IN HONOR OF THE DCPCA 10TH ANNIVERSARY

10

AND STILL WE RISE:

STORIES ABOUT THE JOURNEY FOR DC HEALTH CARE REFORM

District of Columbia Primary Care Association

District of Columbia
Primary Care Association

★ MISSION

The District of Columbia Primary Care Association is a health action and advocacy organization improving health care and health coverage for the District's low-income, uninsured, and medically vulnerable residents. DCPCA works with its members to advance policy and develop programs like Medical Homes DC that help ensure everyone gets the right care, at the right time, in the right place. Our mission is to facilitate the development and sustainability of an effective, integrated health care system in the District of Columbia that guarantees access to primary health care, and eliminates disparities in health outcomes.

Everyone Covered. Everyone Cared For. Anyone Can Help.

AND STILL WE RISE:

STORIES ABOUT THE JOURNEY FOR DC HEALTH CARE REFORM

The stories you read in this book are collected from telephone and in-person interviews, transcribed remarks from DCPCA's 10th Anniversary Annual Meeting, "And Still We Rise: A Family Reunion," on October 25, 2007, and written reminisces collected from friends and partners of DCPCA.

We thank each and every one of you for your participation — we could not tell this story alone.

★ MESSAGE FROM OUR CHIEF EXECUTIVE OFFICER, SHARON A. BASKERVILLE:

My journey in DC health care started when I walked into Community Medical Care in September of 1978, with a brochure from the liquor store in hand, and my three little boys in tow. I was welcomed with such attention, so much compassion, so much care and respect, that I couldn't help but come back (little did I know it was the first week they were open). Over time I went from well-cared-for patient to employee — the product of someone's belief in my abilities and willingness to give me a chance. I moved up quickly, from receptionist, to business manager, to catch-all "patient care coordinator," until our executive director moved on and one day I found myself the leader of this proud, homegrown community clinic.

Back then, none of the clinics were really talking to each other, and we certainly weren't talking to hospitals and other players in the health care system. Up until ten years ago none of us were really sitting at the table together. Because of pervasive neglect of public health in the District, these community health centers had, for the most part, grown up independently to fill the need — out of good will, motivated people, and a spirit of compassion.

It wasn't until about ten years ago that we had no choice but to get organized. Patients who received their health insurance through Medicaid — low-income folks, the families that our clinics had been treating for years — were going to be moved into a managed care system. Third-party managed care organizations (MCOs) would be contracting with District government to process payment for care. We knew there was a danger in this of losing our place; we weren't organized enough to approach the MCOs and ensure that our patients would continue to receive care in their communities. But at the same time, we looked at ourselves and realized how on the mark we were. We were strong, mission-driven organizations, and we had to fight. We had to stand up and say, in this new system, "you must preserve a place for our city's historic safety net providers!"

A group of clinics got together to organize and present a unified front: the Non-Profit Clinic Consortium (NPCC). We stood up to bullies, we tried to empower each other, clear up misunderstandings, and speak the same language. We developed our own cultural pride — there was us and there was them. We heard about something called the Primary Care Roundtable meeting, which was bringing together people from inside and outside the community health center world. I was sent to serve as a representative of the NPCC.

That first year was so different for me — getting out and seeing a world outside the health center was exciting and challenging. There were big, fancy offices; it was so different from the world we lived in, with a whole different way of doing business than we did. Going to meetings instead of being in the clinic all the time really made me start to think, and before long, I was on fire. I felt a strong calling to provide greater voice for the uninsured and vulnerable. I had never been to the John A. Wilson Building, I had never even watched a Council hearing, let alone participated in one. The experience truly led me to realize the need for system change, and I realized I had hard choices to make about my path — my youngest son was eight years old and I had $37 in my bank account at the time. But I realized I had to let go of the clinic to pursue this passion. I resigned from Community Medical Care and the very next day, not even knowing about the resignation, Debi Tucker called and asked if I would consider leading a Primary Care Association for the District.

I was excited, but I was also terrified. This wasn't the same as organizing grassroots folks — this was a serious change, culturally and professionally. I became a patient when I was 24. Twenty years later I was 44. What would I put on my resume? I had been on welfare. I have a high school diploma, no credentials, I never went to college. I asked them to put me through the same process as all other applicants, but in the end the salary they were offering would have doubled my pay. So I said I would do it for $10,000 less — that's how I stumbled into it. They took a huge gamble on me, but they saw more in me than I saw in myself.

When a patient walks through a clinic's front door, a relationship begins, and none of us knows where that relationship will lead. It can take you anywhere — it can change the face of a person, neighborhood, or an entire city. As DCPCA approached its tenth anniversary, I wanted to call up these stories. Let people talk about how they wandered in, what made them stay, and what their memories are. Ten years is an appropriate point to stop in the crossroads — to see it all in whole cloth, and to honor what it took to get us where we are today. I wanted to provide a space to share the enormous knowledge of these people, their ideas of what the work is, why we value it, and why it must be invested in.

At Community Medical Care, we would go on an annual retreat to renew and refresh ourselves with stories. Jim Hall, the doctor who founded the clinic, was fascinated by Native American stories and imagery. Nina Masson, our nurse, was a poet. We always wrote our annual reports in stories and poetry; snapshots in our lives at the community clinic together. Some of the first writing I did is in those early annual reports. We chose to express ourselves in the tradition of the storyteller, and it held us together for twenty years at the clinic. It's always the stories that keep us together.

It has been ten years at DCPCA, and more than thirty years for some of our community health centers. We are at our crossroads right now, a place to mark time. As we work to build up a robust, coordinated, well-functioning health care system we must remember that from tiny acorns, mighty oaks will grow. The seeds of our work, the acorns, are in these stories — the tales of a spark of passion that leads us all here. And as we build up strong oaks in our community, we can not lose sight of the acorns.

The magic is in the acorn. The acorns are what make future growth possible.

With thanks for your support, and sincere hopes for the future,

Sharon A. Baskerville
Chief Executive Officer
DC Primary Care Association

As we celebrate

and mark our ten-year journey at DCPCA, we recognize that the struggle for health reform began long before DCPCA was founded in the late 1990s. Innumerable nurses, doctors, caseworkers, healers, caregivers, spiritual leaders, administrators, and advocates have come together over the past forty years and made the sometimes difficult and unpopular choice to serve the people, the residents of this city, that others had left behind. DCPCA works on behalf of the District's medically vulnerable residents — who may be low-income, uninsured, undocumented, homeless, or simply lacking access to a medical home — but we have built our organization on the foundation of a "safety net" health care system that developed over the course of many years, due to the courage and kindness of earlier reformers who believed all residents of the District of Columbia should have access to high quality health care services. The first such organization to rise up with a focus on providing health care to the underserved was the Washington Free Clinic (WFC), a neighborhood institution which ultimately closed its doors in January 2007, after nearly forty years of service to residents of the District.

1967 THE SPANISH CATHOLIC CENTER IS FOUNDED BY THE ARCHDIOCESE OF WASHINGTON TO PROVIDE EDUCATION, HEALTH, AND SOCIAL NEEDS TO IMMIGRANTS.

1968 THE WASHINGTON FREE CLINIC IS FOUNDED.

★ GARDINER LAPHAM, FORMER EXECUTIVE DIRECTOR, WASHINGTON FREE CLINIC:

I moved to Washington, DC in 1998. I was a nurse with a degree in public health at the time and I was looking for volunteer opportunities. I was fortunate to find a volunteer position at the Washington Free Clinic where I worked on a weekly basis in the general medicine and women's clinics. At the time little did I know how involved I would ultimately become in determining the organization's future.

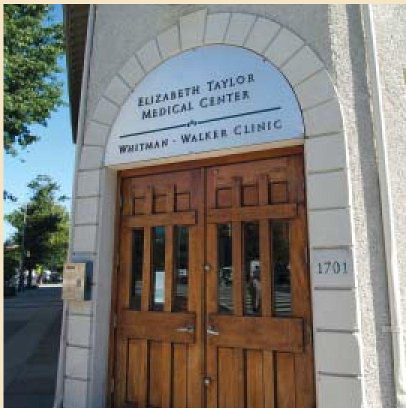
The Washington Free Clinic is the oldest free clinic on the east coast and the third oldest in the country. Its mission was to provide free health care services to individuals who lacked access to medical care through a volunteer-driven model with an emphasis on education, empowerment, and outreach. During these early years, the Clinic mostly worked with lay volunteers, under the supervision of volunteer doctors, to screen and treat patients for sexually transmitted diseases and other related problems. Even as the health care environment changed in the 1990s and the Clinic was forced to add more full-time paid staff, it stayed committed to a volunteer model, a model that made our delivery of care special.

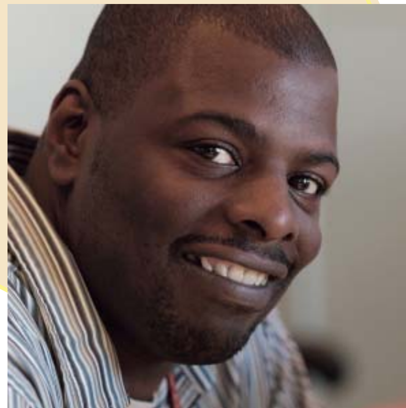
Sharon Baskerville was one of first people I met when I moved to Washington. I remember Sharon said one thing that is so great about the clinic is it felt like an old comfortable shirt. We may have been on the third floor in a shabby space, but the place was so personal, so small, all the volunteers were so happy to be there. It was a friendly place where people felt welcome. And these are people who often don't feel welcome in health care settings, because they are worried about documentation, language barriers, or other barriers to care.

