attack by a foreign country on the United States. It was Pearl Harbor, December 7, 1941.

If you look at the United States attacking foreign country that was not involved in any way in a conflict with the U.S., you look at January 17, 1893 when our monarchy was overthrown by the United States government. It was declared illegal by the United States Act, but in the land grab of the Spanish American war in 1898, Hawai'i was included in the take of that land. The Organic Act made us a territory of that country of the United States. Today, right now, we are seeking recognition with the United States government to establish nationhood.

So out of that context—and hopefully Dr. Robinson, this will add to your presentation on Pacific Islanders and some of the stresses that we go through in order to live in a contemporary society—I report this to you as history, not as a point of argument. What I would like to do is present with our executive director some of the things that we are

trying to do in initiating cultural values and interdisciplinary services to provide to our people so we can get away from victimization to look at opportunities in establishing the services that are needed to heal the people.

I am Kauila Clark. I serve as a board member, but more than that I am a traditional practitioner of Native Hawai'ian ceremony and healing practices, and what we are trying to do is trying to develop that with the strong support of our community. In fact, I would like the board members to stand up because this really presents the work that they are doing in addressing our community. With that introduction I would like to turn it over to Mr. Bettini because he'll give all the technical information and I'll give the community information. Mahalo.

RICHARD P. BETTINI: So I'm going to bore you to death and he's going to be really interesting! I'd like to tie, first of all, this to what happened yesterday with the start of this conference. There are two aspects that stuck out in my mind. One is this conference that was established several years ago, led and directed by consumer board members. And I'd like to say thank you to all of the consumer board members that came a great distance to be here and that have participated at this conference. I know we have our board members stand up, but can some of the other consumer board members that are here also stand up please, so we can thank you in participating.

The other thing that we heard yesterday is that the health center movement started in the Civil Rights era and that there are many executive directors that have been around a long time and there was a real interest in making sure there's a new generation. I think I speak for the younger new generation of...what? (laughter from the audience) I wasn't expecting such a loud laugh at that.

There's such a thing called the Waianae Model of Integrative Health Care (see fig. 28). It's nothing you'll

find in the textbooks and a year from now it will be a different model. The model that we have this year is not a model for you to adopt. It's a way of saying every community should have its own model of health care, and that the consumer in that community should be a very big part in designing and developing that model and governing that model. And, so we're going to talk a little bit about each of these aspects.

I understand from some of the older executive directors that 10 years ago there was major paradigm shift for health centers. Out of the blue...you know we used to get by. Health centers used to be paid on a cost basis. In other words, whatever our cost was the Medicaid program was happy to pay it. And, boy that was a wonderful time. And, we didn't have much warning, but around 10 years ago, a little bit longer maybe, all of a sudden we got word that in 6 months that cost based reimbursements had been waived by our state and we're moving to something called managed care. We didn't quite know what that was so I went to the U.S. continent to a workshop. I took a track...there was a conference about managed care. I took a track called "Avoiding Adverse Selection." Boy, there are some remarkable strategies in managed care on how to avoid high-risk patients. It was quite impressive. Then I thought about our mission as health centers: our mission is to go out and get the highest risk patients. And, I thought, how are we going to reconcile these two worlds?

Well, my board...we had a strategic planning retreat about it and actually we brought some health centers...we did a thing on what health centers could do to adjust to manage care. And we thought 'Gee, maybe we should start our own HMO?' Because from what we could tell—and we had a little bit of experience with managed care—is the actuaries, these people who at managed care companies that figure out risk formulas and stuff, they were trying to tell us that women in their childbearing years are between



Fig. 28



Fig. 29

18 and 35. And, in our community half of our deliveries are to teenagers. And what they were going to do—and they showed us how they were going to pay us—we were going to get paid a little bit more for women, be capitated for women in the childbearing years. Capitation means instead of getting paid for the service, you get paid a flat amount no matter how much health problems, or conditions, or visits people have. So, we were thinking about that, and they said, we're going to pay you only about 30% of the normal capitation for teenage girls because it's such a healthy population.

So we thought, 'Should we do this health plan?' What happened was, we invited the CEO of the large Blue Cross provider to our board meeting. And he told our board, "You guys can never ever start an HMO. There is just too much to it." Well, that's all my board had to see and hear, and at that point we knew we were going to start one. And Aloha Care was born. And Aloha Care is one of the most successful health plans in the state of Hawai'i. It's now the third largest HMO, Medicaid HMO. We have \$90 million in revenues. I see one of my executive committee members here. It's run and owned by health centers.

