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Medical Care For the Underserved: A Faith-Based Approach in Hartford, CT

Navid Mahooti

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Medical Care for the Underserved:

A Faith-Based Approach in Hartford, CT

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B.S., Gordon College, 1996
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Submitted in Partial Fulfillment of the
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Medical Care for the Underserved: A Faith-Based Approach in Hartford, CT

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2006
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To my beautiful Lisa: Your love and patience are incomparable. I am so thankful that you are by my side. I love you.

To my Lord Jesus Christ: In this world of uncertainty, Your reassuring words in John 18:37, “Everyone on the side of truth listens to me”, are the brightest, most hopeful I’ve ever heard. May the contents of this thesis honor and bless You.
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Introduction

Throughout history medical care has been a commodity more readily available to people who are able to pay for it. In much of the world, healthcare is a privilege, not a right. The United States is one of these countries; it does not have a system of universal healthcare insurance. Residents of the U.S. rely on private insurance primarily through their employers. The government provides healthcare insurance to qualifying individuals through Medicaid and to the elderly through Medicare. Government subsidized health centers also provide care to some of the uninsured and underinsured, who, along with individuals living in rural locations and certain ethnic and racial minorities, are collectively known as underserved populations. More than 15% of the U.S. population is uninsured and/or underinsured, and the vast majority of these individuals receive minimal preventive medical care at best.

Groups of health care professionals and others committed to caring for underserved populations have been present in virtually every generation. These individuals have different motivations for their willingness and desire to care for the underserved. Spiritual, religious, and/or faith-based beliefs and convictions are common motivating factors. The Christian faith is responsible for numerous charitable, medical related organizations that are committed to serving the poor.

The Christian Medical Fellowship (CMF), a Hartford-based non-profit organization, is one of these organizations. For over a decade CMF has provided care to underserved individuals in Hartford and around the world. CMF has encouraged and supported health care professionals to nurture their faith while
practicing medicine through local, national and international projects. One of CMF’s new major projects is to develop a faith-based health center in Hartford, the CMF Health Center (CMFHC), to care for the underserved populations in the Hartford area.

The purpose of this thesis is threefold. One aspect of this project is to provide relevant statistics relating to underserved populations, discuss the need for routine and preventive care, and to provide an overview of current models of healthcare available to the underserved. The second aspect of this project investigates the role of the Christian faith as it relates to medical care. This component provides a brief history of the Christian faith in medicine, examines the role of different faith-based medical clinics and health centers, and looks at the best practices of such facilities. The final component of this thesis describes the population and needs of Hartford, CT, and provides a best-practices model for the CMFHC.

Insured Populations

According to a March, 2005 survey by the Kaiser Commission on Medicaid and the Uninsured (KCMU), virtually all elderly Americans receive Medicare health insurance coverage. Of the 255.1 million non-elderly Americans who live in the U.S.: 61% receive employer-sponsored insurance (down from 66% in 2000); 16% receive Medicaid, State Children’s Health Insurance Program (S-CHIP) or other

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a While the term “clinic” connotes a smaller facility than does “health center”, for simplicity’s sake the two are used interchangeably throughout this paper.
b “Elderly” refers to those who are 65 or older.
c S-CHIP (Title XXI) is different from Medicaid (Title XIX). S-CHIP gives state a higher federal match/contributions than Medicaid. According to the Centers for Medicare and Medicaid Services website, S-CHIP “is Title XXI of the Social Security Act and is jointly financed by the Federal and State governments and administered by the States. Within broad Federal guidelines, each State
public insurance,\(^a\) and five percent have private non-group insurance. Overall, 82% of the population is insured and 18% is uninsured.\(^3\)

**Underserved Populations: An Overview**

The uninsured comprise a portion of those people with inadequate access to health care, referred to as underserved populations. The underserved includes people who are geographically isolated from medical care facilities (e.g. people living in rural areas), non-proficient English speakers (e.g. ethnic minorities), racial minorities, the working poor, and/or unemployed. This thesis will focus on insurance status as a primary factor in access to health care, particularly in urban areas. The following section gives an overview of the rural underserved and compares them with the urban underserved; it then focuses on the urban underserved.