What's so interesting to me about DC's nonprofit clinics is that they all have different personalities. The Washington Free Clinic has a different personality than Mary's Center for Maternal & Child Care which has a different personality from La Clínica del Pueblo and so on. What was unique about the Free Clinic is that it served as a medical home to people from all ethnicities. On any given day at the Clinic you could hear Spanish (mostly) being spoken but also Amharic and French. The Free Clinic was also special because it was run and shaped by volunteers, people who donate so much time, talent, and resources. That volunteer model is an interesting one. But it was ultimately a hard one. In DC it's an especially hard one to depend on. The Free Clinic had to bring in more and more paid staff over time. That was the challenge — to have a small clinic trying to do so many things and deal with staff and systems and bureaucracy and still support a small patient base.

A new model

for delivering care was developed with the Washington Free Clinic, and within the next few years a number of other groups formed out of this same sense of common purpose to provide services to those not adequately looked after by the public or private systems. By the end of the 1970s, WFC was joined by organizations like the Spanish Catholic Center, SOME (So Others Might Eat), Community of Hope, Bread for the City, Community Medical Care, Whitman-Walker Clinic, and Columbia Road Health Services. At the same time, the DC Department of Human Services was struggling to run an effective system of neighborhood health clinics through the Commission for Public Health. Growth developed around special patient populations, with specific cultural, medical, behavioral, or demographic concerns. The Gay Men's VD Clinic was created in response to the needs of a rapidly growing gay community, establishing a safe, compassionate, and non-judgmental place for men to seek help — and eventually evolved out of its parent organization, the Washington Free Clinic, into what we now know as the Whitman-Walker Clinic. A similar clinic "boom" erupted around services for substance abusers, homeless individuals and families, and immigrant communities in the District. For these groups, often on the fringes of society, the development of welcoming and culturally-appropriate services was crucial — providing clients with a lifeline to healthier, more stable lives.





1970 — SOME (SO OTHERS MIGHT EAT) FOUNDED BY AN INTERFAITH GROUP LED BY FATHER HORACE MCKENNA.

EARLY 1970s — APPROXIMATELY 15 NEIGHBORHOOD HEALTH CLINICS EXIST IN DC, RUN BY THE COMMISSION FOR PUBLIC HEALTH UNDER THE DC DEPARTMENT OF HUMAN SERVICES.

★ JEROME SIKORSKI, FORMER VOLUNTEER, WASHINGTON FREE CLINIC; BOARD MEMBER, WHITMAN-WALKER CLINIC:

To understand the whole emergence of the Washington Free Clinic (WFC), you have to understand some of what was going on in the '60s and how that played out in our nation's capital. The counterculture came forward with sex, drugs, and rock and roll. If you were interested in discovering this new world, you headed to Georgetown on the weekend. Georgetown was not the overpriced operation that we all now know, it was a slum. Most of the buildings were still boarded up, unused, and drugs were pretty easy to find. That of course, combined with rock and roll, led inevitably to sex and then — what to do? You couldn't go to your family doctor because he was part of the establishment, and you weren't exactly going to go to your old pediatrician. So the WFC raised its head, and ended up in the basement of the Georgetown Lutheran Church.

Between 1968 and 1973, some volunteers got the very savvy notion that there were a lot of young gay men showing up, and that they would probably reach more if they isolate[d] that program into its own entity. And of course they were right — in short order the Gay Men's Venereal Disease Clinic (GMVDC) became the largest program that the WFC was operating. One of the volunteers by the time I arrived on the scene in 1977 had a gift for language, and said when somebody asks what does GMVDC stand for — without missing a beat he said "Good Men Very Devoted to Christ." A sense of humor was very important in all this.

By 1978 we decided that we could do more on our own and separated from WFC — I was one of the incorporating founders of the [new] Whitman-Walker Clinic. I remember putting together a budget which was one page — $15,000 was the annual budget, and we didn't know where it was coming from. So some things never change with nonprofits. By the early '80s when the AIDS epidemic broke, we were the only organization that was willing to come forward, and so we assumed leadership. It's been a tremendous 30 years — I can't believe that we're all still around.

★ MARY ANN SACK, ASSISTANT EXECUTIVE DIRECTOR, SOME (SO OTHERS MIGHT EAT), INC.:

I began my career at SOME as a volunteer nurse in 1984. At that time the clinic had a small staff and ran largely with volunteers. In 1987, I became the medical clinic coordinator. I served in that capacity for 15 years.

When I began volunteering at SOME, the medical clinic had been in operation for two years and was a grassroots organization. The clinic was small and we had few resources. It was a fun and exciting time to be at SOME — we were adept at finding ways to meet the needs of the patients — begging and borrowing, each staff person or volunteer contributing socks, underwear, and toiletries. We even had small gifts for the birthdays of regular patients. We strongly believed that quality health care needed to be holistic, accessible, and comprehensive.

Over time, the medical clinic has become more professional, adding services and specialty care, and developing and improving standards of care. At times it has been hard for some staff who miss the "grassroots days," but there is recognition that the benefits of growth and change outweigh the increased paperwork, meetings, and adherence to new standards. In the process we have kept our initial mission of personal care, building trust, and breaking down barriers to care.

I recently encountered a woman in SOME's medical clinic who had completed our substance abuse treatment program and our Center for Employment Training. She is now working at SOME. There are numerous such stories — people with jobs, housing, and who have gotten their GED, who have gone to college. Those are the stories I'm really proud of — individuals who have been empowered to improve the quality of their lives and to be able to contribute to the community and assist others to begin the process.

★ FLORA HAMILTON, EXECUTIVE DIRECTOR, FAMILY AND MEDICAL COUNSELING SERVICE, INC.:

Our agency started out as a private practice in social work, founded by four social workers in 1976, more than 30 years ago. We wanted to provide culturally appropriate behavioral health services to the African-American community. However, we had very limited resources. In fact, we all kept our full-time jobs in the beginning. We all did clerical work as well as social work. I never imagined it would develop into what it is today. It was really a labor of love.

We were originally in the Munsey Building next to the National Theatre downtown. After a year, we moved to Anacostia in order to be accessible to the underserved population we were targeting. Initially, we rented an office of a physician located there. Eventually, we moved into our own suite of offices and we have even expanded since then. Today, we have seven suites in that same building — the Anacostia Professional Building. It's across the street from the "The Big Chair."

1973 — THE GAY MEN'S VD CLINIC, PART OF WASHINGTON FREE CLINIC, BEGINS OPERATING IN THE BASEMENT OF THE GEORGETOWN LUTHERAN CHURCH.

1974 — ZACCHAEUS FREE MEDICAL CLINIC FOUNDED, LATER TO BECOME PART OF BREAD FOR THE CITY.

1975 COMMUNITY OF HOPE FOUNDED BY DR. TOM NEES AS A COMPASSIONATE MINISTRY OF WASHINGTON FIRST CHURCH OF THE NAZARENE.

1976 BREAD FOR THE CITY FOUNDED.

1976 FAMILY AND MEDICAL COUNSELING SERVICE, INC. FOUNDED.

In the early days, we got referrals, many from DMV, Department of Motor Vehicles, relating to people who had problems with alcohol. That's how we got involved with the population of substance abusers. Our practice began to develop in that area, as well as mental health services. After a while, we were able to hire one secretary and pay the rent.

Toward the end of the 1980s, I was reading in the paper about the AIDS epidemic, though it wasn't called that back then. The concern about AIDS was focused on middle-class white gay men. I remember reading an article about Newark, NJ, that reported that substance abusers were also dying of this new epidemic. I knew our population was at risk so I applied for a prevention grant from the CDC, Centers for Disease and Control and Prevention. It wasn't long before we discovered a lot of our clients were already infected. And that is when we realized: prevention wasn't enough.

In order to address the challenges associated with AIDS, we decided to have treatment services in-house. We started with mental health services and case management for people who were HIV positive. Primary care was a big thing that we needed to get people to address. But we didn't offer primary care services. We were social workers.

So then in 1994, we applied for support for primary care. That's the story of how we became a health clinic providing both physical health care and mental health services. In the beginning, we had one physician and one examining room. Today, we have four exam rooms, three physicians, two physician assistants, and four medical assistants.

★ SHARON A. BASKERVILLE, CEO, DCPCA; FORMER PATIENT AND LATER EXECUTIVE DIRECTOR, COMMUNITY MEDICAL CARE:

In those days, I got hired because I lived in the neighborhood and I could type 35 words a minute — and within six months I became the business manager, which shows you what desperate times there were. [One of the] highlights of lessons I learned on how to run an organization is when Pepco came in one day to cut the lights off and the waiting room was full of patients. So I wrote them a check, and they left… and then I called and stopped payment on it. Which is what you do, 'cause I was poor, so I knew how to handle being poor — and we were poor.

★ VENETA MASSON, CO-FOUNDING STAFF, COMMUNITY MEDICAL CARE:

In the '70s I came to Washington, DC, to take a job with an international health organization. I was traveling a lot, but was lucky enough to find a church, and that church was called Church of the Savior. In that church, one time, I heard a man speak named Jim Hall. He was a physician, headed for a career in academia, doing research on lobsters at the time. And yet he was making a call for a health ministry for an underserved neighborhood in Washington, DC.

I can't possibly tell you his whole story, but suffice it to say I heard that call and I thought to myself "what a great hobby this would be for me." I knew very little about Washington, and I thought "I'm going to join this task force that he's talking about." So I warn you to watch out for hobbies — they can consume your life.

The church believed in both an inward spiritual journey and an outward engagement with the world, so out of that task force, Community Medical Care (CMC) eventually emerged. We had a little place on 9th Street NW right across from [what is now] the Convention Center.

Dissention is not always a bad thing — out of the little seedbed that CMC came from also emerged Columbia Road Health Services and Community of Hope. We were all about the size of Whitman-Walker at that time — just little ones on the edge. But these little clinics were very family oriented, and it was as if — I don't want to idealize anything — but it was as if there was a patient-staff community. We all learned from and valued each other. And certainly over these many years, even though I am no longer a part of this effort, Sharon Baskerville was part of my life for most of 20 years and continues to be to this day.