Well, the lesson of this is that we learned not to get clobbered at the last minute again. And that we've got to listen to what is going on and be prepared. We heard Dr. Shekar say that there is a change coming. There's huge deficits and I can tell you there's not many pots of money in the federal budget that are the size of the deficit that can be cut. You've got Medicare, Social Security, the Department of Defense, and Medicaid. And, three of the four have got very powerful voting blocks and lobbies. One doesn't—you can guess which one.

So we have to be prepared. There is something coming called, we heard, "pay-for-performance"—that we're going to be paid based on our performance by health care payers. And after 10 years ago, we've adopted a philosophy. The winds of health care are going to change with politics, but

if a health center can always deliver value to the payer, you will always survive. They might not know that you are providing value, and they may try and get rid of you for a while, but they will eventually discover that you truly do deliver something very valuable at a reasonable cost. So that is how our model is based.

I've said enough about the current health care environment, let's go on to demographics. You can see that we have a large number of patients below poverty level there. About two-thirds of our patients, 24,000 patients live below federal poverty level guidelines. The majority of our revenue is Medicaid. Quest is the managed care plan, the managed care Medicaid plan in Hawai'i. And so I think it's a very unique and difficult population to provide services for.

Now there are certain things that the current health care delivery system doesn't do very well (see fig. 29). It doesn't address certain issues that are predominant in our community. And that includes: obesity, substance abuse, and many more things. We heard a lot about the Collaborative, the Diabetes Collaborative. We're trying to look at precursors to diabetes, and at prevention. How do we get to the root causes?

We just converted a year ago from a paper medical record to an electronic health record. And what this is doing for us is it's giving us a lot more insight. Most health centers' data systems are set up to pay bills, claims. And most health payers don't pay for nutrition, they don't pay for exercise...they pay for a lot of [other] things. Because some claims aren't filed sometimes things like enabling service needs or dietary issues are not tracked. But now that we have an electronic health record every single time, we have the heights and weights for every single patient, and for adults automatically the BMI [Body Mass Index] is calculated. And when a provider sees a patient the BMI beeps up there. If they are obese, it's identified at the time of the visit when the patient sits down with a doc.

### **Hawaiian and Traditional Healing**

- Lomilomi – Traditional soft, deep muscle massage.
- La'au Lapa'au – Herbal Healing.
- Ho'oponopono – Traditional Hawaiian family conflict resolution.
- Pale Keiki – Traditional care for women before, during, and after childbirth.
- La'au Kahea – Healing through prayer and chants.

The dynamic of sharing information between the traditionalist and the western practitioners has opened the eyes of both sides to look at how better we can serve the community. —KAUILA CLARK

Fig. 30

And so if you look at the statistics, these are staggering. Notice, I'll point out just two things. In the Samoan population—know by the way that obesity is about a 30 BMI, morbid obesity is about 35, that's a point in which disease is eminent—the average Samoan patient at our clinic is morbidly obese, and 35%, I think it is, of Hawai'ian patients, 32%...34% are morbidly obese. How are you going to intervene with the diabetes and hypertension—and now there's correlation to cancer—if you're not addressing the problem of obesity and if payers aren't paying for obesity [education and prevention]? Kauila, do you want to talk a little bit in our model how important the community is?

KAUILA CLARK: We have a very active board in advocating for the community. We come from the largest Hawai'ian community in the world. And, more than half of our services provided to community is to the Native Hawai'ians. The board is more than 50% Native Hawai'ian. They are really the driving force behind to a lot of the activities that the health center does. In the process of empowering the community, one of the things that the community wanted was a traditional Native Hawai'ian healing center. And, so we talked about it at the board. We passed the program, we initiated the program, and what happened was in the first 3 months, we saw over 12,000 patients. And so our executive director took 3 looks at that when he saw many people

wanting those kinds of services. The services that we provide (see fig. 30) are lomilomi, which is healing massage, a traditional soft deep muscle massage; herbal healing; the ho'oponopono is a traditional family conflict process; pale keiki is transitional care for women before and during after childbirth; la'au kahea, which is spiritual healing. The interesting aspect about the model that was set up is that it gave the opportunity of the traditional healers to meet and talk about the way you process and provide healings.

