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

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

—JOSE JOÉL GARCÍA

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

And I’m very glad that Mr. Van Coverden was here. And I echo your words that we need to face the future, but we have to do it based on the foundation that we have, and the prayers that we share when we confer, when we have council, when we get together like this. These are very, very important things to define where we’re going. And as David was saying many times, and this is true with my children—as I share and I’m thinking about my grandchildren already—that I want them to see this video and I want this to be the first of many videos that tells our story because we’ve been so busy doing it. We haven’t been telling the world exactly why we’ve been doing what we’re doing. We’re just doing it all the time. We’re activists. But we’re activists that are bringing together the art, the science, and the spirit, the spirit of our movement.

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

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

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

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

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

JOSE JOÉL GARCÍA, JD
CEO of Tiburcio Vasquez Health Center and Board Chair of the Alameda Health Consortium
really what our movement is all about. And I thank the Tides Foundation for beginning again to have us tell the story. I want all of you who’ve been with the movement already to slow down a little bit about telling your story. To those of you who are new to it: it’s your story, you know? Build it! You know, correct it when it’s not what it should be!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“All right. If it won’t take long.”

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

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

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

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

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

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

That’s why community clinics work, not just because we save money, not just because it’s preventative, not just because it makes health care available to people who hadn’t had it. It’s because we take the whole person, and we transform the whole life.  —SYLVIA DREW IVIE
person would not be to compete with the executive director, but to make the board of directors run in the way it’s supposed to run so that at your October meeting, you have your peer review of one another. At your December meeting, you have other things that are on the list of things that board of directors [do] so that it’s not haphazard. So that the board keeps its feet to the fire in doing all the things it’s supposed to do to have a really good and functioning board. I just want to leave with that. It’s not really a sexy idea but I really think it’s a good idea. About how we can improve the effectiveness of our boards and give them the support they need and doing the things that they have to do to run our agencies well. So Sherry, congratulations on your 30 years. Thank you for having us to tell our little piece of the story. [Good luck] to all of you and your programs.

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

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

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

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

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

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

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

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

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

And we said, “The agreement has to be that you cultivate the talent in the community to participate in the studies, and the data belongs to the community.” —KAUILA CLARK
We have $35,000 of exercise equipment donated by the Honolulu Club that we’re going to put under our kitchen so that they know that as soon as they eat, they got to go downstairs. We have a partnership with YMCA where we have a walking path to YMCA, where we can use their swimming pool when we can get there and walk back. We’re devising a whole pathway system where people can walk on the premises to exercise.

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

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

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

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

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

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

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

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

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

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

But what now? What we're looking at is different parts of the campus being developed for different purposes. One of the exciting things (to show the international nature of our campus and are welcome to anyone regardless of ethnicity, religion, or nationality), is that we just got a bodhi tree, from the original bodhi tree from India. And we planted it on our campus and we've designated that area for yoga and for meditation. So we try to be inclusive. It was part of the Hawaiian tradition to include people and so that extension of inclusion is something that we offer to all people. Because we are all ohana, or family within the community.

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

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

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

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

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

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

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

VIDEO CLIP PRESENTATION FOLLOWS.

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

We had one patient who came to the meetings on a regular basis and would complain about our not having dental services and he made a statement, “How can we have health, when we don’t have good teeth?” It was a really simple but really profound statement of connection between good eating, good nutrition, and health. And it actually became sort of a slogan for our campaign when we were raising money to start our dental clinics. So having patients there is a way of empowering not only the patients themselves, but our organization. And as the clip showed, it’s an opportunity for patients to directly address governmental decision-makers. We’ve been very successful in drawing large numbers of people, and the idea is: if you bring the people, the politicians will come and that’s something that’s worthwhile. Seems like these people kind of line up and they’re very eager to attend.