★ PATRICIA HAWKINS, ASSISTANT EXECUTIVE DIRECTOR, WHITMAN-WALKER CLINIC:

[When] Whitman-Walker started, in the gay community, everybody was dying. People were dying all around us. When I became a volunteer we didn't even have the test yet. The first patients we saw, we wiped off all the doorknobs as soon as they left. That was the last time we did that. We thought: if we get it, we get it.

The clinics have always believed in integrated care models. Even in the early days, a lot of us had food banks. We tried to get transportation for our clients. We distributed

1978 — COMMUNITY MEDICAL CARE FOUNDED BY DR. JIM HALL AND VENETA MASSON.

1978 — WHITMAN-WALKER CLINIC OPENS ON 17TH STREET NW.

1979 — COLUMBIA ROAD HEALTH SERVICES FOUNDED BY DR. JANELLE GOETCHEUS.

clothing. Many of us had housing programs. Along with providing health services, we took on a lot of social justice issues around poverty.

[In the clinics] we share so many of the same struggles. We've all been there. We all know what it's like not to be able to make payroll. That shared experience creates tight bonds. You couldn't find a more compassionate, more dedicated group of people.

1983 LA CLÍNICA DEL PUEBLO IS FOUNDED.

We are able as a group to do so much more than we were able to do as individuals. But until we get to a point when everybody has a medical home, our work is not complete. We are working toward a day when all people get good care, whether you're insured, not insured, or as wealthy as Rockefeller. We look forward to universal health care, a concept that takes many of us back to our roots.

★ JANELLE GOETCHEUS, CHIEF MEDICAL OFFICER, UNITY HEALTH CARE, INC.; MEDICAL DIRECTOR, CHRIST HOUSE:

I went to medical school wanting to provide health care for underserved persons. I always thought of doing that in underserved countries. I am ashamed I wasn't aware of all the concerns in this country. I came to Washington, DC, in 1975 to visit, and was taken into a low-income apartment building in Adams Morgan. The building was in terrible condition; water was coming into people's apartments. I never knew people had to live like that. They shared with me what it was like to get health care. It was an eye opening experience. That was a turning point for me.

1985 HEALTH CARE FOR THE HOMELESS, WHICH WILL LATER BECOME UNITY HEALTH CARE, IS FOUNDED.

[My husband and I] were headed overseas at the time. We made a decision to return to DC, and a year later, we moved into that same building to form a small health service. I later went on to form Columbia Road Health Services — we also put a health service in the building where Community of Hope was located.

★ JUAN ROMAGOZA, FORMER EXECUTIVE DIRECTOR, LA CLÍNICA DEL PUEBLO:

I first came to Washington in 1986 for a conference on sanctuary and Central America. When I arrived, I discovered many Salvadorans from the part of El Salvador that I come from, the east side. That is my community. Even today, I recognize people from my town. Someone told me there was an opening on Tuesday nights at La Clínica del Pueblo, an Adams Morgan clinic that had been founded in 1983. I began volunteering — in education, in intake, and also using my medical skills. I provided medical care,

under the supervision of the medical director. I started doing everything. I cleaned. I opened the clinic, I closed it. Everyone at that time was a volunteer.

In the 1980s large numbers of people were coming here from Central America. The Latino community changed the face of Washington, DC. They say 100 Salvadorans came to DC every day in those days. But when they had health problems they didn't have a place to go.

In the 1980s and 1990s, people in my community were afraid to go to the hospital or to a clinic, because of immigration status and language barriers. At that time, you could find few people speaking Spanish in hospitals. So, people simply didn't go to the hospital. Instead, for medical care, they would go see individuals who worked out of apartment buildings in our community who actually took advantage of Spanish-speaking people. They offered a more personal approach which appealed to Latinos, but those people had no medical training. As a result, many people died.

The Latino community expects a holistic response to health problems. We talk about how to integrate the different disciplines in treating them. In contrast, the American system is fractured, very short-sighted. That was a surprise to me. The American system divides you; there are so many specialists and little connection between them. To be effective, you need to involve the patient. But here, the doctor is the last word in American medicine. We believe the patient needs to have control. Today we have close to 100 paid employees, including full-time and part-time employees and consultants. We serve 5,000 clients at La Clínica del Pueblo.

★ MARIA GÓMEZ, MEMBER, DCPCA BOARD OF DIRECTORS; PRESIDENT AND CEO, MARY'S CENTER FOR MATERNAL & CHILD CARE:

During the 1960s and 1970s, there was a need for health care services that extended to Latino families in the District, but these individuals mostly came to our city as employees of the Central and South American embassies. Furthermore, a large percentage of the Latino population were residents of Puerto Rico, and were eligible for Medicaid benefits.

In 1968, there were solid public health services in the city. I remember using the one on Upshur Street NW during the height of Martin Luther King riots. It has been closed for many decades but served as home for basic maternal and child health services. At the time it was mandatory to bring your own interpreter — if you did not bring someone who could translate for you, you would be denied services. There was no

1988 — MARY'S CENTER FOR MATERNAL & CHILD CARE FOUNDED BY PRESIDENT AND CEO MARIA GÓMEZ.

1990 — THE LATE DON VOGEL, FOUNDER AND FIRST PRESIDENT OF THE CARL VOGEL CENTER, BEGINS THE ORGANIZATION IN MEMORY OF HIS SON, CARL, WHO DIED OF AIDS IN 1989.

recourse or appeal, and no advocates existed to assist you. Needless to say, I learned English quickly and became the lifetime interpreter for my family.

A Medicaid office to access health insurance also existed in those times and not much has changed — there were long lines, but I recall that receiving the actual Medicaid card was more expedient. It was also easier to find a physician who would accept Medicaid back in the 1970s. However, patients were never given a choice of where to go for diagnostic tests or hospitalization. If you were a Medicaid patient, or if you were uninsured, you went to DC General Hospital or Providence Hospital for care. These were the only two hospitals in the city who would accept uninsured patients. You knew that you would be there all day — even if you went for the most minor problem.

The only Federally Qualified Health Center (FQHC) was on 14th and Irving in the heart of the immigrant community, but the area was very hostile and would chastise individuals if they did not bring an interpreter. Because of this hostility, small volunteer groups started opening clinics — I recall Spanish Catholic Center, which catered to adults who migrated to the US. Prenatal care was rarely offered by free clinics and many did not provide family planning services because they were faith-based.

Many factors contributed to what I saw as a need to open a clinic that provided care to women and children. There was a great need in the community — immigrants were migrating from their homelands in Central and South America to escape war, poverty, and death, so the number of undocumented immigrants in search of care was on the rise. There were many women who would forego prenatal care because there was nowhere to access it. Uninsured immigrants were hit hardest because they did not qualify for Medicaid. We started Mary's Center out of a basement in 1988, and it has now grown to an organization that sees more than 8,000 clients a year in two locations. We are very proud of the work that we do at Mary's Center.

As community organizations were growing, **a number of changes were taking place in the District. The Home Rule Act, giving the District limited local control through a legislative Council and Mayoral administration, had only been passed by Congress in 1973. There were many challenges for local control over health care services. The public health care system was sparsely coordinated and suffered from a serious lack of investment. The Department of Health became a separate entity from the Department of Human Services only in 1998, just as the District of Columbia Financial Responsibility and Management Assistance Authority (aka, the "Control Board") was working to reorganize neighborhood health services into a coordinated model under the Public Benefit Corporation. The situation was changing rapidly as community health centers began to band together to join government and private interests at the negotiating table.**

1990s

CONGRESS PLACES THE DISTRICT UNDER THE AUTHORITY OF THE DISTRICT OF COLUMBIA FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE AUTHORITY, OTHERWISE KNOWN AS THE CONTROL BOARD.

★ JIM HARVEY, FORMER CHAIR, COMMUNITY HEALTH CARE, INC. BOARD OF DIRECTORS:

Imagine DC without an FQHC system. That was a distinct possibility in the late 1980s. Cities across the country were being told to consolidate health services to the uninsured, or face the possibility of no federal funds for health care at all. DC had two FQHCs — East of the River and Upper Cardozo. Reid Tuckson was Commissioner of Public Health in those days.

I had been appointed to the Board of one FQHC when Dr. Tuckson enlisted me to accompany him to a meeting with the Assistant Surgeon General. Together we convinced this career fed to give us time to merge the two FQHCs and keep federally supported health care in the District. I was selected to lead the merger negotiations — representatives from each Board were selected to meet and make it happen.

Sometimes I wished I had brought a whistle and wore a striped shirt because the most I could do in meetings was literally keep people from climbing across tables to attack someone. After six weeks, we had a merger. I was drafted as Board President and we served the people of the District for over six years. After I left, the clinic ran into some challenging times. When all seemed lost, Health Care for the Homeless stepped in and assumed the control of the FQHC, and people were spared the loss of health care. Now we can boast five FQHCs in the District. That's a long way from the one we were told was the limit 20 years ago.

★ MARLENE KELLEY, FORMER COMMISSIONER OF PUBLIC HEALTH; CHAIR, UNITY HEALTH CARE BOARD OF DIRECTORS:

My career started in 1969 when I graduated from medical school and did my internship and residency at DC General Hospital. From there I went into the neighborhood health clinic on H Street NE — it's no longer there, but at that time I remember about 15 clinics in existence. It was a difficult time because health care was not funded as it should have been, so we had to struggle. Several of those clinics closed over the years.

In the 1990s, the climate in the District was not the best. We were thought of as the capital of fraud, abuse — it was a time when we were all struggling. As a result, the city was under the egis of the District of Columbia Financial Responsibility and Management Assistance Authority — we called it the Control Board, and it led our lives.