We have a kupuna board or advisory board. A kupuna are the elders, they're master healers that sit at the table and really advise the healing center in the way to approach and process methods. And so they were talking about pale keiki, and so the doctors talked about what they had to do, and the traditionalist said, "Why do you go through all that trouble? All you have to do is take the placenta after birth and throw it into boiling hot water and what it does is pushes the blood through and so your baby will get color." The dynamic of sharing information between the traditionalist and the western practitioners has opened the eyes of both sides to look at how better we can serve the community. The community is the voice, they express the need and then we respond to that need. And, we have greater participation by the community members. They come from the community, the advocacy. Then the implementation is by the health center. ■

## INTEGRATING SPIRITUAL, FAMILY, COMMUNITY, AND INDIVIDUAL WELL-BEING

*An Interview with James Allen Crouch, MPH, Executive Director, California Rural Indian Health Board*



Ralph Silber (left) and James Crouch (right)

When Indian community talks about spiritual well-being, there is a blur between what the Western mind might think of as spirituality and behavioral health.

**LUELLA J. PENSERGA:** *Could you speak a little on the issue of cultural competence in health care?*

**JAMES ALLEN CROUCH:** Traditionally, tribal health programs have tried to maintain a perspective on health care that is much broader than just physician practice. The Indian communities' interest in health care, I believe, takes place within the context of thinking about health in a much broader way that includes: spiritual well-being, community well-being, family well-being, and finally, the health of the individual. And the individual is nested inside of those other larger structures. We believe that the Tribal Health Council Programs in California—many of them demonstrate the application of that framework. The issue of cultural competency is a term that has come in from the outside. But the construct that is spoken about, I believe, is older than even the terminology of “cultural competency.”

Tribal health programs try to integrate Western traditions with traditional healing practice in a number of ways. One way obviously is to provide clients with access to traditional healers—something that the client is interested in and is maybe asking for. Of course that varies by tribe and by geography, so it's different in different places. That's

just the most obvious method of integrating that broader construct.

When Indian community talks about spiritual well-being, there is a blur between what the Western mind might think of as spirituality and behavioral health. Certainly in that realm, there is a lot of firm belief that traditional practice is particularly appropriate and aids to the resilience and well-being of the community, the family, and the individual. Many traditional practices actually address all four of those levels of existence.

The community health system in California and the tribal health system are very similar in their desire to address all of the health of the individual. I don't know that we do it any better than the community clinic, but [the tribal health system] is within the context of cultural belief and practices.

I think the most outstanding model of seeing this approach to health care is embodied in a facility that I would urge everyone to go see, which is Potawot Health Village in Eureka, California, operated by the United Indian Health Services [UIHS]. That serves as the central clinic for Humboldt and Del Norte counties. Potawot Health Village has won architectural awards for its

integration of traditional North Coast culture and design, and functional aspects of a clinic system that provides medical services, dental services, behavioral health services, community health education services, and certainly lots of community activities.

Part of what is really beautiful about that facility is [that] the Yurok tribal community has a traditional design for a redwood-planked house. And this clinic facility, sitting on a 40-acre site in coastal Northern California, is in essence, a series of Yurok houses placed in a circular fashion—shoulder-to-shoulder you might say. The idea of the Village is that it is a healing place. The concept is that, literally, to visit this site is meant to be reaffirming to the individual and the family and the community.

In the entrance way of the clinic, [it] feels very much like a large meeting area, incorporating traditional designs and arts and crafts from the area. It's a really open and welcoming place. Lots of community meetings are held in that space. It's redwood—very evident in the building materials and the very high, high ceilings. As you go beyond the entrance area, the circular shape of the clinic facilitates the flow of clinic traffic. But more importantly, in the center of that circle—the integral center of the building actually—is a herb garden and a live creek that flows through the facility that is termed the “Healing Garden.” It's been planted and landscaped with traditional North Coast medicine plants. It's a place for respite for workers and for clients, and [it] is the view that each waiting area—whether you are getting medical, dental, or any other kinds of services—shares throughout the interior of the building.

Part of being welcoming to the community (providing space for meetings and gatherings is another way in which the facility addresses the community) is having on the 40 acres, 20 acres of the land in wetland restoration. And throughout the 40 acres there is a walking path that has been set up to encourage both community/free recreation, and also organized activities by staff and groups operated out of the clinic. That wanders through the 20 acres [of] restoration area. They also, on that land, operate a garden. Because nutrition is part of health. Food is part of identity. And one of the programs at the clinic is a weekly sale of the produce from the garden. The land also holds a small area for a traditional salmon barbeque process that is used on the North Coast that requires a beach-like environment for the slow smoking of salmon, which as we all know, is a very healthful food and certainly native and central to the North Coast people.

