



RESEARCH REPORT

Three Decades of Mary's Center's Social Change Model

A Community Health Center's Approach to Addressing the Social Determinants of Health

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Foreword

Where and how we live, the strength of our bonds and engagement in our communities, and our ability to continually learn and grow affect our health and well-being. Few organizations understand this better than Mary's Center, a community health center based in Washington, DC, that takes a holistic approach to well-being. By linking health care to community-based support services, the center is creating value at the individual, family, community, and systems levels—and delivering results.

Mary's Center has been at the forefront of change in community health and innovation and is a leader among federally qualified health centers in childhood immunizations, asthma and cholesterol treatments, and weight and depression screenings. It has evolved from providing traditional and transactional services to adopting a more sophisticated delivery model that better reflects what we are coming to understand as the social determinants of health. The center respects and understands that multilingual, multicultural, culturally competent, and trauma-informed services are a powerful lever for social change, and so that approach is core to its work.

Mary's Center's social change model—the intersection of comprehensive medical care, dual-generation education, and social services—yields results. We can see that change, over time, in the well-being of those served by the center. The field has much to learn from this model with regard to serving underresourced communities.

Reflecting on Mary's Center 30-year history, three themes emerge as key to the center's success and innovative approach:

1. **Frictionless services.** How clients access services and whether they're able to do so easily matters—whether that client is a pregnant mother seeking prenatal care or a young child who needs afterschool tutoring. With frictionless services, handoff from one service to the next is seamless, and reporting and analytics track well-being in real time. We need only look to the revolution taking place on our smart phones to witness the proliferation of this kind of highly customized, client-focused, tech-driven service in every other sector. How might we expect such frictionless service when it comes to receiving our health care?
2. **Moving from theory to action via rapid prototyping.** Part of Mary's Center's success comes from being responsive to the changing needs of its community. The center has learned by constantly moving from theory to action, testing its hunches, evaluating its work, and starting that cycle over and over again. The results are often life-changing for families, with greater numbers of parents reading with their children through participation in dual-generation

educational programs, and a greater likelihood that afterschool program participants graduate from high school and enroll in college.

3. **Person-centered policymaking.** Mary's Center believes in the people it serves and in their innate strength, dignity and power. The center has developed a culture that values its participants and views them as full of hope, courage, and possibility, rather than as problems to be solved. Staff learn from their clients' experiences. And that knowledge informs how the center advocates for the kinds of policy reforms required to serve communities.

César Chávez once said: "History will judge societies and governments—and their institutions—not by how big they are or how well they serve the rich and the powerful, but by how effectively they respond to the needs of the poor and helpless." Mary's Center has lifted up those among us who have often had nowhere else to go for help. And while what the Center has accomplished over the past 30 years is important, what it has learned is priceless. The following report helps us all understand a piece of that journey.

Rafael López

Adapted from Rafael López's remarks at Mary's Center's 30th anniversary symposium "Successful Pathways to Education, Health, and Well-Being: The Role of a Community Health Center," on October 16, 2018. López was managing director of health and public service practice with Accenture North America. Previously he served as the commissioner of the Administration on Children, Youth, and Families as a senior policy advisor at the White House Office of Science and Technology Policy within the Executive Office of the President and with the Domestic Policy Council. Before that, he was an associate director at the Annie E. Casey Foundation.

Executive Summary

This report tells the story of the first 30 years of Mary's Center, documenting its evolution from a basement clinic to a nationally recognized federally qualified health center (FQHC) serving nearly 55,000 participants in 2018. For over a year, the Urban Institute research team reviewed documents and collected staff, participant, and community perspectives on Mary's Center's history, approach, and outcomes. Our resulting report describes Mary's Center's social change model—an integrated care approach to addressing the social determinants of health—including its progression over time and how Mary's Center applies it in day-to-day operations.

Mary's Center's ongoing experience provides a useful framework for understanding the benefits and opportunities of providing comprehensive medical, social, and educational services in under-resourced communities. It also highlights some of the challenges to implementing and sustaining such an approach. As Mary's Center enters its fourth decade, its leadership is interested in more precisely defining the theory of change behind its social change model, both to rigorously evaluate its effectiveness and to provide a model for other health care organizations interested in addressing the social determinants of health.

Mary's Center's History

In 1988 Maria Gomez opened Mary's Center in the basement of a rowhouse in Washington, DC's Adams Morgan neighborhood—initially focusing on prenatal services for women fleeing violence from civil wars in El Salvador, Honduras, and other Central American countries. By 1994, Mary's Center outgrew its basement offices and moved to a new Adams Morgan location that remains its headquarters today. Over time, Mary's Center broadened its participant pool and service mix while still primarily serving low-income women and children. As Adams Morgan and surrounding Northwest Washington, DC, gentrified, Mary's Center followed its participants as they moved by opening new community health centers in DC and in Maryland. Two of the biggest drivers of Mary's Center's growth were a \$3.4 million investment by Venture Philanthropy Partners to increase its organizational capacity in 2004 and becoming an FQHC in 2005.

Mary's Center's social change model is the backbone of its service delivery approach and is grounded in the social determinants of health perspective that treating someone's physical health in isolation from their complex individual, family, and community contexts is insufficient to improve their

overall well-being. The model includes health, social, and educational services—including sharing a location in Washington, DC, with the Briya Public Charter School, which provides dual-generation educational services. Guided by the social change model, Mary’s Center has progressively expanded its service offerings to meet a wide range of medical, social, and educational needs.

Participant and Community-Level Outcomes

Mary’s Center has consistently been ranked in the top tier of FQHCs nationwide. In focus groups, participants discussed the unique role that Mary’s Center plays in their lives, through personalized care and a diversity of supports. Staff similarly described their efforts to improve the care their participants receive, from ensuring good experiences and customer service to advocating for participants to receive vital services through Mary’s Center, other private partners, or government. Going forward, Mary’s Center is exploring ways to rigorously evaluate the health and economic outcomes of their services.

In addition, staff and community stakeholders noted Mary’s Center’s extensive relationships and partnerships with local service providers and policymakers, and its role as an advocate for policy and regulatory changes that align with its mission. Mary’s Center was described as an influential voice in shaping local health care policy, particularly for underserved immigrant communities, and in advocating for improvements to the services available to low-resourced people in the DC region.

The Social Change Model in Practice

Two organizational characteristics emerged as central to Mary’s Center’s successful growth and ability to sustain the social change model: its strong, entrepreneurial organizational culture, and its “high-tech/high-touch” approach to operationalizing the model. Specifically, Mary’s Center’s has benefited from strong leadership that grounds the organization’s growth in its core mission and values. But it has also devoted institutional resources to strengthen staff’s awareness of the model and ability to apply it. A staff survey showed that most respondents understood the model, felt Mary’s Center adhered to it, and felt able to meet participants’ most common nonmedical service needs. In interviews, senior staff described a combination of personalized, coordinated care and communication among staff as the “secret sauce” behind operationalizing the social change model—with electronic medical records supporting staff coordination.

Yet, Mary's Center's operations carry persistent financial pressures and other obstacles to growth, including a high share of uninsured participants and services that are not eligible for reimbursement. In addition, if not managed properly, rapid organizational growth can lead to inequities in the quality of services, as well as staff burnout. Some staff reported a tension between rapid growth and productivity demands, while continuing to provide a high standard of patient-centered care. Finally, rigorous evaluation of the Social Change Model will be necessary to demonstrate the value of Mary's Center's approach and to attract further funding. This will require additional resources to support data management and research.

Key Take-Aways and Lessons for the Field

The experience of Mary's Center highlights barriers to addressing the social determinants of health, as well as opportunities to overcome them that can inform other health care system stakeholders.

First, a critical part of Mary's Center's success comes from **understanding its participants and the communities they live in**. Mary's Center leadership and staff emphasize the importance of strong connections with key stakeholders—including participants, local service providers, policymakers, and funders. Building productive relationships takes time and resources across different levels of the organization, and Mary's Center invests explicitly in developing these connections.

Second, providing integrated care to address the social determinants of health takes more than just expanding service offerings; it requires **ongoing investments in people and procedures**. At Mary's Center, investments include efforts to ensure staff understand and buy in to the social change model, are equipped to make meaningful connections with participants and to collaborate with other care providers, and can track participants.

Third, addressing the social determinants of health requires **flexible funding**. The social change model relies on grants and donations from various sources to pay for services that do not qualify for Medicaid or other public reimbursement. Over time, Mary's Center's ability to find funding for these services has been critical to its success. But the need for flexible funding is ongoing, and Mary's Center invests significant energy in demonstrating the value of its services and identifying resources. New financial models such as pay for success or performance-based financing may offer some promise, but these models will require investments in data and evaluation capacity to demonstrate results. Ongoing public and private-sector support will be needed to further develop and evaluate the social change model.

Finally, Mary's Center's entrepreneurial culture highlights **the value of experimentation and incremental expansion**. A core lesson from Mary's Center is that incrementally adding and testing new services, or expanding as opportunities arise, can be challenging but helps increase organizational capacity and demonstrate success. Other organizations and funders interested in social determinants of health interventions can learn from Mary's Center's success at identifying modest, incremental opportunities to incorporate staff, procedures, or services that help understand and address participants' nonmedical needs.

Errata

This report was corrected October 21, 2019. In the first paragraph on page 13, “Mary’s Center had more than 45,000 additional primary care encounters in 2009 than in 2016” has been changed to “Mary’s Center had more than 45,000 additional primary care encounters in 2016 than in 2009.”

Introduction

Mary's Center is a federally qualified health center (FQHC) that has been serving the Washington, DC, region since 1988. FQHCs operate in areas with high need for health care, also known as medically underserved communities, and they offer a comprehensive set of services based on local needs. The centers serve everyone, regardless of insurance status or ability to pay, and more than half their governing board members must be health center patients. Nationally, FQHCs served an estimated 28 million people in 2018, most of whom were low income, uninsured or publicly insured, and racial or ethnic minorities (NACHC 2018a, 2018b). Within DC, Mary's Center and its fellow community health centers serve 36 percent of all Medicaid patients (NACHC 2018c).

Launched with funds from the Washington, DC, Mayor's Office on Latino Affairs and Department of Health, Mary's Center was founded as a small community health center to deliver bilingual, culturally competent health services to pregnant women and infants living in DC's Ward 1 neighborhood. Early program participants were primarily Central American women fleeing violence and war in their native countries. These women were adjusting to life in the US and had limited access to health care and social services.¹ In its first year, Mary's Center served 200 people with a budget of \$250,000. It now serves more than 54,000 people, across eight locations, with an annual budget of more than \$68 million.²

Throughout Mary's Center's three decades of growth, its core mission has remained the same: to provide high-quality, culturally appropriate, multilingual care to underserved residents in the Washington, DC, region, regardless of their ability to pay. Over time, participants' evolving needs led Mary's Center to expand from primarily prenatal and infant care to a broad mix of medical, dental, social, behavioral, and educational services. These services are rooted in what Mary's Center refers to as its social change model. The model recognizes that sustaining a healthy population requires addressing the "social determinants of health"—factors such as income, housing, nutrition, community resources, and safety that drive many health inequities (box 1).³

BOX 1

Defining the Social Determinants of Health

Several definitions exist for the social determinants of health, including these three:

The World Health Organization: “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.”