One in four DC residents were poor. We had an infant mortality rate that was twice the national norm, and we led the nation in eight of the ten top causes of death. Anthony Williams was CFO at the time; he and the Control Board were very concerned about the amount of money used on a health care system in such disarray, with all of these poor health care statistics. So it was mandated that the Public Benefit Corporation (PBC) be formed [to run the health system] — DC General Hospital and the clinics got together and began to meet around putting this entity in place.

Alice Rivlin, was Chair of the Control Board, and thought the PBC could create a better health environment — a community-oriented quality health situation for the residents of the District. Even though the Control Board mandated [the organization of the PBC], our clinics continued to deteriorate due to inadequate funding for infrastructure maintenance, and several of them closed. There were many contentious meetings. It was difficult to figure out how to [come together and] integrate the doctors and other staff members from the clinics into a hospital environment, and vice versa. Some of the staff left — they just didn't want to get involved with changes that had to occur to make this a viable entity.

CHILDREN'S HEALTH PROJECT OF DC FOUNDED. 1994

The deed was finally done in late 1997, and at that time, eight neighborhood health clinics, four dental clinics, and the school health services were all turned over to DC General and the PBC. The Department of Health at that time continued to provide some services: STD (sexually transmitted disease) and TB (tuberculosis) services, immunization, breast screening education, substance abuse counseling and treatment, health and human services facility inspections, ambulance inspections, and certification and inspection of food establishments.

Despite all this work, DC General and the PBC continued to run cash deficits — by the year 2000 they were over $1 million dollars in debt. Now something else had to be done; the Control Board said they had to put something else in place, and the federal government also put pressure on the District and the PBC. There were attempts to restructure, but no action was taken until the Control Board and the Mayor again became involved. In addition, the federal government put stipulations on the District's appropriation that mandated restructuring. Eventually, a number of transitions took place to expand the safety net delivery system, integrate school health, care for the corrections population, and provide other targeted services.

1995 REPRESENTATIVES OF HEALTH CLINICS MEET TO DISCUSS FORMING AN ORGANIZATION, CALLING THEMSELVES THE PRIMARY CARE ROUNDTABLE.

1995 MANDATORY MANAGED CARE PROGRAM BEGINS FOR MEDICAID ENROLLEES.

1995 THE NON-PROFIT CLINIC CONSORTIUM COMES TOGETHER.

★ HARVEY SLOANE, FORMER DIRECTOR, DC DEPARTMENT OF HEALTH:

I grew up in Washington but I spent a lot of my adult life in Kentucky. I moved to Louisville and started a community health center — we had one of the first in the country. I ran that and then I got involved in politics and was Mayor of Louisville.

When I came back to Washington in 1995, and I'd read in the paper that the DC Medicaid program had paid out $1.6 billion dollars for the care of probably no more than 50,000 people. I said, "gee whiz, we could really cover a lot of people, if we did that right." So I went to my newly elected councilmember and she said, "well you know, they're looking for a health commissioner down at city hall."

Mayor Marion Barry had just been elected to his last term. I assure you, there wasn't a big line to get in. So I worked — my whole point was to promote primary care. There was another guy who joined the administration shortly after I did named Paul Offner — unfortunately he has passed away. Together we tried to get as much of the dollar out of the city government and into the community — the health centers and other care delivery organizations could do a lot better than us, as we weren't doing very well. I think it was exactly 10 years ago in 1997 that I left, so it's very exciting for me to see what has happened with primary care in Washington, and people around the city are getting such better care now than they did when we were around.

I'm now working in Russia on HIV/AIDS control, and I have to say, my experience in DC government really did prepare me for Russia.

★ SHAUNA SPENCER, ASSOCIATE DEPUTY DIRECTOR, OFFICE OF PROGRAMS AND POLICY, DC DEPARTMENT OF MENTAL HEALTH:

I've worked in health care for almost 30 years. I became involved in primary care when I moved backed to the District in 1989 and went to work for Group Health Association, a large HMO (health maintenance organization). In 1994 Group Health was bought by a large for-profit chain and I went to work for Planned Parenthood of Metropolitan Washington. I became actively involved in Medicaid reform in Maryland; that included serving on a number of committees concerning access and special populations and the state's Medicaid Advisory Committee. As Medicaid Managed Care was being implemented in Maryland, the District began its own process.

In 1995, several nonprofit organizations — Mary's Center, Community Medical Care, La Clínica, Whitman-Walker, Planned Parenthood of Metropolitan Washington —

were concerned about what managed care would mean for their Medicaid revenue. Nonprofits hadn't charged in this way for services before; we didn't think of services in terms of billing codes. Managed care was frightening due to the uncertainty about its impact on already fragile revenue streams. [The health centers] all operated on sliding scales, saw people regardless of their ability to pay, and wrote grants like crazy.

The Annie E. Casey Foundation offered to help us figure out what managed care would mean to our business operations, even though we didn't see ourselves as businesses; we were mission-driven organizations. The Casey Foundation arranged for experts to come in and teach us about Medicaid managed care. Those sessions were the genesis of the Non-Profit Clinic Consortium run by Dr. Robert Cosby.

1996

HEALTH CARE FOR THE HOMELESS EXPANDS AS THE FEDERAL GOVERNMENT'S GRANTEE FOR THE COMMUNITY HEALTH CENTER PROGRAM.

★ ROBERT COSBY, FORMER EXECUTIVE DIRECTOR, NON-PROFIT CLINIC CONSORTIUM; CHIEF, OFFICE ON DISABILITIES AND AGING, DC DEPARTMENT OF HEALTH:

It was the best of times, it was the worst of times. I used to say that when I gave testimony in front of the Council. We had, [in the mid 1990s], 11 clinics that really were the backbone of the historic safety net for primary care here in the District of Columbia. But it was a time when people were not getting the type of health care that they needed across the city.

We had the first rally for primary health care in this city, at 441 4th Street NW, and I think we had about 300 people that came through, on behalf of more than 20 agencies — it was held outside 'cause they wouldn't let us inside the building. We moved to a better way of managing our organization such that all clinics would be able to say that they provide quality health care with a seal of approval. We looked for [Joint Commission on Accreditation of Healthcare Organizations] accreditation, we looked for [American Medical Association] accreditation — anything that would help clinics to say that they were on par with anyone else.

We were very proud to be able to get the first primary health care methodology for reimbursement, the rate was set and still exists today for both Medicaid and Alliance payments. It wasn't enough then, I think the case is made that it still is not enough. But we're very grateful to the District for all the work that they were able to do, and certainly in seeing all the people that have been behind this, on the front lines or behind the scenes.

What we did with the Non-Profit Clinic Consortium (NPCC), and what I think NPCC should be very proud of, is what we're seeing now. There were opportunities for

people to actually discuss advocacy, as well as to talk about how health care was and was not being provided. The clinics are medical homes — this model is one that NPCC worked with and DCPCA got underway.

★ VINCENT KEANE, MEMBER, DCPCA BOARD OF DIRECTORS; CEO, UNITY HEALTH CARE, INC.:

In 1990, I became executive director of Health Care for the Homeless. We provided case management, mental and physical health services for families and individuals staying in the shelters, and for men and women living on the streets. In 1996, our organization was asked to take over two health centers, one in Columbia Heights and one in Southeast that had been part of an organization which had gone bankrupt. That was when Health Care for the Homeless first began to broaden its mission. In 1997, we changed our name to Unity Health Care.

The year the District closed DC General Hospital, [we took on an additional] seven health center sites. We started out with a staff of 50 and today we have 850. We started by serving 15,000 homeless people in the 1990s; today we serve 70,000 people throughout the District.

In the 17 years I've been working in the District, the health care landscape has changed for the better. Through creative leadership and consistent advocacy, we have ensured that underserved people who were once served by DC General are not left out. We are looking more and more at that population.

Advocacy by DCPCA has put primary care at the top of the city's agenda. In the past, the climate was hostile, the focus was on keeping beds filled and emergency rooms open. But an emergency room is not the place to go for primary health care. We've been shouting about that for a long time. It was Sharon who put primary care on the fast track. What is important is being able to provide the systems, not just the one visit to a doctor. What is important is connecting people to a system of care, not just an occasional visit to the doctor.

I've been doing this a long time. Before DCPCA was created, we were just a lot of advocates all screaming about the need to do good work. We felt we needed a systemic approach to get primary care into the forefront of health care delivery system. Sharon has given vision, and great leadership, toward the vision of primary care for all. She's had wonderful advocates and board members work with her — all toward the goal of sustaining our health clinics so we can be there for our clients. It's a means to an end. Better health care. Better outcomes.

A new approach

was signaled by the founding of a Primary Care Association (PCA) for the District. Funded by the federal government, under the US Department of Health & Human Services, Health Resources and Services Administration, PCAs existed in most states at the time — working to build and strengthen primary care infrastructure for residents of their jurisdiction. The founding of the PCA was a huge cultural step for community health centers that were interested in preserving their own missions, strategic approaches, and patient-care models. But it was a natural progression from the spirit of collaboration that was just beginning to show real results for residents of the District who relied on publicly funded health care services.

1997 — DCPCA APPLIES FOR AND IS GRANTED 501(C)(3) TAX EXEMPT STATUS, AND RECEIVES FUNDING AS A BUREAU OF PRIMARY HEALTH CARE GRANTEE TO IMPROVE PRIMARY CARE SERVICES FOR THE VULNERABLE IN THE DISTRICT.

1997 — THE CONTROL BOARD TAKES ACTION TO FOUND THE PUBLIC BENEFIT CORPORATION (PBC) — SIX HEALTH CLINICS, ALONG WITH ALL SCHOOL HEALTH SERVICES IN THE DISTRICT, ARE TURNED OVER TO PBC CONTROL.

1997 — HEALTH CARE FOR THE HOMELESS CHANGES ITS NAME TO UNITY HEALTH CARE, INC.