**Characteristics of Rural Populations**

Rural populations comprise a significant proportion of the underserved: nearly 25 percent of the U.S. population lives in rural America, but only ten percent of physicians practice in these areas. This undersupply of physicians has led to 2,150 Health Professional Shortage Areas (HPSAs) designations in rural and frontier areas of all states and U.S. territories; urban areas account for just over 900 HPSAs.\(^4\)

Rural residents tend to be poorer. On the average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. The disparity in incomes is even greater for minorities living in rural

---

\(^a\) Other public insurance programs include Medicare, military coverage, and others.
areas. Similarly, rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts. Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years. Hospital closures are partly responsible for the disparity in HPSA designations, and the closures have forced rural residents to travel great distances to reach a doctor or hospital.\(^5\)

Geographic barriers contribute to the neglect of routine medical care. Such neglect leads to an increased prevalence of morbidities related to chronic illness. Rural populations have a greater prevalence of certain illnesses themselves when compared to populations living in Metropolitan Statistical Areas (MSAs). Cerebrovascular disease was reportedly 1.45 times higher and hypertension was also higher in rural than urban areas: 101.3 per 1,000 individuals in MSAs and 128.8 per 1,000 individuals in non-MSAs.\(^6\)

Quality of care also differs between the geographic settings. Medicare patients with acute myocardial infarction (AMI) who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.\(^7\)

Table 1 is adapted from the National Rural Health Association website,\(^8\) and compares different characteristics between rural and urban populations.
Table 1. Comparison of Selected Characteristics Between Rural and Urban Populations

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of U.S. Population</td>
<td>Nearly 25%</td>
<td>75%+</td>
</tr>
<tr>
<td>Percentage of U.S. Physicians</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Number of specialists per 100,000 population</td>
<td>40.1</td>
<td>134.1</td>
</tr>
<tr>
<td>Population below the Federal Poverty Level (FPL)</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Average per capita income</td>
<td>$19,000</td>
<td>$26,000</td>
</tr>
<tr>
<td>Adults who describe health status as fair/poor</td>
<td>28%</td>
<td>21%</td>
</tr>
<tr>
<td>Population covered by private insurance</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>Population who are Medicare beneficiaries</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicare beneficiaries without drug coverage</td>
<td>45%</td>
<td>31%</td>
</tr>
<tr>
<td>Medicare expenditures per capita compared to U.S. average</td>
<td>85%</td>
<td>106%</td>
</tr>
<tr>
<td>Medicare hospital payment-to-cost ratio</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of poor covered by Medicaid</td>
<td>45%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Characteristics of the Uninsured

It is estimated that over 45-46 million non-elderly Americans are uninsured.9,10 Although America leads the world in health care expenditures, it is the only wealthy industrialized nation that does not ensure that all citizens have health care coverage.11 Table 2 is adapted from the January 2006 KCMU,12 and provides statistics on the uninsured as a function of age, income, and work status.
Table 2. Percentage Uninsured as a Function of Age, Income, and Work Status

<table>
<thead>
<tr>
<th>Function</th>
<th>Category</th>
<th>% Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children Under 19</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Adults 19-34</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Adults 35-64</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Income&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 200% of FPL</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>100-199% of FPL</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>&lt;100% of FPL</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 1 Full-Time Workers</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Part-Time Workers</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>No Workers</td>
<td>19%</td>
<td></td>
</tr>
</tbody>
</table>

Adults are more likely to be uninsured than children: adults make up 70% of the non-elderly population, but nearly 80% of the uninsured. The working poor make up the great majority of the non-elderly uninsured: greater than 80% come from working families and 65% earn less than 200% of the Federal Poverty Level (FPL).<sup>13</sup>

**Characteristics of the Underinsured**

People who subscribe to medical insurance plans with significant gaps in coverage and/or plans that do not cover all the services they need are considered underinsured. A 2002 Kaiser Family Foundation<sup>14</sup> publication revealed that 38% of insured individuals reported that they or their families experienced at least one problem accessing medical services in the previous year. These individuals may not be able to afford the cost-sharing associated with covered benefits, or they may be affected by benefit caps—a maximum amount that a health plan will pay for an individual over his or her lifetime. Among the insured, this 2002 Kaiser report

<sup>a</sup> “Poor” people are defined as those with an income less than 100% of Federal Poverty Level (FPL), which was $19,307 for a family of four and $14,680 for a family of three in 2004; “Near Poor” earn between 100-199% of the FPL.

<sup>b</sup> FPL: Federal Poverty Level
revealed a number of barriers to health care access and their consequences, as listed in Table 3. Individuals with these barriers are considered to be underinsured.