The Centers for Disease Control and Prevention: “the complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services and structural and societal factors.”

The Robert Wood Johnson Foundation: “Health starts where we live, learn, work and play.”

Source: Institute for Alternative Futures, *Community Health Centers: Leveraging the Social Determinants of Health* (Alexandria, VA: Institute for Alternative Futures, 2012).

The social change model is the backbone of Mary’s Center’s service delivery approach and is grounded in the social determinants of health framework that treating someone’s physical health in isolation from their complex individual, family, and community contexts is insufficient to improve their overall well-being. With this as a guiding principle, Mary’s Center aims to provide comprehensive, integrated care. It has done so by progressively expanding its service offerings to meet a range of medical and nonmedical needs in house, and by equipping staff to develop strong connections across service areas. For example, a caregiver who brings their child to Mary’s Center for a wellness visit may be asked about their own medical or mental health needs, English language literacy or employment goals, or if they need to be connected to food assistance or income supports. A medical provider can then introduce a participant to other medical, dental, or social services providers within Mary’s Center, or provide a referral for additional services with one of its partners. The goal is to both help participants maintain and improve their health and “put them on the path toward good health, stable families, and economic independence.”⁴

[Mary's Center's] core mission is to ensure that people are healthy and able to care for themselves, able to care for their children so that the children can grow up healthy, [and] they can become good contributors to the next generation—that's part of social change.

—Mary's Center staff member

The three pillars of the social change model are comprehensive health care services, including dental and behavioral health, social services, and education (box 2). Community health centers—including those in the DC area—commonly address the social determinants of health, but Mary's Center is distinctive in the breadth of its service offerings, the centrality of the social change model to its operations and mission, and its emphasis on education. One national study of 176 community health centers found that only 10 percent provided adult education services and only 22 percent provided workforce development services (Institute for Alternative Futures 2012).

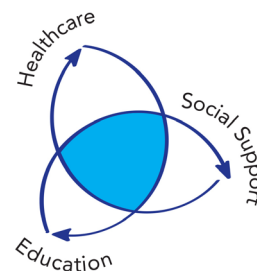
Mary's Center also relies on longstanding partnerships with hundreds of local organizations to provide a wide variety of services that support its social change model. One of Mary's Center's most important relationships, critical to the educational component of the social change model, is its 20-year partnership with the Briya Public Charter School. Briya, which is located with Mary's Center, offers early childhood and adult education to more than 600 adult DC residents and their preschool-age children each year. Briya and Mary's Center also partner to provide workforce development programs, including two certification programs: medical assistant and child development associate.

BOX 2

Mary's Center's Social Change Model

The social change model strives to address the many aspects of health and well-being that alter quality of life and educational and/or economic advancement.

- comprehensive medical care
- dual-generation educational services
- social services



Source: "Our Model," Mary's Center, <https://www.maryscenter.org/about-us/mission-and-model/>.

We want to show why this model is important to low-resource communities and why it's a great model for people who are not low resourced as well.

—Mary's Center staff member

Purpose of This Report

Policymakers and practitioners potentially have much to learn from Mary's Center, given its three decades of successful growth, its commitment to health equity and providing high-quality care to underserved communities, and its steadfast focus on social determinants of health.

As Mary's Center approached its 30th anniversary, it partnered with the Urban Institute to describe and document its growth and evolution. Urban's assessment is part of Mary's Center's strategic planning goals as it enters its fourth decade. These goals include expanding its research and evaluation efforts and sharing the social change model with other organizations involved in designing, funding, or delivering health and social services to underresourced communities. Mary's Center has received national recognition for its clinical outcomes and is regarded locally as a high-capacity strategic partner in DC's health and social service system. Going forward, Mary's Center hopes to leverage its expertise to establish a more formal advisory or consulting role to assist other health care providers interested in adopting the social change model.

The goal of this report is to tell Mary's Center's story and highlight lessons learned for community health centers, medical providers, health policymakers, and others interested in addressing the social determinants of health. For close to a year, the Urban research team collected staff, participant and community perspectives on Mary's Center's history, approach and outcomes. This included document review, an online survey of over 300 Mary's Center staff members (representing about half of all staff), and interviews or focus groups with 16 staff, 35 current and former participants, and 14 community partners (see appendixes A and B).⁵ Urban researchers also participated in Mary's Center's research advisory group to get input from board members, executive staff, and researchers from different disciplines. Concurrent with Urban's work, researchers from the National Institutes of Health and the University of Maryland were exploring ways to measure the application of the social change model and quantify its impacts on clinical outcomes and its costs and benefits. The early results of this ongoing work were presented in October 2018 at Mary's Center's symposium, "Successful Pathways to Education, Health, and Well-Being: The Role of a Community Health Center."⁶

This report synthesizes the information gathered by the Urban team and presented at the 2018 symposium. Throughout, we present the words and data collected from Mary's Center staff members, funders, nonprofit partners, community stakeholders, and participants.

Mary's Center's History

In 30 years, Mary's Center has grown from a basement clinic providing prenatal care for immigrant women in the Adams Morgan neighborhood into one of the largest health care clinics in the Washington, DC, metropolitan area. Its evolution has been shaped by the experiences of its founder and current president and chief executive officer, Maria Gomez, RN, MPH.

Gomez immigrated to Washington, DC, from Colombia with her mother when she was 13 years old. Attending a DC public high school opened her eyes to the challenges low-income immigrants face receiving a quality public education and successfully navigating the college application and enrollment process. She realized many young immigrants needed more support than their parents or high school guidance counselors could offer. After graduating high school, Gomez received her bachelor's degree in nursing science from Georgetown University and a master's in public health from the University of California, Berkeley. By the 1980s, Gomez was working at a city-operated health clinic where she attracted a following of immigrant women seeking culturally competent prenatal care. She saw the demand for high-quality health care among recent immigrants and came to believe she could have a bigger impact operating independently. In 1988, with support from the Office on Latino Affairs and a dozen dedicated women, she opened Mary's Center in the basement of an Adams Morgan rowhouse on Columbia Road (exhibit 1).

EXHIBIT 1

Opening of Mary's Center's Original DC Location in 1988



Source: Mary's Center.

Exhibit 2 (see page 9) provides a timeline of key events in Mary's Center's first 30 years. Mary's Center initially focused on prenatal services for immigrant women fleeing violence from civil wars in El Salvador, Honduras, and other Central American countries. The women were often separated from their children, and many had unplanned pregnancies, sometimes as a result of rape. Stigma, lack of insurance, and limited English and health literacy often led them to avoid prenatal care until they were close to full-term, making their pregnancies higher-risk. From the beginning, Mary's Center's services included home visiting, to help establish trust and ensure that participants' social and economic circumstances were being addressed alongside their prenatal care.

Mary's Center really understands the population they're serving. It's this response to their population's needs that creates loyalty and strong word of mouth.

—Community stakeholder

Mary's Center continues to provide prenatal care as a critical component of its social change model (box 3). Its reputation as a trusted, culturally competent provider of prenatal care became the building block for its expansion, as it grew to meet the evolving needs of its participants. For example, given that so many participants had young children, Mary's Center expanded to family planning, pediatrics, and services for children with special needs. It also expanded into social services and English literacy programs to support its participants' successful integration into their new communities.

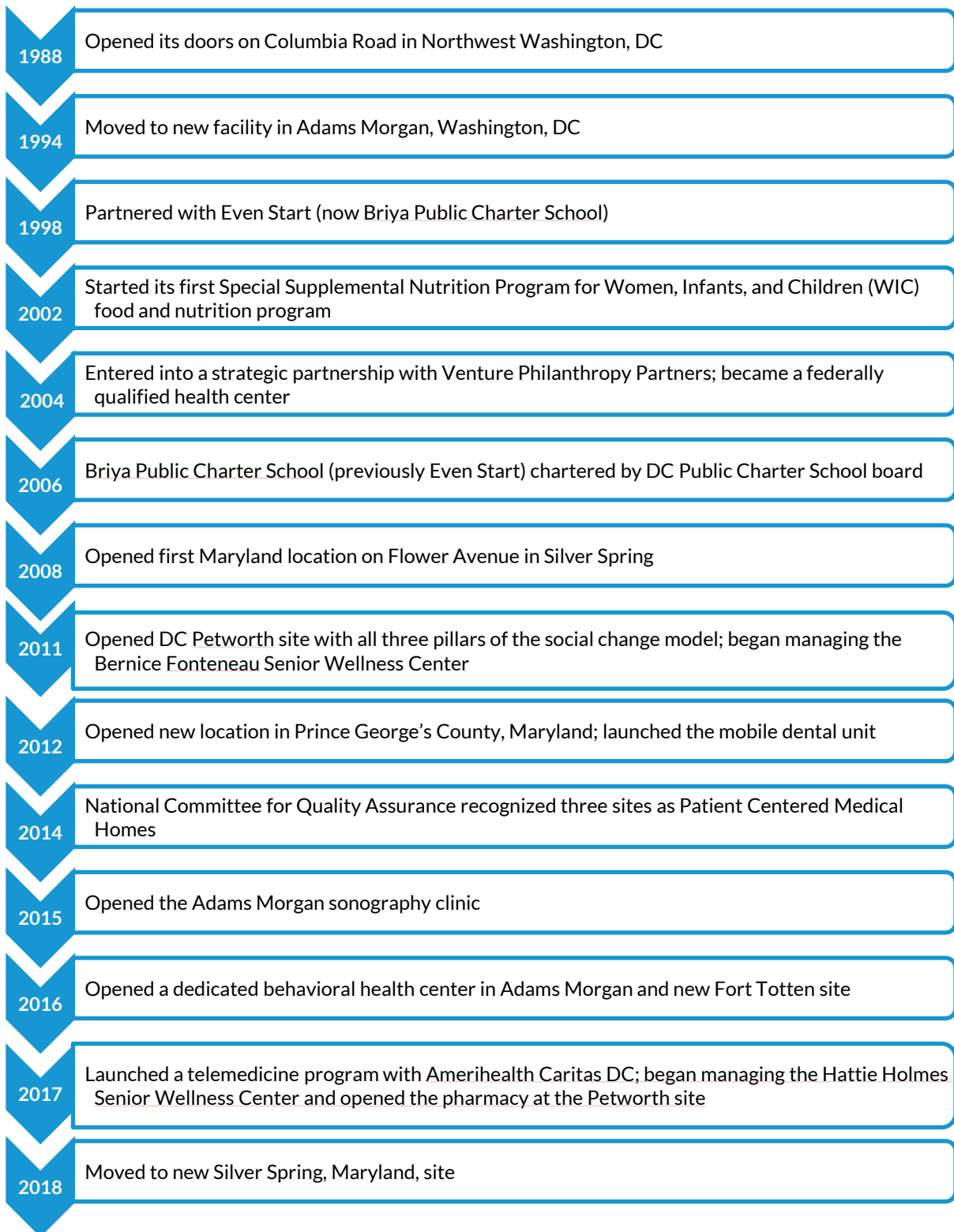
BOX 3

Example of the Social Change Model in Practice

Mary's Center's Centering Pregnancy program combines medical, educational, and social services by bringing together groups of 6 to 10 women at similar stages in their pregnancies for prenatal care, group education, and peer support. Women receive individual medical care from a certified nurse-midwife and participate in group sessions where they learn how to take their vitals and measurements, and receive education on nutrition, family planning, stress, and other themes. The group sessions are also meant to help women build support networks and follow best practices in prenatal care.