But the facility is not the only way in which UIHS tries to integrate culture and community into Western medicine—they also bridge the contradiction between tradition and innovation. They are one of the first programs in our Tribal Health community to move towards electronic medical records and electronic practice management systems that have facilitated the management of their clinic.

They have been innovative in the investment in technology to assist in their pharmaceutical practice.

And all of that sits side-by-side with what could be considered one of the most extensive art collections of North Coast art and craftwork, beautiful basket collections that are spread throughout the public areas of the building. So it really, truly is a facility that reinforces community, reinforces family and traditions with family, and addresses the spiritual and physical well-being of all of its individual clients and users. I would encourage people to look at it. It's truly unique and a wonderful expression of inclusion of local culture and traditions into the delivery of the most state-of-the-art health care services.

LUELLA J. PENSERGA: *I guess in your comments you've addressed the strategies we should consider to reduce and eliminate disparities in health care?*

JAMES ALLEN CROUCH: Well, I'd like to address that a little bit more specifically because one of the problems, one of the things we share (tribal health programs and community health centers) besides a belief in community-controlled primary care, is a dependence on federal sources of reimbursement (either grants or contracts, and of course access to billing opportunities through third-party coverages like Medi-Cal or Medicare). And I think one of the policy issues that we need to think more about as a community of primary care clinics is the importance of maintaining those streams of third-party coverage for our clients. In this era of increasingly constrained resources, we need to learn to work together across organizational boundaries to foster a better understanding (and American political community) about the need for adequate health care services, and the inter-dependence of each of us on the other's health. Sometimes I am accused of saying that the real issue here is money. I'm not just trying to speak to that. But certainly without adequate resources, the long tradition of community-controlled health care will inevitably find itself unsustainable.

LUELLA J. PENSERGA: *Would you like to add anything else?*

JAMES ALLEN CROUCH: I will tell you one fabulous story you won't believe. Part of this cycle of life that Potawatomi tries to express is that death is a part of life (right now in American news there is a lot of death-denying going on). But in order to foster the restoration of their lands, and in order to balance the newness of what they were doing with what should have been there but had been interrupted (this land used to be a pasture) they brought in some pine trees that had died in the forest and they planted them. And one day they realized—like totem poles in a way, [they had] thought of them as individuals in honor of certain people—literally, one of those trees came back to life. ■

## ABOUT THE SPEAKERS

*Merrie Kim Aipoalani* Merrie Kim Aipoalani has significant local and state government legislative experience. Currently, she is the chief of staff of Hawai'i State District Representative and Housing Committee Chairperson Michael P. Kahikina (since 2000). Her prior legislative experiences includes ten years as legislative analyst to Honolulu City & County Councilmember John DeSoto (1986 - 1997) and previous to that, four years as legislative aide to then Honolulu City & County Chairperson Patsy T. Mink (1983 - 1986). Merrie is an active community member. Since 1983, she has served on the board of directors for the Waianae Coast Comprehensive Health Center in various capacities. She is also a member of the Nanakuli Hawai'ian Homestead Community Association, Valley of Rainbows, and Nanakuli High School Alumni Association. Merrie received her undergraduate's degree in Human Services from Leeward Community College.

*Richard P. Bettini, MPH, MA* Richard P. Bettini, MPH, MA is the Chief Executive Officer of the Waianae Coast Comprehensive Health Center where he has been employed for 25 years. He is a graduate of the University of California Berkeley School of Public Health. In addition to serving as the Waianae Coast Comprehensive Health Center Chief Executive Officer for the last 11 years, Mr. Bettini is the Board President of AlohaCare, Hawai'i's third largest HMO serving primarily Medicaid patients. He has been active in the Association of Asian and Pacific Community Health Organizations, currently serving as its Vice President.

*Tanya Broder, JD* Tanya Broder, JD is an attorney with the National Immigration Law Center, where she focuses on health care and public benefits for low-income immigrants across the country. She writes articles and policy analyses, provides technical assistance and training for health care and social service providers, legal aid, legislative staff, and community-based organizations.