★ SHARON ZALEWSKI, FOUNDING CHAIR, DCPCA BOARD OF DIRECTORS:

My first entre into health care was with Community of Hope back in the early 1980s. I served as the program director of the Washington Free Clinic in the late 1980s, then I worked for Health Care for the Homeless in the early 1990s, then I went back to the Free Clinic in the late 1990s, and now I'm in Montgomery County, MD — trying to bring the lessons that we learned here in the District across the border; our patients certainly come across the border sometimes.

When DCPCA got started, I was the first Chair, and I was recruited by a group of people that were meeting in something called the Primary Care Roundtable. Between Dr. Harvey Sloane and Marlene Kelley, the Roundtable [came] together with leaders in health care, hospitals, and HMOs (health maintenance organizations). They'd been meeting for a couple of years, and the environment was very difficult. The nonprofit clinics were struggling in church basements or attics, barely paying our bills, barely paying our staff, and using a lot of good volunteers — but we didn't have a stable base for delivering services.

The hospitals were doing a lot of uncompensated care, and the public health hospital was starting to fall apart at that time. Everything was relatively inefficient, and in a state of flux — it was actually scary. I used to go home at night and pull the blankets over my head thinking, "how am I going to get the next buck? How am I going to see the next patient? How are we going to get the pharmacy stocked?"

We were meeting together and a small group of people started to emerge — from the hospital association, the academic health centers, the hospitals, the nonprofit clinics — a group of us sat down and said there are these things called Primary Care Associations, and they're associated with federal dollars. Maybe we could do something like that? Maybe we could work together to make that happen.

Largely through the efforts of Dr. Sloane, Marlene Kelley and Regina Knox Woods, we received an initial grant as a cooperative agreement with the DC government, so we had this sort of underlying government support pushing funds out into the community. We had no staff, there were four or five of us [volunteering]. We really worked with nothing. We worked early, we worked late at night, we all had day jobs — I was working at the Washington Free Clinic trying to pay our bills too. It was a time of high energy and high hope for us. The Eugene and Agnes E. Meyer Foundation funded our first strategic plan back in 1996.

One of the more interesting things about DCPCA at that time is also that we had to go and convince the feds — I remember all these high level feds coming, and here I was in the top floor of St. Stephen's Church in this dark, dingy place. These high level feds came over and said "do you really think that you can do this?"

We were pulling together a group that no other PCA had ever pulled together — with the hospitals, the HMOs (health maintenance organizations), the nonprofits, the academic health centers — all of these groups were major players. And all of the people worked for them who were doing this in addition to their day jobs.

★ DEBI TUCKER, FOUNDING COORDINATOR, DCPCA:

I got involved in health care issues at a young age — I spent many hours of my childhood in hospital rooms with my mother. We didn't have a lot of money or know much about health care resources. My mother died young, and looking back, I think that if only we had had more information, maybe she would have lived longer.

My interest in health care continued when I moved to DC to go to George Washington University in 1971. I volunteered at the Washington Free Clinic, which was located in a church basement in Georgetown. In 1980, I began working as Coordinator for the DC Consortium of Academic Health Centers. When my son was small, I decided to do consulting out of my home. Carlessia Hussein, who had just left a position as Deputy Director of the DC Department of Health, and I, along with Joan Lewis, who was interim president of DC Hospital Association, were frustrated with the District's fragmented health care delivery system. It became clear that we needed to bring together primary care providers and link them with other providers in the continuum of care.

In 1995, we brought together 50–60 stakeholders for a summit to talk about models for integrated health delivery systems. Representatives from the free clinics were already beginning to come together on common issues. Eventually, we worked with the Department of Health on a federal grant proposal to the Bureau of Primary Care to establish DCPCA.

At that time, primary care associations consisted only of FQHCs (Federally Qualified Health Centers). The District only had one FQHC, and one "look alike." We envisioned a different kind of model, one that would bring together various components of the health care system to work toward an integrated care system. When we set up the board, it was a unique experiment to include representatives from managed care, hospitals, nurse practitioners, family practice physicians, and health professional schools. The Bureau of Primary Care was very resistant. But thanks to Vince Keane of

1998 — ELIGIBILITY FOR MEDICAID IS EXPANDED THROUGH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, COVERING CHILDREN AND THEIR PARENTS UP TO 200% OF FEDERAL POVERTY LEVEL (FPL).

1998 — THE DC DEPARTMENT OF HEALTH SEPARATES FROM THE DC DEPARTMENT OF HUMAN SERVICES. HARVEY SLOANE IS APPOINTED THE FIRST DIRECTOR.

Unity Health Care, who supported and advocated for this new model, the Bureau gave us the initial funding to create DCPCA.

Sharon Zalewski was the first Chair and I became the Coordinator — literally running the organization out of my basement. Fortunately, Joan Lewis and DCHA agreed to house DCPCA in one of their offices. DCHA generously provided us with space and in-kind contributions of support staff and supplies. DCPCA probably would not have survived without DCHA's support. When Sharon Zalewski left, Sharon Baskerville became Chair and then Executive Director. It was clear from the start that she had the passion and experience to move this organization forward.

A lot of this succeeded because of pure commitment to the common good. People put aside their personal and professional agendas to look at the bigger picture. It was a lot of work but also a great amount of satisfaction. I've always believed that everyone should have access to the health care services they need. It's rewarding to know that DCPCA still supports this philosophy and the initial mission we envisioned 10 years ago.

DCPCA had a vision for health care that would use a "medical homes" model to strengthen DC's safety net system. The concept of a "medical home" was a good fit for community health centers with long histories in their neighborhoods, providing patient-centered, coordinated, and culturally-appropriate care to their clients. Before long, the District government committed funds to Medical Homes DC — an effort led by DCPCA to improve access to primary care in the District's many medically underserved neighborhoods. The local funding community mobilized around the goal set forth by the District to provide a 50% match in fundraising, ensuring the city's continued investment.

★ KATHY FRESHLEY, SENIOR PROGRAM OFFICER, EUGENE AND AGNES E. MEYER FOUNDATION:

I began working on health care for Meyer in 1995 at the time when the District shifted Medicaid and health care reimbursements from fee-for-service to managed care.

There was tremendous concern by funders that this change would deeply impact the 13 nonprofit safety net clinics that provided more than 60% of health care services to low-income people in the city. Funders, nonprofit health clinic leaders, and some committed government leaders began meeting to understand how the patchwork system worked and could be improved. The goal was to transform the current inefficient and costly system to provide 100% access and zero percent disparities for low-income, uninsured residents.

The birth of the DC Primary Care Association was a logical response born out of tremendous concern. Not only were funders and safety net clinics concerned, but hospitals, HMOs (health maintenance organizations), and governments were deeply affected by a changing health financing environment. The Meyer Foundation's first grant to what would become DCPCA was $5,000 in 1996. Since that time Meyer has invested $980,000 to support its public policy advocacy and health care system reforms.

Initially a considerable amount of work was necessary in order to build trust among its members. However, DCPCA's members understood that if they worked together they could transform the way health care was delivered and financed in the city — and this transformation could dramatically improve health outcomes, especially for low-income residents. The tenaciousness of Sharon Baskerville, her staff, and members earned DCPCA the respect of the philanthropic community and the DC government.

1999 DCPCA RECEIVES ITS FIRST GRANTS FROM THE CONSUMER HEALTH FOUNDATION, ANNIE E. CASEY FOUNDATION, AND EUGENE AND AGNES E. MEYER FOUNDATION.

★ MARGARET O'BRYON, CEO AND PRESIDENT, CONSUMER HEALTH FOUNDATION:

Over the past ten years, I have watched DCPCA as it has grown from a small advocacy organization to the multi-functional, multi-million dollar enterprise it is today. The Consumer Health Foundation has been privileged to participate in the gestation and hatching of one of its signature endeavors, Medical Homes DC — a $145 million, 10-year project to rebuild the primary care system for low-income DC residents.

While acknowledging that DCPCA's work is complex and its accomplishments many, I want to raise up what I believe is one of its most significant roles. Over the past decade, DCPCA has been a leader in building political will for change so that efforts

that promote a progressive health reform agenda are supported, and those that protect the status quo are challenged. As I think about DCPCA's work in this arena, a wonderful story and image come to mind. It is a story that has taken on "shared meaning" within the private funding community. The time was the late 1990s in a conference room filled with local and national funders, health care providers, advocates, and public officials. The event was a briefing on the status of health and health care in the District for low-income, uninsured, and/or underinsured residents. The meeting went on pretty routinely until the microphone was passed to Paul Offner. Paul was serving as the head of the Medicaid program and health care finance in the city. He came to the District from a long career of public service and with a profound belief in the power of good public programs to change lives. He was an ardent reformer, a kindred spirit to DCPCA and to so many of us in the room. At the end of his presentation, Paul was asked what the private funding community could do to support the health care reforms he was advocating. With no hesitation and in his strong, yet quiet and considered way, he issued several challenges. He challenged the funding community to help provide coverage to ineligible children (another story); and he challenged us all to help build political will by developing and becoming an educated, strong, savvy, and vocal constituency that could push for the reforms we knew must be enacted. Paul died of cancer in 2004 at 61.

The gauntlet thrown down by Paul was immediately picked up by DCPCA and its leader, Sharon Baskerville. Using all of the forces within its power, DCPCA built the base envisioned by Paul, held the collective vision for positive change, and continues to lead the charge for equitable and just health care for all. It is an enviable legacy, the effects of which have benefitted thousands and thousands of adults and children living in our city. It is a legacy which propels our work moving forward.

A new era of innovation

was dawning in the District, with leaders, public officials, and funders truly willing to invest in system change. Community residents, clients, and patients were engaged like never before in this process, in part because recent progress provided a seedbed for leaders to rise and once again challenge the established ways of doing business. As the health system in DC was overhauled, advocates stood to ensure that the needs of low-income and medically vulnerable residents were not overlooked. The closure of DC General Hospital was a difficult and controversial undertaking for District government. But thanks to the tenacity of the activist community, the passing of DC General bore fruit in the form of refocused investment in coverage through the DC HealthCare Alliance, and a true commitment to primary care through Medical Homes DC.