EXHIBIT 2

Mary's Center Timeline, 1988–2018



As Mary's Center grew and the babies it helped deliver grew older, Gomez and her staff became increasingly concerned about the effects of trauma on children and adolescents. This prompted a greater focus on education as a key component of the social change model. In 1998, Mary's Center began its partnership with the Even Start Multicultural Family Literacy Program—the precursor to the Briya Public Charter School. Launched as a US Department of Education demonstration project in 1989, Even Start initially provided early childhood and adult education and literacy services to Central American and Vietnamese families newly immigrating to the DC area.⁷ The similarities in target population and organizational mission made Even Start a natural partner. Mary's Center later received a federal grant to formally integrate Even Start in its organization and to provide health education services.

In 1994, Mary's Center outgrew its basement offices and moved to a new Adams Morgan location that remains its headquarters. The larger space allowed Mary's Center to expand its staff and offer a greater breadth of services.

Mary's Center does a better job than other FQHCs in engaging and supporting their patients to build trust between each other. They have patients and participants that really trust and rely on Mary's Center to show up for them. When you have that feeling and belief and attitude and you tell other people, you change communities.

—Community stakeholder

Managing Growth and Becoming a Federally Qualified Health Center

By 2004, Mary's Center was serving just under 6,000 participants a year and juggling the daily operational demands of a fast-growing organization with the need for long-term strategic planning. An internal report from 2002 noted that, while Mary's Center was providing high-quality medical and social services, it lacked a predictable funding stream, and its recent growth had “put serious strains on the organization's ability to manage, fund, and support existing programs” (Gramlich, McKay, and Berl 2002). The report recommended that, before expanding locations or services, Mary's Center should improve its organizational infrastructure. Specifically, the report recommended that Mary's Center hire

a senior human resources manager, improve record keeping and internal program evaluation activities, and hire more front-office personnel.

To make these improvements, Mary's Center applied for and received a four-year, \$3.4 million investment partnership with Venture Philanthropy Partners (VPP), a philanthropic entity that works intensively with a small number of Washington, DC–area nonprofits to improve their institutional strength. The VPP partnership was pivotal to Mary's Center's expansion, allowing it to design and follow a financially viable growth plan to broaden its services and clientele. It also allowed Mary's Center to hire senior staff to support its financial, operations, and development functions. This senior leadership team took over much of the day-to-day operations, allowing Gomez to identify and pursue longer-term strategic goals (VPP, n.d.). Through the partnership with VPP, Mary's Center also invested in administrative and financial systems, including electronic health records to better coordinate participant care and track participant outcomes.

Through Mary's Center's business planning process in partnership with Venture Philanthropy Partners, they realized they needed to expand beyond maternal and child health as part of their theory of change.

—Community stakeholder

The VPP investment period (2004–08) was a time of accelerated growth for Mary's Center. It opened two new clinics, its annual revenue increased from \$7.6 million to \$12 million, and its annual number of children served increased from 2,500 to 6,414 (VPP, n.d.). One of the main accelerants for this growth was Mary's Center's 2004 designation as an FQHC.

Becoming an FQHC fueled Mary's Center's growth in several ways. First, FQHCs receive an annual operating grant from the US Health Resources and Services Administration (HRSA). Second, FQHCs receive special reimbursement status, allowing them to receive higher payments for billable services provided to Medicaid and Medicare patients. Third, through the 340B Drug Pricing Program, FQHCs can purchase prescription drugs at significantly reduced costs. Finally, under the Federal Tort Claims Act, employees of FQHCs receive medical liability coverage. This coverage saves Mary's Center, and other FQHCs, millions in annual malpractice insurance fees that they can then reinvest in services.⁸ In exchange for these benefits, Mary's Center must comply with FQHC requirements including

- serving all uninsured patients on a sliding fee scale, regardless of ability to pay;
- having a voting majority of its board members be Mary's Center health center patients; and
- submitting annual reports to HRSA on the number of participants served, their demographics, services received, and health outcomes.

In 2006, during the VPP partnership, Even Start transitioned to a DC Public Charter School, which allowed it more financial stability and long-term growth capacity. The school was renamed Briya in 2013. As a public charter school, Briya operates as a separate entity from Mary's Center, with a separate governing board. But the close partnership with Mary's Center remains, and Briya is integral to the social change model. In 2017, Briya served 47 prekindergartners and 597 adult students (DCPCSB 2017). The school operates in four sites in Washington, DC: Adams Morgan, Mount Pleasant, Petworth, and Fort Totten. All Briya sites except Mount Pleasant are located with Mary's Center services. Mary's Center staff estimate that up to 70 percent of Briya students receive medical or other services from Mary's Center (Butler, Grabinsky, and Masi 2015).⁹

VPP's four-year investment term for Mary's Center ended in 2008, but Mary's Center has secured alternate funding for the senior-level positions and administrative systems that have been so critical to its growth and maturity. Over the next 10 years, Mary's Center continued to expand to new locations and offer additional services. As Adams Morgan and surrounding Northwest Washington, DC, neighborhoods gentrified, Mary Center's immigrant participant base moved to more affordable DC neighborhoods and, when those neighborhoods in turn gentrified, to the Maryland suburbs. Mary's Center followed its participant base, opening two new clinics in Washington, DC, and two in Maryland.

Over time, Mary's Center also added services, including a sonography clinic and a behavioral health center at its Adams Morgan location, a pharmacy at its Petworth location, and a new pediatric dental suite in its Fort Totten location. It started an HIV Primary Care program, which includes HIV screenings, administration of the HIV prevention drug Pre-Exposure Prophylaxis (PrEP), and a medication-assisted treatment program, which combines Suboxone to manage opioid withdrawal symptoms with counseling and behavioral therapies.¹⁰ It also took on management of two senior wellness centers in Northwest DC: Bernice Fonteneau and Hattie Holmes. In addition to increasing its physical footprint, Mary's Center has increased its capacity to provide services in the community through mobile clinics, school-based behavioral health therapists, and, most recently, telehealth services and an expanded home visitation program.

Evolving Services and Participant Mix

Over time, Mary's Center has broadened its participant pool, in keeping with its mandate as an FQHC, while continuing to primarily serve low-income women and children. It has also greatly expanded the mix and scale of its services through the social change model. Even as the uninsured rate has decreased nationally, the share of Mary's Center's participants that are uninsured has grown.

Shifts in Participant Characteristics

Table 1 shows the demographic characteristics of Mary's Center participants in 2009, 2013 and 2017, drawn from the center's annual reports. Though Mary's Center still predominantly serves Latinas and children, an increasing proportion of its participants is male and non-Hispanic. The proportion of participants that is 12 or younger has remained between 30 and 35 percent, while female participants have declined from 70 percent in 2009 to 63 percent in 2017. The proportion of Latinx participants (who may be of any race) has also declined, from 84 percent in 2009 to 70 percent in 2017. The proportion of black participants has increased (from 5 percent to 15 percent) as has the proportion of Asian participants and people who identify as multiple or other races (from 4 to 8 percent). Mary's Center continues to serve primarily immigrants: a 2015 survey of participants at four locations found that 92 percent of respondents were born in another country, with El Salvador, Guatemala, Honduras, or Mexico the most represented nations of origin.

Becoming an FQHC required Mary's Center to serve all populations, including men, which explains some changes in the characteristics of Mary's Center's participants. Washington DC's changing demographics and Mary's Center's expansion into locations with larger populations of African Americans, Ethiopian immigrants, and indigenous Latin American groups who may not speak Spanish or identify as Latinx, also likely explain some of the change.

TABLE 1

Demographics of Mary's Center Participants, 2009–17 (percent)

	2009	2013	2017
Child (0–12)	31	30	33
Female	70	65	63
Hispanic/Latinx (any race)	84	70	70
Black (non-Hispanic)	5	15	15
White (non-Hispanic)	3	5	6
Other (non-Hispanic)	4	9	8

Sources: Mary's Center annual reports.

Note: Not all reports include detailed demographic information.

A Growing Uninsured Population

The health insurance status of Mary's Center participants has shifted over time—particularly as Affordable Care Act coverage has supplanted DC Healthcare Alliance coverage (table 2). The DC Healthcare Alliance is a locally funded insurance program launched by the city in the early 2000s for low-income residents ineligible for Medicare or Medicaid; this group includes a significant number of Mary's Center participants because of their immigration status. The DC Healthcare Alliance reimburses FQHCs at about 60 percent of Medicaid reimbursement rates.¹¹

As of 2016, around 52 percent of all Mary's Center participants received Medicaid, 13 percent received DC Healthcare Alliance coverage, and 27 percent were uninsured; the remaining participants were on Medicare or commercial insurance. The national uninsured rate decreased markedly after the passage of the Affordable Care Act (Cohen, Zammiti, and Martinez 2017), yet Mary's Center's uninsured rate increased from 19 percent in 2006 to 25 percent in 2016. The share of Mary's Center participants covered by Medicaid increased during this period from 34 percent to 51 percent, but the share covered by the DC Healthcare Alliance declined from 42 percent to 13 percent.¹²

Washington, DC, enrolled roughly 34,000 people with Alliance coverage in Medicaid as part of its Affordable Care Act Medicaid expansion, thus explaining part of the shift to Medicaid.¹³ But the DC government also recently imposed stricter eligibility requirements for Alliance coverage, and those may also explain why Alliance coverage declined.¹⁴ Though most Mary's Center participants are likely income-eligible for Medicaid, many may be ineligible or may be forgoing enrollment because of their immigration status or that of their family members. Mary's Center's expansion into Prince George's County, Maryland, which does not have a local health insurance program, may also explain part of the increase in uninsured participants. In Prince George's County, roughly 11 percent of all residents lacked medical insurance in 2016, compared with 4 percent in Washington, DC.¹⁵ At Mary's Center's Ontario Road location, only 8 percent of participants were uninsured as of March 2019, and 68 percent were enrolled in Medicaid or other safety net insurance programs. In its Prince George's location, 31 percent of participants were deemed uninsured.