*Ahmed Calvo, MD, MPH, FAAFP* Ahmed Calvo, MD, MPH, FAAFP is Chief, Clinical Quality Improvement Branch, Division of Clinical Quality, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, where he has been charged with the responsibility to ramp-up the HRSA Health Disparities Collaboratives to service 16 million people via 100% engagement of the Federally Qualified Health Centers network.

*Carmela R. Castellano, Esq.* Carmela R. Castellano, Esq. is the Chief Executive Officer of the California Primary Care Association (CPCA), an organization representing more than 600 California community clinics and health centers and their patients. Presently Ms. Castellano sits on the Board of Directors for the Chicana/Latina Foundation, the Public Health Institute, the Latino Coalition for a Healthy California, and Capital Link.



*Connie Chang* Connie Chang is the chairwoman of Asian Health Services' Board of Directors and is a trustee of the Oakland Zoo working to bring Giant Pandas to Oakland. She currently is an Early Childhood teacher and is the assistant head teacher at the Infant/Toddler Center at U.C. Berkeley. She is also active as a mentor in California's program to train new teachers. In her spare time she referees tennis tournaments and is captain on several tennis teams.

*Kauila Clark, MFA* Kauila Clark, MFA, Waianae Coast Comprehensive Health Center Board Member, is a resident of Makakilo on the island of Oahu in the State of Hawai'i. He is married and has three sons. Kauila received his BA degree from Graceland College, his MFA from University of Puget Sound, and is currently working on his PhD from the University of Kansas.

*James Allen Crouch, MPH* James Allen Crouch, MPH is the Executive Director of the California Rural Indian Health Board, Inc. He is a member of the Cherokee Nation and oversees a multi-funded Tribal Organization providing direct health care services, technical assistance and advocacy to over 45 tribes in California. Mr. Crouch's formal education began in Drumright, Oklahoma. He completed his secondary education at Singapore American School, Republic of Singapore. He received a B.A. from the American University in Washington, D.C., School of International Services and a Masters in Public Health from the University of California, Berkeley, School of Public Health.

*Patricia A. Ford* Patricia A. Ford is the Chair-Elect for the National Coalition on Black Civic Participation. She is the campaign director of Unity '04, a nationwide voter registration/voter mobilization drive coordinated by the National Coalition on Black Civic Participation committed to generating unprecedented voter participation in the 2004 Presidential election. Ms. Ford began her career as a union activist in the early 1970s while working as a clerk at Alameda County's Highland Hospital, where she led a successful effort to affiliate the union with SEIU as Local 616. In 1978, she became the first African-American woman elected as president of Local 616, and she later served as the local's executive director.

*Ellen Friedman* Ellen Friedman has been with Tides since 1987, and serves as Vice President of Tides Foundation and Tides Center. Currently, Ellen directs the Community Clinics Initiative, a partnership between the Foundation and the California Endowment to strengthen community health centers throughout California. She brings a long history of advising individual donors on issues of philanthropic planning, violence against women, Jewish Spirituality, and environmental issues. Before coming to Tides, Ellen served as a Program Officer at the Conrad N. Hilton Foundation in Los Angeles. She is a board member of the Presidio Alliance, the 3 Guineas Fund, and the Family Violence Prevention Fund.