★ KIM BELL, SECRETARY, DCPCA BOARD OF DIRECTORS; EXECUTIVE DIRECTOR, DC AREA HEALTH EDUCATION CENTER:

In 1999 I was fortunate enough to be offered the opportunity to serve as the statewide director for the DC Covering Kids initiative — which is part of a national initiative funded by the Robert Wood Johnson Foundation.

Part of that initiative was about ensuring that all uninsured children had access to health care, so that their parents knew about the programs and were able to access and navigate the very complex application system. But the foundation for that was a coalition. They asked us to put together a statewide coalition.

At the time, in 1999, you [were] ask[ing] for a very diverse group of people to come together. You're asking government entities to come together, private citizens, consumer groups, advocacy groups, service providers — we didn't even trust one another, much less were we able to come together to coalesce around a strategy to ensure all children had access to health care coverage.

But I am proud to say that after seven years of funding by the Robert Wood Johnson Foundation, for the first time in this city we pulled together. We had the fortitude, the push and the drive, and the commitment to come together around a coalition at the end of the day. Seventy people came together. I came from an advocacy community — I'm a born and bred community-based advocate. But I've learned, in having the opportunity to be a leader as part of this group, that I am also supported, and at times carried, on a tough road to health. This is a journey that we all take together and I'm proud to be part of that journey.

★ RUTH LUBIC, FOUNDER, FAMILY HEALTH AND BIRTH CENTER:

The concept of the freestanding birth center was established in 1975 as an alternative maternity service for families disenchanted with care which did not honor the social, emotional, and spiritual aspects of childbearing. It spread rapidly throughout the country until close to 200 are operating today. At the outset, the model honored the wishes of families through providing respectful care which enhanced the normal aspects of childbirth, yet provided the consultation and care needed by some women and families. It did this through the formation of professional teams which provide the warmth of personalized nurse-midwifery care along with the availability of obstetrical care needed sometimes by some women. Originally, it was middle class women and families who sought out this care. Because they defied ideas, beliefs,

2000 — DCPCA IS SELECTED AS THE DISTRICT'S GRANTEE FOR THE ROBERT WOOD JOHNSON FOUNDATION "COMMUNITIES IN CHARGE" GRANT.

2000 — RUTH LUBIC USES HER MACARTHUR FOUNDATION "GENIUS GRANT" TO FOUND THE FAMILY HEALTH & BIRTH CENTER.

2000 — DC CREATES A LOCALLY FUNDED MEDICAID PROGRAM TO COVER IMMIGRANT CHILDREN INELIGIBLE FOR TRADITIONAL MEDICAID WITH FAMILIES EARNING UP TO 200% OF FPL.

and practices of in-hospital maternity care, birth centers have had a struggle to demonstrate success.

Here in the District, the concept arrived in 2000 as a humanitarian effort to reduce the disparities in maternal and infant outcomes experienced by African-American families — it was welcomed by DCPCA into the safety net clinic network. The effort in Ward 5 has been successful beyond expectation — in the significant reduction of rates of babies born preterm, at low birth weight, and by cesarean section, among the African-American families being served. [Also] in the cost savings — in the empowerment of women and their families, and in the recognition by foundations, politicians, and press.

2001 DC GENERAL HOSPITAL CLOSES ITS DOORS IN MAY.

2001 THE DC HEALTHCARE ALLIANCE IS FORMED TO PROVIDE HEALTH INSURANCE FOR DC RESIDENTS UP TO 200% OF THE FPL.

2002 DC ADDS ITS SECOND FEDERALLY QUALIFIED HEALTH CENTER (FQHC), COLUMBIA ROAD HEALTH SERVICES.

★ MOTHER AND CLIENT AT FAMILY HEALTH AND BIRTH CENTER:

I see mothers who were on the streets, smoking marijuana, who are now breast feeding. I mean, you go from being on the streets, doing hoodlum things to "oh, I'm not doing that because I have to feed my child. I have to breast feed my child." That is information that I got from the birth center. If we had that in every community, I definitely think that natural births would be on the rise — breast feeding would be on the rise, which is so important. I never knew anything about it. I am 32 years old and just finding out the benefits of breast feeding.

When I went, it was just like a little family. They cared about my whole, entire situation. I was about to lose my job due to my pregnancy. I was going through a lot of rough times with that, and they did a lot of referring for me. It was just great to see somebody who didn't even know you who was willing to go out of their way for you.

★ SANDRA ALLEN, FORMER COUNCILMEMBER (D-WARD 8), COUNCIL OF THE DISTRICT OF COLUMBIA:

There was so much going on at that time. I was Chair of the Health and Human Services Committee on the Council — during that time, they were combined. I remember going to a meeting, in Sharon Baskerville's office, where we were trying to make sure that everybody who was eligible for health care services in the District could enroll. We decided that we needed to re-do the form. Well, the first time around it didn't work too well, 'cause we really weren't doing outreach and getting it to the people like we should have been. There were a lot of people in the District who were eligible, who had no idea that they could get health care.

Then I became Chair, after nine months on the Council. So I'm still green — it takes a little bit of time to understand what you're supposed to do once you get there. We came up with the money [from the tobacco settlement], which Sharon and I thought we had at one time. We were on our way to Chicago to talk with the Robert Wood Johnson Foundation [in pursuit of funding for Medical Homes DC]. We already told Robert Wood Johnson Foundation the city was going to back us — we were getting ready to get on the plane and we find out that the tobacco money had been "securitized" — so we had no money.

But we didn't tell Robert Wood Johnson that, when we got there. We just kept going with what our original plan was, and we were funded. I just remember Sharon said, "what's wrong Sandy?" And I said, "they took our money." She said, "what'd you say?" I said, "we don't have any money. They decided that we're not top priority — that it was better to save the money in a rainy day fund than to spend it to save us."

2003 — THE CENTERS FOR MEDICAID AND MEDICARE IMPLEMENT A WAIVER GIVING MEDICAID COVERAGE TO CHILDLESS ADULTS BETWEEN THE AGES OF 50 AND 64 YEARS, UP TO 50% FPL.

★ SHAUNA SPENCER, ASSOCIATE DEPUTY DIRECTOR, OFFICE OF PROGRAMS AND POLICY, DC DEPARTMENT OF MENTAL HEALTH:

In the 1990s, I was Senior Vice President for Managed Care and Business Development at DC General Hospital; in the last year I had responsibility for the community health centers and school nursing as well. Primary care was always at the center of my work.

The decision to close DC General Hospital brought on a very difficult time for the city. As the first Director of the Health Care Safety Net Administration, I went to the DC Department of Health on the day the Control Board announced to DC General senior staff that the hospital would be closed. It was one of many rough days to come.

2003 — DCPCA RECEIVES A THREE-YEAR $2.5 MILLION GRANT FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES TO FUND MEDICAL HOMES DC, A 10-YEAR INITIATIVE TO IMPROVE THE DELIVERY AND QUALITY OF PRIMARY CARE FOR LOW-INCOME AND UNINSURED DISTRICT RESIDENTS.

There were rival political forces and rival advocacy groups, each claiming they knew what was best for health care in the city. Underlying the politics and passion were the often life and death needs of residents of underserved communities. Too many District residents had long histories of living with segregationist rules that effectively denied them access to affordable, quality health services. Then the government comes along and says the only hospital where they could always get care would be closed.

Now there was the massive task of closing down DC General and the simultaneous process of implementing the contract with Greater Southeast Community Hospital, working with the subcontractors and building an infrastructure. Suddenly with the flip of a switch, a new system was born. The pieces were there, but the fabric, the weaving would take time.

Thinking back on those days, I am struck by the leadership and courage on both sides of the debate. In the middle of a politically and racially charged environment, I believe that most individuals acted with the best of intentions to meet the health care needs of the city's low-income residents. In hindsight, we can always ask, was closing the hospital the best decision? The city leadership stood up and said "this is what we think is best" in the face of tremendous opposition. We don't often see that. We don't often see the kind of cooperation between the executive and legislative branches that resulted in the creation of the DC HealthCare Alliance.

2005 DCPCA HOLDS ITS FIRST TOWN HALL MEETING ON THE MEDICAL HOMES DC INITIATIVE.

Today we have a health system. Is it perfect? No, but I doubt you can go to many big cities, or even small ones, and get the same quality of care and range of services you can get in the District for low-income families.

The DC HealthCare Alliance is unique. It's a reflection of this city, its residents, its leaders, its family and health advocates, and a reflection of the DC Primary Care Association being out front and saying this is what we have to have.

★ GEORGE JONES, VICE-CHAIR, DCPCA BOARD OF DIRECTORS; EXECUTIVE DIRECTOR, BREAD FOR THE CITY:

2005 DC GOVERNMENT AWARDS $1 MILLION FOR MEDICAL HOMES DC CAPITAL PROJECTS GRANTS TO EIGHT HEALTH CENTERS.

A kaleidoscope of images go through my mind when I think about where we came from since those days — when I got to DC in 1996, I knew very little about health care. I'm the director of an organization called Bread for the City, and we had five programs — medical care is one of them, but we also have a food panty and a clothing room and legal services and social work, so every day I'm trying to figure out how to split myself into five pieces to be sure I can understand these disciplines.

But one of the most important things that happened to me when I got here in the District was that I started to meet some of the leaders in the health care community, and in the Non-Profit Clinic Consortium, which was formed by these leaders — Mary's Center for Maternal & Child Care, Whitman-Walker Clinic, Bread for the City, Washington Free Clinic — all the leaders who I think have had a huge role in helping make the transition from where the health care system was when I got here in 1996 to where it is in 2007.