In recent years, as the neighborhoods around its DC locations have gentrified, Mary's Center has also tried to recruit households with higher incomes and private insurance. In 2013, it launched the “Get Care to Give Care” campaign, to inform insured participants that medical insurance reimbursements for one privately insured participant allow Mary's Center to serve uninsured participants and help defray the over \$6 million in free care the center provided in 2017.¹⁶ The campaign also helped Mary's Center counter the perception that its services were only for immigrants or people with low incomes. These

efforts may have helped Mary's Center increase the proportion of participants with private insurance from 3 percent in 2008 to 7 percent in 2018 while remaining an important resource for the region's uninsured residents.

Recruiting higher-income participants is important to Mary's Center for more than just financial reasons. In interviews, senior staff sometimes expressed frustration that, despite having clinical outcomes that compare favorably to universities and private clinics, Mary's Center is still perceived and stigmatized as a health clinic exclusively for poor people of color and immigrants. In addition, the organization believes it is empowering for their low-income participants to see that higher-income residents and their children also use Mary's Center.

TABLE 2
Insurance Status of Mary's Center Participants, 2006–18 (percent)

	2006	2008	2013	2018
Medicaid	34	35	47	52
DC Healthcare Alliance	42	26	13	13
Private insurance	5	3	5	7
Medicare	<1	<1	1	1
Uninsured	19	36	34	27

Source: Mary's Center annual reports.

Evolving Service Use

Each of the three social change model pillars—medical care, social services, and dual-generation education—encompasses a range of direct services provided either by Mary's Center or through referrals to more than 70 community partners. For Mary's Center's 30th anniversary symposium, an external researcher analyzed Mary's Center's electronic medical records data, combined with Briya student data, for 2009 through 2016 (Sinaii 2018). The analysis sorted encounters into five major social change model service categories for adults ages 18 and older:

1. comprehensive team health (i.e., primary health care),
2. social services (e.g., home visiting, afterschool programs),
3. dual-generation education (Briya programs),
4. dental health, and
5. behavioral health.

Table 3 shows changes in total Mary's Center service encounters (i.e., distinct visits and services provided) and encounters by type between 2009 and 2016. During this period, the annual number of Mary's Center encounters nearly tripled—from 36,410 to 101,750. Dental care increased from less than 1 percent of all encounters in 2009 to 13 percent in 2016 and behavioral health care increased from 1 percent to almost 10 percent. Although Mary's Center had more than 45,000 additional primary care encounters in 2016 than in 2009, primary care made up a declining share of all patient encounters, decreasing from 81 percent to 74 percent. Social services also make up a declining share of total encounters, decreasing from 18 percent to less than 4 percent. Staff attribute this decline in social service encounters to the expansion of Mary's Center behavioral health services, as opposed to less frequent social service use. Participants now access behavioral health services directly, rather than through an initial encounter and referral from the social services department.

TABLE 3

Types of Encounters among Mary's Center's Adult Participants, 2009 and 2016

Service	2009		2016	
	Number	Percentage	Number	Percentage
Total encounters	36,410	100.0	101,750	100.0
Primary health	29,419	80.8	74,990	73.7
Social services	6,445	17.7	3,866	3.6
Dental	146	0.4	12,922	12.7
Behavioral health	400	1.0	9,972	9.8

Source: Taken from Ninet Sinaii, "Mary's Center's Social Change Model Quantitative Research Study," presentation at Mary's Center Symposium, Washington, DC, October 12, 2018.

Note: Adults are ages 18 and older.

Educational services made up less than 1 percent of all encounters in 2017, and Briya students represent a small share of Mary's Center's total participants. Briya served 625 adult students and approximately 50 preschool-age children in 2016 (Briya 2019) compared with Mary's Center's 18,352 adult participants.

As part of a larger quantitative analysis of the social change model, Sinaii (2018) identified the percentage of adult participants who received both primary care and other services, along with the percentage who received only primary care or only other services. Table 4 shows the results for 2009 and 2016. During this period, the number of people receiving services annually through Mary's Center increased from 7,685 to 18,352. In 2009, 72 percent of participants used Mary's Center exclusively for primary care services. By 2016, that share had fallen to 60.6 percent. The share that used Mary's Center exclusively for other services besides primary care increased substantially over the same period, from 1.9 percent to over 15 percent. These participants may have used dental or behavioral health services

or attended Briya Public Charter School in 2016 without accessing primary care services from Mary's Center that year. The share of adult participants who used primary care combined with one or more nonmedical service remained flat, at about 25 percent, although the number of participants receiving both primary care and other services at Mary's Center more than doubled. Mary's Center leadership points to the decreasing proportion of participants who receive both primary care and other services at Mary's Center as evidence that the organization needs to invest more internal resources to better integrate services across its departments.

TABLE 4

Rates of Primary Care and Other Service Encounters among Mary's Center's Adult Participants, 2009 and 2016

	2009		2016	
	Number	Percentage	Number	Percentage
Total adult participants	7,685	100.0	18,352	100.0
Those receiving primary care plus one or more service	2,006	26.1	4,405	24.0
Those receiving primary care only	5,533	72.0	11,121	60.6
Those receiving non-primary care services only	146	1.9	2,826	15.4

Source: Taken from Ninet Sinaii, "Mary's Center's Social Change Model Quantitative Research Study," presentation at Mary's Center symposium, Washington, DC, October 12, 2018.

Note: Adults are ages 18 and older.

Participant and Community-Level Outcomes

A rigorous analysis of Mary's Center's health outcomes is beyond the scope of this report. This section, however, summarizes some of these outcomes from our document review and provides insights gathered through interviews and focus groups with Mary's Center staff, participants, and partners to understand Mary's Center's impacts on the people and community it serves.

Participant Outcomes

Mary's Center has consistently been ranked in the top tier of federally qualified health centers nationwide. In 2017 and 2018, it received the US Health Resources and Services Administration's Health Center Quality Leader Award, provided to community health centers that rank highest in clinical quality measures among nearly 1,400 centers nationally (Butler, Grabinsky, and Masi 2015).¹⁷ In 2016, Mary's Center was ranked in the top 25 percent of all FQHCs nationally for cervical screenings, child immunizations, cholesterol treatment, adolescent weight screening and follow-up, depression screening, and asthma treatment.¹⁸ Despite its history as a prenatal care provider, however, Mary's Center rated below average among FQHCs in access to prenatal care in the first trimester and in rates of babies born with low birth weights. Mary's Center senior staff believe this may be because their participants do not seek prenatal care in the first trimester and sometimes arrive in the US during their second or third trimester.

In addition to providing high-quality clinical care, Mary's Center strives to be a leader in care coordination and disease management. The National Committee for Quality Assurance has recognized Mary's Center as a level 2 patient centered medical home. Mary's Center earned this designation based on its ability to provide integrated care through technology and interdepartmental coordination.¹⁹ Providers that achieve this level of coordination have been proven effective at reducing health care costs and emergency department use, improving patient experiences, boosting the delivery of preventive services, and improving care coordination for patients with chronic health conditions (Grumbach and Grundy 2010).

Mary's Center also regularly reports its outcomes for its social service programs. Unlike with its clinical measures, however, these outcomes cannot be benchmarked against other community health

centers. Mary's Center reports that 99 percent of participants in its teen afterschool programs avoided pregnancy, graduated from high school, and enrolled in college. Virtually no participants in Mary's Center home visiting program had reported cases of abuse or neglect after program enrollment, and 91 percent of participants in its social support programs demonstrated reductions in mood and/or behavioral symptoms (Mary's Center 2015). Further, 85 percent of participants in Mary's Center's dual-generation educational program reported reading with their children, and 91 percent participated in parent-teacher conferences.²⁰

After seeing that many of its medical assistants were inadequately trained and struggling with student loans, Mary's Center partnered with Briya to offer its own medical assistant program. According to Briya program data, 90 people have enrolled in the program since 2013: 86 completed the program, and 73 received their registered medical assistant certification. Staff also report that hundreds of graduates of Briya's child development associate program have gone on to start licensed day cares.

Through focus groups, interviews, and surveys, Urban was able to get a more nuanced picture of Mary's Center's impact on participants. Common themes that emerged were the importance of supportive, culturally competent, and personalized care, and the center's commitment to underresourced communities.

Participant-Centered Care in a Supportive Environment

Several participants and community stakeholders highlighted the warm, familial environment—a few participants referred to Mary's Center as *“la clínica de la familia.”* Several alumni of a program for immigrant teens described Mary's Center as an important safe space for themselves and for their families. The ability to receive care in their native language (most commonly Spanish) was noted by both staff and participants as very important.

Several participants pointed to Mary's Center as helping them integrate into American society, make connections in their communities, and raise their children in their new country. This included help navigating access to health care services, public benefits, and educational services and connecting participants to others experiencing similar challenges. For youth, Mary's Center's afterschool programs provided a “gateway” to college and careers.

The teen program helped me make friends, it was a second home as a new arrival to the US, and I met people like me.

—Mary's Center participant

Participants also noted the personalized care and the diversity of supports they received from Mary's Center—whether in the form of appointment reminders or follow-up calls or staff extending extra effort in times of crisis or vulnerability when support was needed most. Mary's Center staff members estimate most participants receive services over several years, providing opportunities for staff to get to know participants better than other high-volume health care providers.

Several participants reported they first came to Mary's Center when they were pregnant or trying to get pregnant and, over time, were referred to other services including mental health, pediatrics, dentistry, and even Zumba classes. Participants also reported receiving unconventional types of support from Mary's Center staff, like helping family members apply for visas or organizing field trips for teens in the afterschool program. This type of care helped them feel supported in managing their health care or other needs.

In surveys and interviews, Mary's Center staff confirmed these types of encounters are central to their work and described the extra efforts they make to support participants. Staff provided many specific examples, including helping a young participant with low self-esteem throw a party for her 4th-grade classmates; helping a participant get sober and receive a kidney transplant; helping connect a homeless HIV+ teen to medical and social services; and helping a family avoid eviction.

When I first moved to this country, I was living in a bad place... they were able to help us get out.... Aside from providing health care they cared where you lived and how you lived. I will never forget that, that had a big impact in my life.