- Jane C. García, MPH* Jane C. García, MPH has been Chief Executive Officer of La Clínica de La Raza since 1983. Since then, La Clínica has grown from a \$32 million project to a \$22 million institution. La Clínica is the largest employer in East Oakland and was recently listed as the sixth largest non-profit employer in the East Bay by the East Bay Business Times. With over 300 employees, the community health center serves over 17, 000 families and last year provided over 115,000 encounters. Celebrating its 31st Anniversary, La Clínica, under the leadership of Ms. García, has received National and Statewide recognition. In 1997, Kaiser Permanente awarded La Clínica its first Pacesetter Award under its Children's Health and Safety program.
- Jose Joél García, JD* Jose Joél García, JD serves currently as the Executive Director of the Tiburcio Vasquez Health Center, Inc., a multi-site and multi-service nonprofit community health center that serves the cities of Hayward, Union City, Newark, and Fremont in southern Alameda County, California. He has held that post since August of 1992. Prior to his current administrative post he held academic appointment for over fourteen years as a Lecturer at the University of California, Berkeley, in Chicano and Latin American Studies and an Assistant Professor of Health Policy and Law at the Graduate School of Business at the University of Colorado, Denver.
- Donn Ginoza, JD* Donn Ginoza, JD is the vice-president of the AHS board of directors, and a past president of the board, having served a total of 17 years. Originally a legal services attorney in the early 1980s, he became involved with AHS as the attorney coordinating the Office of Civil Rights complaint on behalf of the Alameda Health Consortium clinics against the county hospital which led to the establishment of a department of translators for non-English speaking patients. He is currently an administrative law judge for a state agency adjudicating labor relations disputes for public employee unions and public employers. He is also a board member for the National Health Law Program.
- George C. Halvorson* George C. Halvorson was named Chairman and Chief Executive Officer of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals, headquartered in Oakland, California, in March 2002. Kaiser Permanente, which comprises Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and the Permanente Medical Groups, is America's leading integrated health care organization. Founded in 1945, it is a not-for-profit health plan serving the health care needs of more than 8.3 million members in nine states and the District of Columbia.
- David E. Hayes-Bautista, PhD* David E. Hayes-Bautista, PhD is currently Professor of Medicine and Director of the Center for the Study of Latino Health and Culture, UCLA; Director, UCLA/ Drew Center of Excellence for Minority Medical Education, David Geffen School of Medicine at UCLA. He graduated from UC Berkeley and completed his MA and PhD in Medical Sociology at the University of California Medical Center, San Francisco. His research focuses on the dynamics and processes of the health of the Latino population using both quantitative data sets and qualitative observations.

- Sandra R. Hernández, MD* Sandra R. Hernández, MD is the Chief Executive Officer of The San Francisco Foundation. Dr. Hernández currently serves on the boards of Blackbaud, Inc., a leading provider of software and online services for the non-profit community, the Lucille Packard Children's Hospital, Foundation Consortium, Corporation for Supportive Housing, National Alliance for Hispanic Health, and the California Managed Risk Medical Insurance Board, which is the governing body for California's Children's Health Insurance Program. Her prior affiliations include President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry, The Pew Commission on Environmental Health, American Foundation for AIDS Research, Grantmakers in Health, the Institute of Medicine's Committee on the Consequences of Uninsurance, and Harvard's John F. Kennedy School of Government Executive Session on Philanthropy.
- Sherry M. Hirota* Sherry M. Hirota is the chief executive officer of Asian Health Services, based in Oakland. In addition to her executive responsibilities at Asian Health Services, her professional and community affiliations include: member of The California Endowment's Board of Directors since its founding in 1996; appointed member of the Advisory Committee on Research on Minority Health of the ORMH, National Institutes of Health; a founding board member of the Association of Asian and Pacific Islander Community Health Organizations; member of the Governing Board, Alameda Alliance for Health until 2002; and member of the Advisory Board of the Bureau of Primary Health Care's National Center for Cultural Competence.
- Sylvia Drew Ivie, JD* Sylvia Drew Ivie, JD is Executive Director of T.H.E. Clinic (To Help Everyone) Clinic, a non-profit primary health care facility in Los Angeles, California serving primarily African Americans, Latino, and Asian Pacific Islander patients and their families. A staff of 100 is able to serve patients in ten languages. Prior to her work at T.H.E. Clinic, Ms. Ivie practiced poverty and civil rights law with the National Health Law Program in Los Angeles, the NAACP Legal Defense Fund in New York and U.S. Office of Civil Rights in the Department of Health and Human Services in Washington, DC.
- Luella J. Penserga, MPH* Luella J. Penserga, MPH is the project director of the W.K. Kellogg-funded Community Voices for Immigrant Health Project, a collaborative project of Asian Health Services and La Clinica de La Raza, in partnership with the Alameda Health Consortium. Prior to her current position, Luella worked at the UCLA Center for Health Policy Research with a senior researcher conducting research on breast cancer screening among women of color in Alameda County. She also worked for seven years at the Asian & Pacific Islander American Health Forum, a national advocacy organization.

*Ninez Ponce, PhD* Ninez Ponce, PhD is an Assistant Professor at UCLA's Department of Health Services. She is also a Faculty Associate with the UCLA Center for Health Policy Research. Trained in health economics, Dr. Ponce's research focuses on understanding macroeconomic effects on health and health care access in low income countries, and among low-SES neighborhoods and ethnic minorities in the United States. She was RAND's resident adviser to the Ministry of Health, Republic of Macedonia, and has worked at the World Bank, Catholic Relief Services in Thailand, and the Asian and Pacific Islander American Health Forum. She is Co-Principal Investigator of the California Health Interview Survey (CHIS) 2001 and 2003.