When I started I knew nothing about health care — now not only have we seen the evolution that has included expanded coverage with the DC HealthCare Alliance — which I think is a great program — but we've seen the development of Medical Homes DC, which has been one of the hallmark initiatives of DCPCA.

Medical Homes DC is a program that is going to fund at least eight of the health centers to expand health care in the city. I'm proud that Bread for the City is one of the first groups that's looking to expand. We're going to go from providing health care to 2,500 people this year to at least 6,000 people. We're so excited about that and I think that's just one testament to the growth and development that DCPCA has helped make happen.

★ KATHY FRESHLEY, SENIOR PROGRAM OFFICER, EUGENE AND AGNES E. MEYER FOUNDATION:

Medical Homes DC is the next system improvement that DCPCA is advancing. Twelve new or expanded clinics are being constructed in medically underserved areas — neighborhoods mainly in Wards 7, 8, 6, 5, and 4.

Meyer is so committed to Medical Homes DC that I served as the co-chair of its private fundraising committee with Margaret O'Bryon, CEO and President of the Consumer Health Foundation. Margaret and I strongly felt that unless low-income people had access to preventative primary care and specialty services to manage chronic diseases, health outcomes would never improve in the city.

Oral health, mental health, and chronic disease management are now being integrated into primary care. Reimbursement rates are slowly being increased, and other reforms to support the health care workforce are being advanced.

In addition, DCPCA is improving the quality of primary care. Standards and protocols are being developed; electronic medical records are being created to permit a patient-centered system that tracks and improves health care delivery and outcomes. DCPCA and health funders continue to refine and move the system forward, now not only within DC but in the region.

These efforts are being fueled by the Consumer Health Foundation, the Meyer Foundation, the Morris and Gwendolyn Cafritz Foundation, Public Welfare Foundation, Kaiser Permanente, Northern Virginia Healthcare Foundation, Annie E. Casey Foundation, Campbell Hoffman Foundation, and the Health Care Initiative Foundation — all members of the Health Working Group of Washington Regional Association of Grantmakers. Health funders and primary care advocates continue to talk, across jurisdictions, about how to advance our common goals.

By forming partnerships between philanthropy, advocacy groups, direct practitioners, and government, there is a better understanding of each other's points of view,

2005

DCPCA RELEASES WHERE WE ARE, WHERE WE NEED TO GO: THE PRIMARY CARE SAFETY NET IN THE DISTRICT OF COLUMBIA, THE MOST COMPREHENSIVE ANALYSIS TO DATE ON THE HEALTH STATUS OF THE DISTRICT'S UNINSURED AND THE HEALTH CARE SYSTEM THAT SERVES THEM. THE REPORT RECOMMENDS MEDICAL HOMES DC TO EXPAND AND IMPROVE THE CURRENT HEALTH CARE SYSTEM.

2005

DC'S MEDICAID PROGRAM IS EXPANDED TO COVER PEOPLE WITH HIV AT DIAGNOSIS, RATHER THAN AFTER THEIR DISEASE HAS PROGRESSED TO COVERED DISABILITY CAUSED BY AIDS.

leading to greater effectiveness and greater change. As the result of DCPCA's steady advocacy, health care is improving in the city for everyone. DCPCA is one of the best investments I feel the Meyer Foundation has made in ensuring a healthy community for all. There's nothing more satisfying than that.

★ KELLY SWEENEY MCSHANE, MEMBER, DCPCA BOARD OF DIRECTORS; EXECUTIVE DIRECTOR, COMMUNITY OF HOPE:

When I first started at Community of Hope in 2001, our health center was in the basement level of a building at 1417 Belmont Street NW. That building served as a church, administrative office, apartment building, and health clinic. Exam rooms were small and often leaked from the ceiling or lacked heat. Exam tables were donated, we had only a few computers, and everything was cozy — and the care provided was of high quality and compassionate. Patients came to see Nurse Practitioner Laura Worby, Pediatric Nurse Practitioner Connie Lierman, and Dr. Kathy Vaughn — all of whom still work at Community of Hope. We provided about 450 medical visits per month.

In 2004, the health clinic moved from Belmont Street into a "real" health center space in the Marie Reed Elementary School, the former location of the Adams Morgan Clinic. I still remember the thrill — and anxiety — of the day when we packed up everything and moved it over. The space seemed huge! We spent a week organizing charts and setting up rooms, and opened for business on the first day of school.

In 2006, after several years of work, we were awarded status as an FQHC. This allowed us to more than double the number of patients we see, and to add much-needed dental care. Our grant from Medical Homes DC helped reconfigure our space more efficiently for patient flow, and provided funds for a state-of-the-art dental clinic with all new equipment, a panoramic x-ray, and digital x-rays. It also provided new exam tables — that actually move up and down! We upgraded our billing and management software, moved to electronic dental records, and reconfigured a bathroom to be ADA-compliant. With the restructuring of space, we've also been able to accommodate new providers. We can provide a medical home, complete with comprehensive dental services and basic behavioral health services, all under one roof. In 2008, we've had almost 1,000 medical visits and over 200 dental visits per month.

Of course, now we are out of room at Marie Reed and we look forward to finding a new site with a Medical Homes DC capital grant to further expand the number of patients we can see. Many current staff don't remember the space at Belmont Street, and have their own stories to tell about the new home at Marie Reed. What has

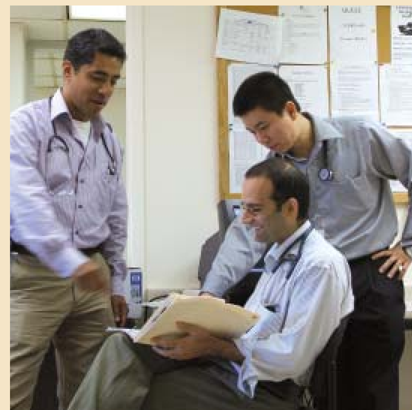
2006 — IN FEBRUARY, THE FIRST MEDICAL HOMES DC CAPITAL PROJECT IS COMPLETED — A DENTAL CLINIC AT SOME, WHICH EXPANDS THE CENTER'S CAPACITY TO PROVIDE ORAL HEALTH CARE AMONG LOW-INCOME AND HOMELESS RESIDENTS BY MORE THAN 33%. THE SECOND MEDICAL HOMES DC CAPITAL PROJECT, A DENTAL CLINIC AND RENOVATION OF PRIMARY CARE SPACE FOR COMMUNITY OF HOPE, IS COMPLETED IN SEPTEMBER.

remained consistent is the dedication of staff to their patients and their passion for providing quality health care.

★ SHAUNA SPENCER, ASSOCIATE DEPUTY DIRECTOR, OFFICE OF PROGRAMS AND POLICY, DC DEPARTMENT OF MENTAL HEALTH:

The DC Primary Care Association is a big tent under which we gather. People under the tent have not always agreed with each other. But the tent just keeps getting bigger so there's room for more people, more voices. The one thing everyone agrees on is that DC residents have the right to quality, affordable, and accessible health care. That's got to be the message inside and outside of the tent. Now that we've added mental health parity to the primary care dialogue, we're talking about the whole person, about health and well being.

Once, when I was working at DC General Hospital, I was walking down the hallway toward the front door. A gentleman was walking down the same hallway toward the door. He was carrying a paper sack. I asked if he knew where he was going, if I could give him directions. He said he was on his way out, he was just discharged. I asked when he would be coming back to the hospital for his follow-up appointment. "Why would I come back?" he asked. I asked if he would be seeing his doctor in a community clinic. "I don't have one," he answered. I think about that exchange when I think about primary care and our goals for building a healthy city. People who leave hospitals have to have something in the community to go back to: a system that meets their needs when they get there.



The foundation

of what we do, as health care providers, administrators, advocates, public servants, or concerned and engaged local citizens, is compassion. Whether working for equity and justice in human relationships, systemic reform that promotes better opportunities for us all, or caring directly for our neighbors, we are bound together by these common stories. The personal connections in our work are the foundation of primary care — it's the caring that must come first. Once mobilized around the will to change, together we can begin the long process of structuring, coordinating, and creating a new system that promotes justice and compassion for all residents of our city.

★ GLORIA WILDERBRATHWAITE, FORMER MEDICAL DIRECTOR, CHILDREN'S HEALTH PROJECT OF DC:

Medical Homes DC is a journey that we're still all on, but the thing that comes to mind for me and what I want to leave us with is a pledge that I made to myself going out all those years on the mobile units for 14 years, and that is: no more white caskets.

In this city, you know, we've all struggled to take care of our children, and the truth about the discussion of Medical Homes DC is when we all started around that table at DCPCA, talking about it, we were talking about something bigger than just what was happening in our health centers. It was about what was happening on the streets, what was happening in the schools and the churches. The fact that our community was disjointed and there was a side of our city that was impoverished and a side of our city that largely was not. We still have that economic segregation in this city, we still have some of those struggles, we've come a long way, but the work is definitely not done, and many have paid a price for that. I've attended too many funerals in this city. I've seen too many children die from bullets and all kinds of craziness that should not afflict a child, and I know you all have too.

So I hope we will change the climate of disparity into one of equity. I think that we could lead the nation in that.

★ ANNA MARIA IZQUIERDO-PORRERA, FORMER MEDICAL DIRECTOR, SPANISH CATHOLIC CENTER:

In 1998, I came to the United States to do a research fellowship. I had planned to come for two years but ended up meeting my future husband and so I stayed. I got a job at the Spanish Catholic Center, an organization that has been in existence for 40 years. It's an agency the Archdiocese of Washington created to help immigrants in the process of acculturation. The Center offers English as a Second Language (ESL) classes and other educational programs, pre-apprenticeship programs, legal immigration services and, of course, health care services. Health care is one of the big issues immigrants face when they come to this country.