—Mary's Center participant

Staff members described their daily efforts to improve the care their participants receive, from ensuring good experiences and customer service at clinics and appointments, to advocating for high-

needs participants to ensure they receive vital services. When asked to describe an encounter with a participant, one staff person wrote, “Today I am working with a diabetic mother who is almost out of insulin and who needs to return to care. I made a home visit, scheduled an appointment, and [I’m] in the process of making sure her insurance has been updated before she arrives at Mary’s Center tomorrow. The mother does not read or write, nor know numbers in any language.”

My mother used to come here, so I came with her since I was little.... It was easy for my mother to feel comfortable to come, especially with translation. She always felt like she was being helped.

—Mary’s Center participant

Finally, some participants noted that, absent Mary’s Center, there would be few services available to them—either in their native language or for uninsured people with limited ability to pay. In interviews, staff similarly discussed the importance of the sliding-fee scale assessment and translation services as key features of Mary’s Center’s care that facilitate access to health services for underresourced families. This is particularly true for undocumented immigrant families and especially those living in Prince George’s County, which does not have a local health insurance program for people ineligible for Medicaid or Medicare.

Community Outcomes

In addition to the care it provides to participants, Mary’s Center has an active and influential policy presence in DC and suburban Maryland. Staff and community stakeholders noted Mary’s Center’s extensive relationships and partnerships with local service providers and policymakers, as well as its advocacy for policy and regulatory changes that align with its mission.

Long-Standing Partnerships

Mary’s Center’s partners range from public health and human service agencies to state Medicaid agencies, hospitals, managed care organizations, local service providers, universities, charities, and even yoga studios.²¹ To advance issues of importance to its participants, Mary’s Center also works with

national advocacy organizations such as the National Association of Community Health Centers and UnidosUS and local organizations such as the DC Primary Care Association, DC Fiscal Policy Institute, Children's Law Center, and the Washington Area Women's Foundation. Mary's Center staff drew parallels between its providers' efforts to establish trust with participants and the work its senior leadership team does to establish relationships and trust with external partners. Both involve time and patience from each side and an outlining of steps to establish accountability for how they will work together to achieve shared goals.

Mary's Center is an advocate and voice for understanding the needs of their patient population. They have a lot of influence in the city.

—Community stakeholder

Policy Influence

Mary's Center was described as an influential voice in local health care policy discussions and in advocating for improvements to the service landscape for low-income people in the DC region. For example, Mary's Center was instrumental in helping design the DC Healthcare Alliance to offer a health insurance option for low-income District residents who do not qualify for Medicare or Medicaid. It also helped advocate for the DC Department of Finance to change its Medicaid billing rules to make it easier for community health clinics to receive fair reimbursement for providing multiple services for a patient on the same day. This removes barriers to effective care for patients with multiple conditions and mobility issues that make it difficult for them to get to a clinic.

Mary's Center has helped local health clinics navigate the changes to their business models after the introduction of the Affordable Care Act. In 2012, Mary's Center received a Healthcare Innovation Award from the federal Centers for Medicare & Medicaid Services to create the Capital Clinical Integrated Network. With this award, Mary's Center worked with other clinics, service providers, and DC government agencies to increase data sharing, coordination, and outreach to improve health outcomes and reduce costs for DC Medicaid recipients.

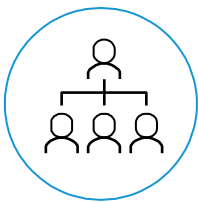
Finally, through the DC Primary Care Association—a network of community health clinics and community-based organizations in DC and Maryland—and other platforms, Mary's Center has helped inform policy and practice for providing high-quality, integrated care to underresourced populations

with complex needs. Mary's Center, and Maria Gomez specifically, have also been cited as the source of expertise for mayoral transition teams in DC to learn about effective delivery of care with an emphasis on immigrant health issues.

The Social Change Model in Practice

Our survey and interviews highlighted two organizational characteristics as central to Mary's Center's ability to grow successfully and to implement the social change model. First is Mary's Center's strong organizational culture with a shared commitment to mission-driven growth. Second is a "high-tech/high-touch" approach to care. Maintaining each component is challenging and requires constant attention, with the main challenges centering on finding resources to meet ambitious service objectives, managing growth, and evaluating the social change model.

Organizational Culture



You can have the model, but if you don't have the culture then it won't work.
—Mary's Center staff member

Staff and community stakeholders described Mary's Center as a mission-driven, entrepreneurial and demanding environment that emphasizes continuous learning and improvement, and challenges staff to perform "at the top of their license." Some of the elements that support Mary's Center's change-driven culture include:

Strong Leadership

Staff and community stakeholders consistently noted Gomez and her senior management team's leadership in driving Mary's Center's growth and maintaining its presence in the community. This strong leadership has been documented as far back as 2002 when Mary's Center conducted an external needs assessment in preparation for its next phase of growth (Gramlich, McKay, and Berl 2002). Gomez's leadership as executive director and the strength of her core leadership team has been a long-standing asset to Mary's Center, as has a culture of accessible senior managers.

Along with being a visionary leader, Maria surrounds herself with outstanding people.
—Community stakeholder

A Mission-Driven, Diverse Staff

Several members of Mary’s Center’s leadership team discussed the importance of hiring a diverse pool of service providers and staff at every level, who understand Mary’s Center’s participants and buy in to the mission and social change model. Senior staff described “leading with the mission” when recruiting staff—particularly at more senior levels—so everyone understands Mary’s Center’s core goals and culture from the start. Mary’s Center provides interdisciplinary training for all staff to foster a shared commitment to the social change model.

When we are looking for a director, front desk person, or IT person, we make sure our mission is in the forefront. Your longevity here depends on if you believe in what we are doing here.
—Mary’s Center staff member

Mary’s Center also hires graduates from its teen program or medical assistant program, as well as people recruited at community outreach events. This helps ensure that staff understand and embrace Mary’s Center’s mission and reflect the center’s participants. Some staff also discussed the importance of developing from within, creating career ladders, and retaining people who know the social change model well and can directly reflect on Mary’s Center’s role in the community.

Finally, senior staff emphasized the importance of hiring a diverse and bilingual staff. Mary’s Center’s goal is to have 70 percent of its staff reflect the race and ethnicity of the largest population of participants served.²² As of 2018, Mary’s Center is close to that goal, and the majority of staff are people of color: 56 percent identified as Hispanic, 22 percent as white, 15 percent as black or African American, and 7 percent as other races. The senior staff are 44 percent people of color and 56 percent white non-Hispanic. As a point of comparison, a national survey of hospitals in 2013 found that just 17 percent of all senior or mid-level managers were people of color (HRET 2014). In total, 75 percent of Mary’s Center’s senior staff and 83 percent of all staff are female.

Multiple staff members also acknowledged that pursuing the social change model can be demanding and that Mary's Center expects a lot from its staff. Nevertheless, Mary's Center has been recognized for its strong organizational culture. *The Washington Post* included Mary's Center as one of the top workplaces in the metropolitan area in 2016 and 2019; 90 percent of Mary's Center staff reported they were enthusiastic and passionate about their work compared with just 32 percent of all US employees.²³ A 2015 employee survey, conducted by the Society for Human Resources Management on behalf of Mary's Center, found that 90 percent of Mary's Center staff were satisfied with their job, compared with 71 percent of other US employees. Ninety-two percent of staff surveyed for this report stated they would recommend working at Mary's Center to a friend.²⁴

The Society for Human Resource Management survey also found that Mary's Center staff was less satisfied with their compensation than other employees nationally, but more satisfied with benefits, opportunities for career development, relationships with management, and overall work environment. In interviews, senior staff acknowledged that providers can often earn 10 to 15 percent more outside the nonprofit sector. This further enforces Mary's Center's emphasis on hiring staff that embrace the mission and can thrive in the organizational culture.

Encouragement of Continuous Improvement

Staff and stakeholders frequently discussed Mary's Center's emphasis on testing innovative new ideas from staff at all levels. It is constantly gathering input on emerging challenges and opportunities, testing new approaches, learning from those tests, and applying the results to the center's practice. Senior staff noted the importance of being opportunistic and nimble, and not averse to change or critical self-assessment. This includes an openness to staff criticism or external assessment of policies and procedures and to suggestions for improvements.

Mary's Center staff are Mary's Center's worst critics. They're constantly identifying areas to fix. It feels like you're working at a startup.

—Mary's Center staff member

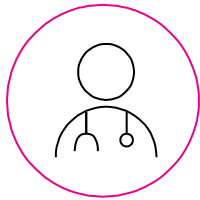
For example, in 2015, Mary's Center partnered with George Washington University to assess participant satisfaction and experiences with Mary's Center. Phone and waiting room surveys revealed

high participant satisfaction with the care they received (98 percent of participants said they would recommend Mary's Center to a friend), but challenges with the appointment reservation system and wait times in clinics.²⁵ Complaints about long wait times is something Mary's Center has in common with many other FQHCs (Ramos et al. 2016). Based on these findings, Mary's Center contracted with an offsite call center to reduce its average dropped call rate from 20 percent to less than 5 percent.²⁶ It also created an interdisciplinary group to design improvements to physical layouts, triage procedures, and previsit paperwork processes to reduce wait times. The changes were piloted at the location with the worst reported wait times and reduced the maximum wait times from 45 to 15 minutes. The changes are now being rolled out to other locations.

Testing and continuous improvement requires sound measurement. Mary's Center's evaluation and outcomes team develops and maintains dashboards to monitor performance for different service areas or initiatives. For example, a medical dashboard tracks about 20 clinical outcome measures (e.g., diabetes, hypertension control, cancer screening, childhood immunization), some of which the US Health Resources and Services Administration requires all FQHCs to report. A separate dashboard tracks prenatal programs. The outcomes team also separately tracks various process and outcome measures required by grant funders or related to internal quality control efforts. An interdisciplinary committee meets monthly to review dashboard measures and track outcomes and consider ways to improve them—with some initiatives requiring dedicated weekly interdisciplinary team meetings. Mary's Center's senior management team and board members also meet quarterly to review metrics, share information on best practices, and address areas for improvement.

Mary's Center staff launch pilot programs and use a “plan, do, study, act” system to test quality-improvement ideas. Outcomes are typically tracked through a medical dashboard. As of 2018, Mary's Center was managing efforts aimed at tracking use of a literacy screening tool, decreasing wait times, improving participant satisfaction, increasing referrals and cross-utilization of services, and optimizing medical outcomes.

Operationalizing the Model



*I think other places might see one thing as their core competency.
The model is our core competency. We don't invest in one more
than the other. They all grow together.
-Mary's Center staff member*

Ultimately, the social change model's success relies not just on making services available to address the social determinants of health, but on making sure staff and participants understand how to access those services. As part of our evaluation, we surveyed Mary's Center staff about their understanding of the social change model and how it is implemented. In total, 305 of Mary's Center's 587 staff members responded to the survey. Appendix A provides response information and selected results.