*Robert G. Robinson, DrPH* Robert G. Robinson, DrPH is the Associate Director for Program Development of the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC). In his capacity at CDC Dr. Robinson has developed national programs that in particular target the needs of Communities of Color, women, blue collar and agricultural workers, gays and lesbians, low income people, and youth. He has developed policy and program initiatives for South America and Sub-Sahara Africa. In addition he assists in policy and program applications related to National Organizations and Health Department efforts funded by CDC.

*Robert K. Ross, MD* Robert K. Ross, MD is the president and chief executive officer for The California Endowment, a health foundation established in 1996 to address the health needs of Californians. Prior to his appointment, Dr. Ross served as director of the Health and Human Services Agency for the County of San Diego from 1993 to 2000. Dr. Ross' service as a clinician and public health administrator includes: Commissioner, Philadelphia Department of Public Health; medical director for LINK School-Based Clinic Program, Camden, New Jersey; instructor of clinical medicine, Children's Hospital of Philadelphia; and faculty member at San Diego State University's School of Public Health.

*Sam S. Shekar, MD, MPH* Sam S. Shekar, MD, MPH was appointed Associate Administrator for Primary Health Care in the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) in 2002. As head of HRSA's Bureau of Primary Health Care, Dr. Shekar manages the \$1.6 billion health center program, which funds more than 900 consolidated health centers that provide services at over 3,650 comprehensive primary care clinics. In addition, Dr. Shekar oversees President Bush's Health Center Initiative, which is designed to add 1,200 new and expanded health center sites by 2006 and increase the number of patients treated annually to 16 million. Dr. Shekar is a Rear Admiral and Assistant Surgeon General in the U.S. Public Health Service.

*Ralph Silber, MPH* Ralph Silber, MPH has more than twenty-five years experience in community health, primary care, and health policy. For almost twenty years, he has served as the Executive Director of the Alameda Health Consortium, the association of ten non-profit community health centers in Alameda County, California. He is also the Chief Executive Officer of the Community Health Center Network, a managed care and practice management organization with more than 25,000 managed care members. Mr. Silber is a founding member of the Board of Directors of the California Primary Care Association and a member of the Legislative Committee of the National Association of Community Health Centers.

*Warren Taylor, MD* Warren Taylor, MD joined The Permanente Medical Group in 1984 as a Board Certified Family Physician working in the Napa Clinic. He was elected to share holder status in 1987 and appointed Chief of Patient Health Education in 1985. After serving as Assistant Chief of Medicine in Napa from 1992 to 1994, he became the Chief of Medicine in Napa from 1994 to 1999. While serving as a Chief of Medicine he was active in a number of projects to re-design primary care and address chronic conditions management starting in 1994. After working in the Napa-Solano area and with Regional groups he became the Medical Director for Chronic Conditions Management for TPMG in 2000 when the position was first created.

*Henrie M. Treadwell, PhD* Henrie M. Treadwell, PhD is Senior Social Scientist and Associate Director of Development in the National Center for Primary Care at Morehouse School of Medicine. She oversees and manages an informing policy initiative, Community Voices, funded by the W.K. Kellogg Foundation, and oversees the men's health programs that were funded as a special cluster by the Kellogg Foundation. Prior to joining the National Center for Primary Care, Dr. Treadwell served for 16 years as program director at the W.K. Kellogg Foundation of Battle Creek, Michigan.

*Thomas J. Van Coverden* Thomas J. Van Coverden is the President and Chief Executive Officer of the National Association of Community Health Centers. In a 25+ year tenure with the association, he is credited with building a strong and effective organization which has become a powerful force – transforming the ideas of non-profit community health providers into a compelling vision for the nation's health care.

*Martin Waukazoo* Martin Waukazoo is the Chief Executive Officer of the Native American Health Centers in Oakland, San Francisco, Fresno and Alameda. He has served as the Chief Executive Officer of Native American Health Center for the past 20 years and has a strong track record for efficient financial, administrative and asset management. Martin's career is highlighted by increasing organizational revenue by 400% over the past ten years; purchasing and now owning its four-story, 20,000 square foot building; and, diversifying services and income streams to meet the growing needs in the community.



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