We try to understand where people come from and serve them accordingly. Just today I had a patient who was discharged from the hospital the day before. He had high blood pressure but didn't know it. He had never gone to the doctor. But then he passed out, and had a massive bleed in his brain. Now he can't speak and he can't move the right side of his body. He came to us for a post-hospitalization follow-up. He didn't have any of the medications from the stack of prescriptions the hospital sent

him home with and didn't know what to do. I spent an hour-and-a half with him. Then he spent two-and-a-half hours with our dietary educator.

Since he can't pay, he won't be able to find a physical therapist to work with him, so we will develop exercises for him. He was also diagnosed, while in the hospital, with diabetes. The message they gave him at the hospital: go figure it out. Some of our visits with patients are really challenging. The other day a patient of mine told me people don't realize the price you have to pay for being poor.

For me, the hardest part is when you look into a person's eyes and have to tell them "there's nothing I can do because you are poor." That's different from saying, "there's nothing we can do because your disease has advanced." For me, the hardest part is to say, "there's an option out there, but you're too poor to afford it." For me, the hardest part is telling someone that "other people deserve health care, but you don't because you don't have money." I think as individuals, there are things we can do. But when we get together as a group and say this is unacceptable, that is really powerful. Those of us involved with DCPCA are a highly educated group of people who know the community. We are able to say, collectively, what's happening is unacceptable.

We still don't have universal health care. So long as we have individuals that live in the richest county in the world that cannot have health care because they don't have the money, we will have work to do. I don't see that happening in the next ten years. We have much work to do.

2007 LA CLÍNICA DEL PUEBLO BECOMES THE DISTRICT'S FIFTH FQHC (FEDERALLY QUALIFIED HEALTH CENTER), JOINING UNITY HEALTH CARE, COLUMBIA ROAD HEALTH SERVICES, COMMUNITY OF HOPE, AND MARY'S CENTER FOR MATERNAL & CHILD CARE.

★ MIGUEL AGUERO, BOARD MEMBER AND CLIENT, LA CLÍNICA DEL PUEBLO:

When I came to the US, I mopped floors and served food at a restaurant in Crystal City, VA. At that time, it was all about survival. I worked there in the mornings. At night, I was a busboy in a restaurant in Georgetown. I worked from 10 in the morning until 5 pm, then worked in Georgetown until 1 or 2 in the morning. But I have to count my blessings. It taught me how to be humble as a person. It taught me that the life of an immigrant is not easy.

I left because I couldn't get access to health care. Another reason I left was the discrimination. I remember waiting in a hospital emergency room for hours because no doctor wants to touch you because you are HIV-positive. They would refuse to take blood for me. Another time, I had a dental emergency. I had an abscess in my gum for three weeks. No dentist would take me because they were afraid of working with an HIV-positive person.

Many immigrants lose their self-esteem when they come to a new country. You're in survival mode. You feel like nobody told you this road would be so bumpy. But with the help of places like La Clínica, you discover inside of you the tools to move forward. That you're valuable. That you're a human being with potential.

2007

EFFECTIVE APRIL 1, 2007, DC MEDICAID PROVIDES COMPREHENSIVE DENTAL BENEFITS FOR ALL ADULTS IN THE MEDICAID PROGRAM.

2007

DCPCA CELEBRATES ITS 10TH ANNIVERSARY!

"Twenty years ago I wandered into Community Medical Care as a patient and a mom with Medicaid and three little kids. The day I walked in, about four people sat down with me to hear what I was doing, what my problems were, and my life history. They met me with compassion, and no judgment, and they looked me in the eye and they treated me like a person with dignity. That was the beginning of my story and look where I am now."

— Sharon A. Baskerville

Leaders walk among us.

And the community health centers in the District of Columbia create change with every patient who walks through their door — sometimes in ways they'd never expect. These are the stories our health care system is made of, encompassing more than forty years of our collective history. DCPCA is proud to have been a part of the past ten years, and we look forward to many, many more — working to improve the lives of all District residents.

★ EPILOGUE

"In all our time together, there have been two community health centers that did not make it to this point in our journey: my former organization, Community Medical Care; and the first organization of all of us to take on this mission, the Washington Free Clinic. The article below is reprinted from the February 2007 issue of DCPCA's newsletter, the DC Primary Care Reformer, as an epilogue to our stories. It speaks to the ongoing nature of our work, and the surprising ways that things can come full circle. The truth is, no one ever disappears, and the mission never dies — we just adapt to sustain the passion born out of that first seed of change."

— Sharon A. Baskerville

★ CAN I GET A WITNESS?!

By Sharon A. Baskerville, Chief Executive Officer, DCPCA

So I am standing on the brink of a very significant birthday, and by the time you read this I will have slid down the slippery slope right into the heart of it. As I contemplate the far too rapid passing of years, I try hard to look on the positive side of what otherwise is defined by wrinkles, gray hair, myopia, and the onset of mild arthritis. When I approached 50 (ah, there's a clue!), I took comfort in the thought that I had been around long enough to be able to claim wisdom, a sure knowledge of some basic core beliefs, and strong opinions. To sum it up, I finally felt like I knew what I was doing.

During this most recent midlife self-examination, I grappled with what made this inevitable process of aging more palatable. The answer came to me suddenly in the middle of a major occurrence in our world of health care delivery to the vulnerable and disenfranchised. At the end of January, a proud old mainstay of what we call the "safety net" health centers —The Washington Free Clinic — passed away in the form as we have known it. In the passing of its institutional life, however, it joined mission, passion, and deep commitment with another proud, not quite so old, mainstay of our "safety net" health centers — the Whitman-Walker Clinic. And it was this event that gave me my epiphany, and brought clarity to what was good about my aging process. I am old enough now to have earned the right to "bear witness" to the inexorable passage of time, change, and circumstance, and to take time to honor it with the reverent pause it deserves.

So here goes. I'm about to exercise my right to bear witness. The Washington Free Clinic was the oldest "free clinic" on the east coast. It rose up in an era of dramatic change and shifting of thought and mores as a country grappled with war, civil rights, gay rights, and women's liberation, to name a few. It was a people's movement, and WFC was change central in its farsighted vision to create a "medical home" — an un-coined term at the time — for those who felt shut out of the mainstream health system. At that time, the homeless were more often runaway teens, hippies, and returning Vietnam vets; WFC offered them safe harbor, health care, and support for

the complicated issues they faced. The Women's Self Help group was a core of the scope of WFC as women searched for a place to deal with issues of reproductive health, burgeoning sexual freedom, and the need to have a supportive place where they could learn ways to develop some sense of control over their bodies' health and well-being. Another key addition to scope was the Gay Men's VD Clinic — a response to the needs of a rapidly growing gay community in DC to create a safe, compassionate, and non-judgmental place to seek help, and to define some of the first efforts in cultural competence.

Some may know — but I bet most don't — that the WFC's Gay Men's VD Clinic eventually evolved into what we now know as the Whitman-Walker Clinic.

Both of these organizations went on to grow and continue to meet the needs of people who were not necessarily welcomed or well-cared for in the mainstream health care delivery system. Each responded to the needs of a community beset by the HIV/AIDS epidemic and an increasing demand for health care. Each responded to changing needs, as the face of the vulnerable and disenfranchised also changed: immigrants; the rising uninsured; a public health system neither responsive nor able to adapt to need, instead holding fast to either bureaucracy or tradition; an HIV/AIDS epidemic which moved from its root community into communities of color, heterosexuals, and the drug dependent. It expanded services so these changing faces could get dental care, obstetrics, pharmaceuticals, or, frankly, whatever was called for that was in their power to deliver.

I can bear witness to the tenacity, dedication, and savvy of the selfless providers and Board members of these organizations as they constantly hustled resources to keep the doors open and health care available. I can bear witness to the upheaval of our political environment and the myriad obstacles needed to be overcome just to survive and stay open. I can bear witness to the ever-growing administrative and fundraising burden put on the staff of these organizations who scraped for every dime to support direct services. No staff person ever wore just one hat. Systems were cobbled together to try to make a whole. Safety net clinics are the shining example of how to stretch an ever shrinking and carved up dollar.

Limited resources and growing needs brought both organizations to the same inevitable conclusion: something had to change. And change in any form is hard, painful, and unsettling. Market forces and circumstance bring many organizations to a crossroads. Some refuse to accept that change is inevitable. Some cling so tightly to their own need to keep things the way they've been that they are paralyzed and unable to find the flexibility to really overcome their challenges. This usually leads to a crash and burn scenario — dramatic and traumatic. In the case of health care

providers, the patients for whom they have sacrificed and fought to serve are the ones who ultimately get hurt.

I'm proud to say that neither of these organizations chose those paths. Each had to give up some dearly held traditions and rich histories, stretching and searching for ways that would lead to strength, sustainability, and most importantly, the preservation of a medical home for their patients.

So, one day in January, there was a gathering of the deeply committed from both sides to announce, grieve, and then celebrate the new "thing" being born. Around red checkered clothed tables spread out in an historic community center, and a buffet feast of good down-home cooking, I bore witness to a family reunion. There was speechifying, tears, and laughter. There was a deep sadness as family related the passing of a matriarch who had held so many cradled in compassionate and caring arms. There was honoring of her son, who had done her proud and forged a new way, but had come to the place in life to hand over the reins to a newer, stronger, sturdier child; the melding of both traditions into the one who will lead into the future, carrying with it the honor and wisdom of both. I bore witness to lineage. And I felt the comfort that only comes to those who have witnessed enough hard-knock life, challenges, joy, and pain to be able to pause and smile through tears and know the mystery of how good things always conquer obstacles and rise anew to face another day.

Can I get a witness?!

DCPCA 10TH ANNIVERSARY

DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION
1411 K Street NW, Suite 300, Washington, DC 20005

(202) 638-0252 ★ www.dcpca.org

Everyone Covered. Everyone Cared For. Anyone Can Help.