Staff Awareness of the Model

We asked survey respondents to rate their familiarity with the model from 1 (not at all familiar) to 5 (completely familiar). Although Mary's Center's 2002 organizational assessment revealed that many staff did not understand the organization's mission, our survey found that most of Mary's Center staff are aware of the model and believe the center adheres to it (Gramlich, McKay, and Berl 2002). Half of staff reported that they were completely familiar with the model, and another quarter reported that they were moderately familiar with it. Only 5 percent reported no familiarity. Staff who work at Mary's Center's Ontario Road headquarters were more familiar with the model than staff elsewhere, with Maryland-based staff the least familiar. On average, Briya staff, who may be at multiple locations, were less familiar with the model than staff in other roles. In a separate question, the survey provided staff with a definition of the social change model and asked how closely they thought Mary's Center followed the model. Over two-thirds of respondents reported that Mary's Center followed it "mostly or completely."

Meeting Participants' Needs

Survey respondents were asked to reflect on how often Mary's Center participants experienced various challenges and their perception of how well Mary's Center can help address them (table 5). This includes whether staff see value in the resources describing the range of Mary's Center services and whether they feel equipped to connect participants to services. While it is not Mary's Center's goal to address every challenge a participant faces, this question was intended to be a snapshot of how well staff feel center services align with participants' most common needs. With some exceptions, staff viewed Mary's Center as equipped to meet the nonmedical needs observed among participants.

When staff members were asked about specific challenges Mary's Center participants experience, the most common response was limited English language skills (54 percent of respondents stated it occurred "very often") and lack of education (e.g., no GED or limited job skills). Behavioral health concerns (e.g., depression or anxiety) and legal issues were the next most common challenges reported by staff. Food insecurity, homelessness, and domestic violence were slightly less common.

TABLE 5

Mary's Center Staff Perceptions of Participant Needs and Ability to Address Them

Area of need	Average frequency of need (1=almost never, 5=very often)	Ability to respond (1=not at all, 5=mostly or totally)
Limited English language skills	4.3	4.4
Behavioral health concerns (e.g., depression, stress, or anxiety, etc.)	4.2	4.6
Lack of education (e.g., no GED or limited job skills)	4.2	4.2
Legal issues (e.g., immigration assistance)	4.1	3.6
Poverty/financial crisis (e.g., emergency need for clothing or financial assistance)	4.0	3.7
Lack of access to benefits (e.g., health insurance, TANF, food stamps/SNAP)	3.8	4.3
Child development/parenting concerns	3.8	4.4
Food insecurity	3.7	3.8
Homelessness/housing insecurity	3.7	3.1
Domestic violence and /or child abuse and neglect	3.5	4.2

Source: Urban Institute survey of Mary's Center Staff conducted July–August 2018.

When asked how capable Mary's Center was to respond to these various needs, staff overall felt that Mary's Center was "mostly or totally" capable of addressing participants' English and educational challenges, as well as behavioral health and child development needs. However, staff felt Mary's Center was only somewhat capable of responding to food insecurity and legal challenges for participants, and less capable of responding to homelessness and housing insecurity. These responses make sense given

Mary's Center's core strengths and the scarcity of affordable housing for people with low incomes both in the DC area and nationwide. In an internal report, Mary's Center staff identified affordable housing as one of their biggest future priorities for local advocacy.²⁷

Supporting Integrated Care

Sixty-five percent of staff reported that they refer participants to Mary's Center or Briya services outside their own departments at least once a week. When asked to reflect on their ability to coordinate across departments to provide referrals and care, 63 percent agreed or strongly agreed they can communicate with staff in other departments and 77 percent indicated that they felt confident they could refer patients to other Mary's Center services.

When asked to describe the perceived value of the various tools and resources Mary's Center provides to help staff make referrals across Mary's Center departments and provide comprehensive care, the "warm handoff" method—where staff members walk participants to meet with other providers rather than relying on a written referral for participants to follow up—was identified as the most effective, followed by the electronic medical record (EMR) system.

This combination of warm handoffs and EMR use is a useful illustration of Mary's Center's ability to leverage technology and remain a high-touch organization. Warm handoffs help facilitate the frictionless coordination of services central to the social change model. When Mary's Center can't accommodate participants' needs, staff will attempt to connect them to other external providers. Staff noted that for participants with busy lives, transportation challenges, and a wariness of medical providers, warm handoffs can greatly increase the likelihood of a successful referral.

We've trained our staff to use warm handoffs. We think it's really important not just to say, "I'll make another appointment for you with a family support worker." Instead, you go and introduce the person to the provider to remove that barrier. Warm handoffs are a big way you connect from one department or staff person to another.

—Mary's Center staff member

In interviews, senior staff described a combination of personalized, coordinated care and communication among the staff as the “secret sauce” behind the social change model. Most of the data available to Mary’s Center about their participants and services is extracted directly from the EMR. An informatics manager is responsible for building data fields and extracting data needed for reporting, dashboards, referral tracking, “plan, do, study, act” endeavors, and pilot efforts. For example, a field was created in the EMR to track use of the literacy screening tool.

Staff members across departments can share relevant information about participants’ medical and service history. Connections are made between data or case management systems as needed (e.g., connecting the dental and medical EMR systems, and the LabCorp system to track blood work), and data sharing agreements are in place to exchange data on shared participants between Mary’s Center and Briya. In one instance, Briya’s school nurse worked with a family support worker at Mary’s Center to address a family’s inability to pay for a medication. Without access to a shared health record among key staff, that support may not have occurred.

Referrals identified in the EMR, while not an exhaustive measure given that informal referrals may also be made among providers, were noted in interviews with Mary’s Center staff as the most explicit measure of integrated care. As such, referrals in EMRs are tracked regularly as an indicator of how well staff apply the social change model.

Ongoing Challenges

Mary’s Center has successfully expanded its operations while staying true to its mission and reputation for providing high-quality care. Yet it faces ongoing challenges. Many of these reflect a natural tension between Mary’s Center’s service objectives and the resources available to support its goals.

Financial Sustainability

One senior-level staff person noted, “Not-for-profit is a status, not an objective.” The two main financial pressures for Mary’s Center are the high share of uninsured participants and the fact that several services it provides as part of the social change model are not reimbursable. Mary’s Center consistently faces funding gaps between the costs of its services and the reimbursements it receives from health insurers.

Reimbursement is particularly challenging for services provided outside Mary's Center's clinics. The success of the social change model depends on nonclinical services, but these services typically do not qualify for Medicaid reimbursement. This is particularly true for social services. While most of the medical and dental staff are paid for through reimbursable services, it is much harder to fund the nutritionists, health educators, family support workers, home visiting staff, domestic violence and teen support workers, and care coordinators that make the social change model work. Mary's Center's school-based therapists are reimbursed for the services they provide to students but have a difficult time receiving reimbursement for time spent with parents, school administrators, and teachers. While some funding has become available for these services, Mary's Center and Briya's leadership is unsure how long it will last.

Similarly, while evidence shows that telemedicine reduces emergency department visits and hospital readmissions and increases medication adherence, the funding for this practice is unpredictable from third-party insurance sources. More broadly, many of the investments Mary's Center makes to develop partnerships; recruit, train, and develop staff; and provide warm handoffs between departments are not eligible for Medicaid or other insurance reimbursement.

This misalignment between the resources necessary to provide effective, personalized care coordination—particularly for people with high rates of poverty, illiteracy, and mental illness—and the reality of how services are paid for is not unique to Mary's Center. It is why, as Gomez notes, health care organizations may increasingly “understand the social determinants of health and discuss its value, but they are less willing to assign resources to address them.” Mary's Center is committed to making these investments, and funds them through a combination of innovative partnerships with payers, individual and corporate donations, and grant writing.

Like most FQHCs, Mary's Center's largest funding source is Medicaid, and most of this funding comes through Medicaid managed care organizations (MCOs) (MACPAC 2017).²⁸ Medicaid MCOs typically receive fixed monthly payments from the state Medicaid agency for each of their members, with some adjustments based on members' age, gender, location, and diagnoses. MCOs are responsible for paying claims to health care providers for member services. Federal law requires that Medicaid reimburse FQHCs for all required services, as well as any other ambulatory services covered under the Medicaid state plan (MACPAC 2017). MCOs have broad discretion, however, in how they reimburse FQHCs for services.²⁹

Mary's Center has negotiated agreements with each local managed care plan specifying what non-required services the center can bill for and what rates it will charge. Though Mary's Center reports

charging lower rates than other DC health care providers for billable services, its overall rates can be above average because of all the non-billable care coordination services it provides. Mary's Center leadership noted it can be difficult to convince insurance companies to pay for optional services, but Mary's Center makes the business case for including them on two levels. First, Mary's Center's high level of engagement is effective at increasing preventive care services such as pap smears, immunizations, body mass index assessments, and screenings for cancer and other conditions. Second, Mary's Center's care-coordination services help people manage chronic health conditions like asthma and diabetes, and that helps avoid unnecessary emergency room visits and lengthy hospitalizations that put managed care plans at greater financial risk.

Because of Mary's Center's reputation, MCOs often send them "panels" of their members with complex medical and social needs, such as uncontrolled diabetes. If Mary's Center can help these members achieve agreed-upon outcomes the health plans send Mary's Center even more complex cases, with more difficult conditions. Mary's Center accepts these more challenging participants and negotiates with the MCOs to cover the costs for the care coordination necessary to provide effective care. Staff noted that this is how they negotiated with AmeriHealth for telemedicine service funding for people with chronic health conditions and mobility challenges.

Despite these occasional successes, getting managed care plans and other payers to cover the costs of care coordination and other services is a struggle. Although the Affordable Care Act has helped accelerate the movement toward value-based payments in health care through payment reform vehicles like accountable care organizations and delivery system reform incentive payments, it remains difficult to find sustainable funding to address social determinants of health (Spillman et al. 2017). Mary's Center staff believe these reforms are not having an impact in helping them find sustainable funding for the social change model. This is, in part, because payers have set the bar too low for what outcomes are needed to receive incentive payments. Thus, payers' motivation is to find the cheapest way to achieve average outcomes, rather than make the necessary investments to achieve the best possible outcomes.

To pay for non-billable services, as well as start-up capital costs for projects like establishing mini-clinics within affordable housing complexes, Mary's Center uses grants and individual and corporate donations. In 2018, 31 percent of Mary's Center's funding came from grants and 7 percent came from individual and corporate donations.³⁰ Mary's Center's development and communications team believe that the social change model assists with fundraising because its approach and outcomes resonate with a broad group of supporters.