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

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

Questions and Answers Session

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

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

To set up our own institution—I would like to see is community health center university in California. A comprehensive university that has people that you know do the cultural competency that we’ve gotten in 30 years. Give the degrees that they deserve that they haven’t gotten yet. Become the teachers themselves. There are physicians that come in actually...the schools actually taught them about community work. They come in and they know we can teach them. The public health schools, the business schools and all that give us the people with the degrees but [who] also understand the community from the beginning, that we don’t have to reeducate them to come in and do the professional service. So there’s a lot of things that we’re capable of doing with partners that we have in the foundation world and also in academia for that matter that is healthy, that understands these different parts. So let’s bring all these people together.
KAULIL CLARK: I think a lot of the future of health care is going to be personal responsibility, and prevention is going to have to play a big part in order to cut cost. And we may have to change our educational institutions. I agree. You know we might have “DC,” a doctor of coaching lifestyles. We might have “DI,” doctor of information. We might have “DA,” doctor of advice. That will help people make decisions on their health care rather than going through the chronic disease stuff and coming with recommendations. Give it back to the people. So that they can dictate their health care plan and their involvement—and I think that’s got to be the future. Because the cost is just getting so far out of hand that we’re going to have to design [a system of care] from community and be community advocates as to how our health care is given, provided, and how we receive our health care.

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

DONN GINOZA: I think that within the next 10 years, there’s going to be a major transformation in terms of the leadership within our organizations. The long time executive directors that we’ve had, people who are firmly rooted in the history of the civil rights movement...we need to find some way that the new people that come in understand that tradition. And of course you know the circumstances have changed. You don’t so much try to teach people the history of this, but adapt to the present circumstances that make everyone around you aware of how racial disparity still exists. How do they...why do they exist? And we have a very, very pluralistic society now. We have large self-sustaining immigrant communities, but we still have isolation in terms of the racial demographics in this country, and that contributes to continued disparities that contribute to racial intolerance. And this is a constant struggle. And we need to be thinking about how we can pass this legacy [of the civil rights movement] on.

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

JOEL GARCIA: I think we should expect what the rest of the world expects—human rights. And I think that a lot of the dialogue we have in this country is in isolation to what is actually the foundational principles throughout the world. Actually it’s ironic because right across the Bay there you go over to United Nations Plaza, that’s where the United Nations team convene, where they have the Universal Declarations of Human Rights. It gives us an ethical disconnect. I think somehow to focus some of that [con-nection] in our youth and let them know that there are [these rights]...and we practice them...even if it’s in isolation and even in communities as we’ve grown up with these movements and so forth, they’re the same things. Civil Rights is about human rights. It’s a broadening of construct.
It isn’t about one [group]… we can all [argue about] which group has had the worst of experiences. We can argue about that but then what’s the solution in common for us then? I know that’s very idealistic.

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

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

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

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

Roundtable Discussions with Community Board Members and Leaders

Top: Board Members share experiences.  
Bottom: Participants meet with each other.
MULTIPLE ROLES OF BOARD MEMBERS

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

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

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

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

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

Offering professional guidance. For example, the health center boards include lawyers, bankers, certified public accountants, and legislators.
BOARD RECRUITMENT, TRAINING, RETENTION

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

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

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

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

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

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

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

Bring business leaders in as partners.
SETTING AND MONITORING STRATEGIC AND OPERATIONAL GOALS FOR THE HEALTH CENTER

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

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

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

Evaluating performance. One board advocated benchmarking procedures in their health center and now those benchmarks are being incorporated into new evaluations of the health centers.
Top: Annie Ong, Connie Chang and Vera Leo play Taiko drums.
Bottom: Sherry Hirota and Kauila Clark conclude the evening with board members.

DINNER AND CULTURAL PERFORMANCE
HONORING COMMUNITY BOARD MEMBERS
Top: Red Willow Lodge Dancers.
Bottom: Conference participants tour the Asian Health Services' dental clinic, where staff showcase their paperless system.