Pay for success financial models—in which an up-front funder supports a promising intervention and is reimbursed later, when certain outcome measures have been met—have been discussed as a promising approach to support efforts not funded through reimbursements.³¹ Mary's Center is also well-positioned to take advantage of the movement toward value-based payments in health care. These reforms are designed to make payers more willing to invest in the social determinants of health to achieve better outcomes.

Managing Growth

Mary's Center's senior staff note that rapid growth has complicated efforts to keep track of available services, assess participants' needs, and connect participants to the right services. Mary's Center is now investing in resources, including hiring a chief transformation officer, to better track how well the organization is integrating its expanding array of services and make improvements in making connections across departments.

If not managed properly, rapid organizational growth can also reduce service quality and lead to staff burnout. Mary's Center's staff described expanding into new services or accepting growth opportunities that help further its mission, and figuring out later how to sustainably fund and staff the efforts. This entrepreneurial spirit is central to Mary's Center's success and culture but can also place a strain on staff. When asked in surveys to describe an aspect of Mary's Center that could be improved, some staff responded that the organization has grown too much or too quickly, which can contribute to low morale and staff turnover. Some staff reported their clinics lack services available in other locations—particularly educational services—or that they felt isolated from other Mary's Center departments. Despite these pressures, Mary's Center's internal data show its annual staff turnover rate over the past three years was 17.5 percent, which is below the health care industry turnover rate of 19.1 percent in 2018 (Nursing Solutions, Inc. 2019). Conversely, some staff felt Mary's Center should expand even further, into other underresourced areas in Washington, DC, or into northern Virginia.

Staff and stakeholders also discussed the challenge of maintaining consistent service quality across locations and departments as Mary's Center grows. Some staff reported a tension between productivity demands and the need to provide patient-centered care. For example, Mary's Center is committed to serving everyone—including people who show up without an appointment. Reserving time for walk-in patients and an emphasis on volume makes it more difficult to maintain a schedule and can lead to crowded waiting rooms and longer wait times. In addition, the social change model requires providers to

spend enough time with participants to build trust, understand their needs, and make warm handoffs between staff.

Evaluating the Model

Rigorous research and evaluation are critical to demonstrate the social change model's value and to set the stage for refinements, expansion, or replication. It could also help address funding challenges by quantifying for payers (e.g., state Medicaid agencies, MCOs, or hospital networks) the value of robust care coordination, social services, and education for improving patient outcomes and containing costs.

An initial analysis found some promising preliminary results for the impacts of the social change model on selected adult health indicators (Sinaii 2018). The analysis compared participants that received both primary care and other services to participants that received just primary care in 2009 or 2016. It found that participants who used multiple services showed lower risk of hypertension, obesity, diabetes and high cholesterol than participants who did not use nonmedical services in the same period. However, these results are preliminary; the analysis excluded children, and it could not control for individual or household characteristics that may be driving service use or results.

The analysis, conducted in partnership with Mary's Center, highlighted the challenges capturing the impacts of social determinants of health interventions. For example, households who access more services may be more vulnerable than others or face more complex medical challenges—or they may be relatively stable and therefore able to take advantage of more service offerings beyond medical health. More work is needed to articulate the theoretical framework for how social change model services may impact individual or family health and well-being, and to quantify impacts. A single measure or set of medical health indicators is unlikely to fully capture the benefits to participants or their families, and EMR data alone cannot currently capture key outcomes like economic self-sufficiency or educational attainment.

Conclusions and Lessons for the Field

One goal of this report is to surface lessons from Mary's Center's experience to inform health care providers, funders, policymakers and others interested in addressing the social determinants of health. Mary's Center's distinctive model and mission developed over three decades, based initially on the experience and perspectives of its initial founders including the CEO, Maria Gomez. As such, some aspects of its approach and culture are unique to its origins. But our examination also reveals several strategic decisions and investments in organizational capacity that have helped support the model and successful growth and that can inform others interested in pursuing this work.

First, a critical part of Mary's Center's success is based on **understanding its participants and the communities they live in**. Mary's Center leadership and staff emphasize their strong connections with key stakeholders, including participants, local service providers, policymakers, and funders. At the direct service level, these connections help staff remain knowledgeable about participants' social and educational needs and allow Mary's Center to reach more participants. Relationships with other service providers also help Mary's Center reach new participants and respond to needs that it does not have the resources to address on its own—whether through referrals or through systems-level policy advocacy to improve health care availability and quality in the DC area.

Building productive relationships and trust with participants, health care system stakeholders, community organizations, local government decisionmakers, and funders takes time and resources from different levels of the organization. Mary's Center invests explicitly in developing community connections by maintaining a visible presence at community events and by recruiting staff who represent and reflect participants and are motivated by the social change model. Senior staff engage closely with health care providers and stakeholders and have taken on advisory and leadership roles in DC-area policy discussions. Comments from Mary's Center staff and participants underscore the importance of having health care providers that understand the participants they serve and are personally invested in their participants' success. Community stakeholders similarly emphasized the value of Mary's Center voice in helping improve and expand the local health care service delivery system. Developing these strengths is the result of deliberate attention to community outreach and connections.

Second, Mary's Center demonstrates that effectively providing integrated care to address the social determinants of health takes more than just expanding service offerings. Encouraging connections across service areas is a continuous process that requires **ongoing investments in people and procedures**. At Mary's Center, investments include efforts to ensure staff understand and buy-in to the social change model, are equipped to make meaningful connections with participants, can collaborate with other care providers, and can track participants. This begins with building a mission-driven, culturally competent staff who understand the model and feel confident about their ability to implement it. Staff and participants alike told stories of individualized care, and the safe space that Mary's Center represents for some families. When the model is working at its best, personal connections are supported by electronic medical records to share information and further facilitate coordinated care. Demonstrating the model is working (and when it is not), and testing ways to improve it then takes attention to data management and analysis.

Mary's Center's senior leadership acknowledge that, as it has grown, it has become more difficult for participants and staff to communicate and stay up-to-date with all the services it provides and ways to access them—and that service quality and both staff and participant experience can suffer as a result. Even with processes and technologies in place, integrated care will not happen automatically. Most recently, Mary's Center's has created a new position, chief transformation officer, to help the organization measure and improve upon its ability to provide integrated care.

Third, Mary's Center's experience demonstrates that addressing the social determinants of health among high-need populations requires **flexible funding**. The social change model relies on grants and donations from various sources to pay for nutritionists, health educators, family support workers, home visiting staff, domestic violence and teen support workers, and care coordinators whose services do not qualify for Medicaid reimbursement. Staff noted that some services had been expanded and retracted over the years based solely upon funding availability. Over time, Mary's Center's ability to find funding has been critical to its efforts to balance growth with internal capacity building—helping the center grow more sustainably and invest in both direct services and management, information technology, and financial systems. In particular, Venture Philanthropy Partner's four-year, \$3.4 million investment was instrumental in helping Mary's Center build its organizational capacity and achieve sustainable growth at a pivotal time in its development.

For the most part, Mary's Center's experience shows that if you provide high-quality services, funders will follow. But the need for flexible funding is ongoing, and Mary's Center invests significant energy in demonstrating the value of its services and identifying resources to maintain services and support continuous quality improvement. For example, addressing housing needs, which have been

identified as an issue that Mary's Center's staff members feel less equipped to meet, will require new funding sources or stronger partnerships. Going forward, new financial models such as social impact bonds or performance-based financing may offer some promise for social determinants of health interventions. These approaches will also require investments in data and evaluation capacity to demonstrate results.

Finally, Mary's Center's entrepreneurial culture highlights **the value of experimentation and incremental expansion**. Fully replicating the social change model may be out of reach or intimidating for community health centers that lack Mary's Center's organizational capacity or are newly exploring the social determinants of health. A lesson from Mary's Center is that incrementally adding or testing new services or expanding as opportunities arise—directly or through partnerships—can be challenging but rewarding by helping increase organizational capacity and demonstrate success. Other organizations and funders interested in social determinants of health interventions can begin to identify modest, incremental opportunities to incorporate staff, procedures, or services intended to help understand and address participants' nonmedical needs.

Mary's Center provides a useful framework for understanding the benefits and opportunities of providing comprehensive medical, social, and educational services in underresourced communities. It also highlights some challenges to implementing and sustaining such an approach. Going into its fourth decade, Mary's Center continues to explore new opportunities to expand and improve. This includes more precisely specifying the theory of change behind the social change model and documenting its impacts—both to more rigorously evaluate its effectiveness and to provide a replicable model to inform other health care organizations' efforts. As the broader health care industry increasingly acknowledges the importance of the social determinants of health, Mary's Center's experience can continue to inform both policy and practice.

Appendix A. Staff Survey Results

EXHIBIT A.1

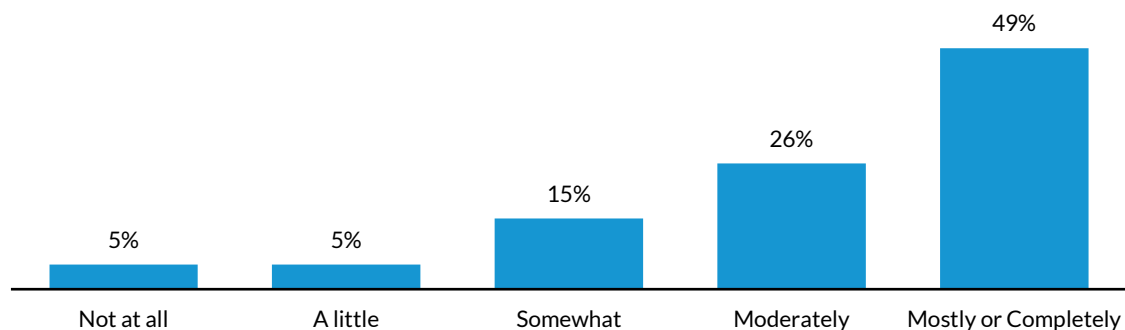
Survey Participation by Respondent Department

Respondent department/role	Survey responses	Total staff	Response rate	Share of responses
Administrative support or operations (e.g., front desk, referrals, billers, operations, communications, marketing, development)	43	65	66%	14.1%
Behavioral health	50	79	63%	16.4%
Dental services	29	52	56%	9.5%
Educational services/Briya	34	107	32%	11.2%
Facilities-maintenance	2	20	10%	0.7%
Finance	3	9	33%	1.0%
Home visiting	21	23	91%	6.9%
Human resources	3	7	43%	1.0%
Medical & health support services (includes MAs, RNs, health educators, nutritionists)	86	181	48%	28.2%
Senior leadership	8	10	80%	2.6%
Social services	26	34	76%	8.5%
Total	305	587	52%	100%

Source: Urban Institute survey of Mary's Center staff conducted July–August 2018.

EXHIBIT A.2

How Familiar Are Mary's Center Staff with the Social Change Model?



Source: Urban Institute survey of Mary's Center staff conducted July–August 2018.

EXHIBIT A.3

Mary's Center Staff Familiarity with Social Change Model by Location and Role

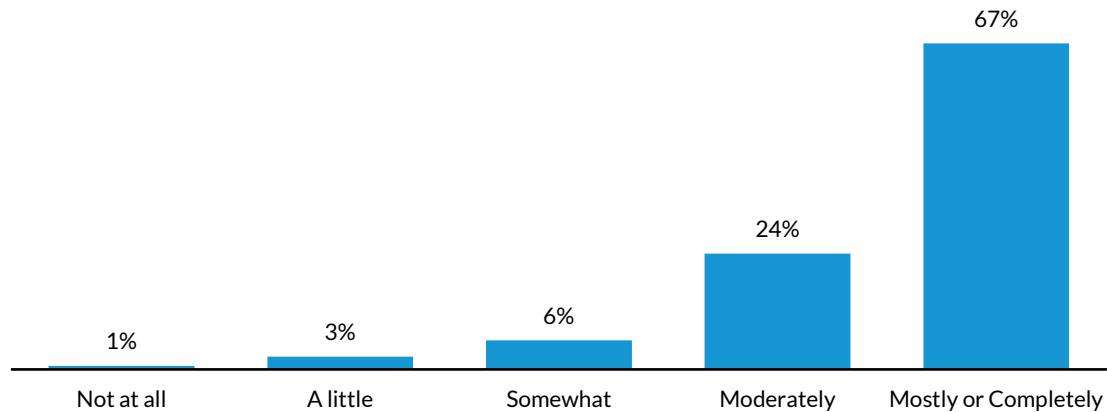
1= not at all familiar, 5=mostly or completely familiar

	Number of respondents	Average score
All staff	259	4.1
<i>By location</i>		
Kalorama and Ontario, DC	60	4.4
Petworth	81	4.2
Fort Totten, DC	53	3.8
Adelphi and Flower, MD	25	3.8
Other	40	3.8
<i>By role</i>		
Medical	76	4.2
Social services	67	4.1
Briya	30	3.7
Administrative	33	4.3
Dental	22	4.11
Other	31	4.5

Source: Urban Institute survey of Mary's Center staff conducted July–August 2018.

EXHIBIT A.4

How Well Do Staff Think Mary's Center Follows the Social Change Model?



Source: Urban Institute survey of Mary's Center staff conducted July–August 2018.

Appendix B. Interview Participants

Interviewee	Title	Organization
Alicia Wilson	CEO	La Clínica del Pueblo
Alis Marachelian	Senior Director, Community Health Initiatives and Strategic Alliances	Mary's Center
Allison Kokkoros	Director/CEO	Carlos Rosario
Bill Bletzinger	Director of Finance and Administration	Briya
Camille Dixon	Family Planning Program Manager	Unity Healthcare
Carlos Marroquin	Chief HR Officer	Mary's Center
Christie McKay	Executive Director	Briya
Dara Koppelman	Chief Nursing Officer	Mary's Center
David Tatro	Former Chief Operating Officer	Mary's Center
Heather Morgan	Chief Development Officer	Mary's Center
Heba Hashem	Former Director of Information Technologies	Mary's Center
Joan Yengo	Chief Program Officer	Mary's Center
Jonathan Blum*	Managing Principal	Health Management Associates
Josephine Morris-Young	Chief Financial Officer	Mary's Center
Julie Wagner	Vice President for Community Affairs	CareFirst Blue Cross Blue Shield
Karen Dale	CEO	AmeriHealth
Dr. Kristin McDay	Obstetrician-Gynecologist	Providence Hospital
Linda Elam	CEO	Amerigroup
Lori Kaplan	Executive Director	Latin American Youth Center
Lorie Preheim	Director of Programs	Briya
Lyda Vanegas	Communications and Public Relations Director	Mary's Center
Maria Gomez	President and CEO	Mary's Center
Dr. Maria Marquez	Pediatrician	Mary's Center
Meghan Tucker	Marketing Director	Mary's Center
Penny Griffith	Executive Director	Columbia Heights Shaw Family Support Collaborative
Rachel Joseph	Chief of Staff	Child & Family Services Agency (DC CFSA)
Shirley Marcus Allen	Lead Partner	Venture Philanthropy Partners
Tamara Smith	CEO	DC Primary Care Association
Tatiana Torres	Director of Community Affairs for the National Capital Area	CareFirst Blue Cross Blue Shield
Dr. Tollie Elliott	Chief Medical Officer	Mary's Center

* Mary's Center board member

Notes

- ¹ Throughout this report, we use “participants” rather than “clients” or “patients.” Mary’s Center describes the people receiving its various medical, educational, or social services as participants to emphasize their agency and active participation in services, and to emphasize that people may not be receiving exclusively health care services.
- ² Number of participants is taken from “About Us: Outcomes,” Mary’s Center, accessed September 13, 2019, <https://www.maryscenter.org/about-us/outcomes/>. Annual budget is taken from 2018 financial reports and is used here with the permission of Mary’s Center
- ³ For a useful description of the social determinants of health, also see the Office of Disease Prevention and Health Promotion: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
- ⁴ See <https://www.maryscenter.org/about-us/mission-and-model/>.
- ⁵ Documents reviewed while preparing this report include Mary’s Center and Briya annual reports, media items, Mary’s Center press releases, and internal reports or materials such as Mary’s Center’s strategic plans and needs assessments, staffing information, organizational charts, and interim documents related to evaluations of the social change model.
- ⁶ For more information on the 2018 symposium, including a recording of the webcast, see the event page on Urban’s website, <https://www.urban.org/events/marys-center-symposium-successful-pathways-education-health-and-well-being-role-community-health-center>.
- ⁷ For information on Even Start see <https://www.childtrends.org/programs/even-start>.
- ⁸ For information of FQHCs and their requirements, see “Health Center: Frequently Asked Questions,” <https://bphc.hrsa.gov/ftca/healthcenters/ftcahcfaqs.html> and Emilie Pinkham, “Federally Qualified Health Centers 101,” PowerPoint presentation, 2016, <http://www.iccmhc.org/sites/default/files/resources/Emilie%20Pinkham.pdf>.
- ⁹ For more information, see: <https://www.briya.org/>.
- ¹⁰ “Addiction and Substance Abuse Treatment,” Mary’s Center, accessed September 13, 2019, <https://www.maryscenter.org/behavioral-health/other-specialties-and-services/addiction-and-substance-abuse-treatment/>; “Sexual Health,” Mary’s Center, accessed September 13, 2019, <https://www.maryscenter.org/medical/other-specialties-and-services/sexual-health/>.
- ¹¹ “Mary’s Center 2014–2018 Strategic Plan,” unpublished internal document, 2016.
- ¹² “Annual Report: Lives We Touched,” Mary’s Center, accessed September 13, 2019, <https://www.maryscenter.org/annual-report/lives-we-touched/>.
- ¹³ Louise Norris, “District of Columbia and ACA Medicaid Expansion,” Healthinsurance.org, accessed June 20, 2019, <https://www.healthinsurance.org/dc-medicaid/>.
- ¹⁴ Soumya Bhat, “The Healthcare Alliance: DC’s Last Step to Making Health Insurance Accessible to Everyone,” DC Fiscal Policy Institute blog, October 23, 2015, <https://www.dcfpi.org/all/the-healthcare-alliance-dcs-last-step-to-making-health-insurance-accessible-to-everyone/>.
- ¹⁵ “Explore Health Rankings,” County Health Rankings and Roadmaps, accessed June 20, 2019, <http://www.countyhealthrankings.org/explore-health-rankings>.
- ¹⁶ “Annual Report: 2018 Highlights,” Mary’s Center, accessed September 13, 2019, <https://www.maryscenter.org/annual-report/highlights/>.

- ¹⁷ See also, “Annual Report: 2018 Highlights,” <https://www.maryscenter.org/annual-report/highlights/>; and “Patient-Centered Medical Home: What Is a Patient-Centered Medical Home (PCMH)?” Patient-Centered Primary Care Collaborative, September 2015, <https://www.pcpcc.org/resource/patient-centered-medical-home-what-patient-centered-medical-home-pcmh>.
- ¹⁸ For more information, see Mary’s Center’s 2016 Health Center Profile on the HRSA website, <https://bphc.hrsa.gov/uds2016/datacenter.aspx?q=d&bid=037030&state=DC&year=2016>.
- ¹⁹ See Mary’s Center’s NCQA report card at https://reportcards.ncqa.org/#/practice/Practice_001G0000011qSy9IAE. For the report cards methodology, see <https://reportcards.ncqa.org/#/methodology>.
- ²⁰ “Annual Report: 2018 Highlights,” <https://www.maryscenter.org/annual-report/highlights/>.
- ²¹ For a partial list of Mary’s Center service partners, see <https://www.maryscenter.org/our-partners>.
- ²² “Mary’s Center 2014–2018 Strategic Plan.”
- ²³ Carlos Marroquin, “Why Mary’s Center Is One of the *Washington Post* Top Workplaces...Again,” Mary’s Center blog, August 30, 2019, <https://www.maryscenter.org/2019/08/30/why-marys-center-is-one-of-the-washington-posts-top-workplacesagain/>.
- ²⁴ These data are taken from an internal report and are published here with the permission of Mary’s Center.
- ²⁵ Julia Grysavage, “Mary’s Center Spring 2015 Needs Assessment Questionnaire,” unpublished internal evaluation, The George Washington University, 2015.
- ²⁶ “Mary’s Center 2014–2018 Strategic Plan.”
- ²⁷ Gordon-Andrew Fletcher, Esq., Shannon Linton, and Allen Wong, “Mary’s Center Advocacy Plan & Policy Statements,” unpublished internal document, 2017.
- ²⁸ “Annual Report: 2018 Highlights,” <https://www.maryscenter.org/annual-report/highlights/>. In DC, 65 percent of Medicaid enrollees belong to one of the city’s four Medicaid managed care health plans (Amerigroup, AmeriHealth Caritas, Health Services for Children with Special Needs, and Trusted Health Plan (<https://www.dc-medicaid.com/dcwebportal/nonsecure/managedCareInfo>)).
- ²⁹ Both DC and Maryland provide “wraparound rates” to fully reimburse FQHCs if managed care organizations provide reimbursement rates lower than what they would receive under the state’s Prospective Payment System.
- ³⁰ These data are taken from 2018 financial reports and are used here with the permission of Mary’s Center.
- ³¹ See <https://pfs.urban.org/get-started> for more information on pay for success.

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