Table 3. Barriers to Health Care Access and Consequences among Insured Populations

<table>
<thead>
<tr>
<th>Barriers to Health Care Access</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>18% postponed seeking care because of inadequate coverage</td>
<td>58% seriously increased stress</td>
</tr>
<tr>
<td>15% had problem paying medical bill</td>
<td>36% painful temporary disability</td>
</tr>
<tr>
<td>10% unable to purchase prescription</td>
<td>21% significant loss of time at important activities</td>
</tr>
<tr>
<td>8% contacted by a collections agency</td>
<td>14% long-term disability</td>
</tr>
<tr>
<td>6% unable to get needed medical care</td>
<td></td>
</tr>
</tbody>
</table>

Individuals with these barriers to care are considered underinsured, and they have little recourse for obtaining services that are not covered or unaffordable. While most states mandate that plans cover certain services, about half of covered workers are in plans that are exempt from state laws. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to treat patients who present at hospital emergency rooms, but it does not apply to patients in other situations and does not exempt patients from the hospital fees. The debt from those fees is oftentimes insurmountable; a Harvard study found that medical bills are a factor in half of all bankruptcies.

While the uninsured have a problem acquiring health insurance, many people who are insured struggle to maintain the health insurance coverage they already have. Fifty one percent of individuals with insurance coverage are worried about not being able to afford insurance and 50% fear benefits will be cut back in the coming year.
The Benefits of Health Insurance: Prevention of Disease Complications

While a significant percentage of the insured are considered underinsured and have barriers to health care, the underinsured have considerably better access than the uninsured. Table 4 is adapted from the 2004 KCMU and compares the barriers to access between uninsured versus insured patients.

Table 4. Barriers to Access for Uninsured and Insured in Past 12 Months

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Uninsured</th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>No regular source of care</td>
<td>42%</td>
<td>9%</td>
</tr>
<tr>
<td>Postponed seeking care because of cost</td>
<td>47%</td>
<td>15%</td>
</tr>
<tr>
<td>Needed care but did not get it</td>
<td>35%</td>
<td>9%</td>
</tr>
<tr>
<td>Did not fill a prescription because of cost</td>
<td>37%</td>
<td>13%</td>
</tr>
</tbody>
</table>

A strong link has been established between health insurance coverage and access to medical services. Lack of health insurance has consistently been shown to compromise a person’s health for several reasons: uninsured patients are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, and more likely to be diagnosed in the late, irreversible stages of disease.18

Adequate health insurance coverage has many benefits. In addition to improving the financial well-being of families by reducing the financial uncertainty associated with health care and the unpredictability of illness, it improves health overall. It has been estimated that insurance coverage could reduce mortality rates for the uninsured by 10 to 15%.19

Major Health Problems of the Underserved

A recent survey performed by the Robert Wood Johnson Foundation revealed that while underserved populations may not necessarily have an increased prevalence
of chronic diseases as compared to non-underserved populations, they are more often debilitating by the sequelae of those diseases. Complications associated with asthma, diabetes, hypertension, heart disease, infections, arthritis, cancer and other diseases are more common among underserved populations, largely because of the lack of routine and preventive care. As a result, underserved patients with the same diagnosis as adequately insured patients are more likely to die.

Minority status is associated with being uninsured. More than one third of the Hispanic population, over a quarter of Native Americans, 21% of African Americans, and 18% of Asian Americans are uninsured compared to 13% of whites (Caucasians). Health insurance undoubtedly plays a role in the cancer outcomes of minority groups. Two examples supporting this are that while Caucasian women from age 40-85+ have the highest incidence of breast cancer among women of all racial and ethnic groups, African-American women in the same age range have the highest mortality. On the other hand, among men age 40 and over, African-Americans have the highest incidence of prostate cancer and the highest mortality.

A dichotomy exists in healthcare. While it is largely agreed that improving access to routine health care services is the best way to promote health and prevent disease, resources are oftentimes disproportionately allocated to treating conditions as opposed to preventing them. For example, insurance plans which do not adequately cover preventive services and medications for diabetics result in patients prone to diabetic complications, such as kidney disease. Patients with end stage renal disease (ESRD) require dialysis, which is prohibitively expensive and one of the qualifying criteria for Medicare coverage.
Financial Impact of the Underserved

The financial burden from the 46 million people who are uninsured in America imposes sizable costs upon society. One report found annual losses to the U.S. economy between $65 billion to $130 billion for illness and premature death of uninsured people. It is estimated that caring for people without health insurance would cost significantly less—between $34 billion and $69 billion.26

Moral and Ethical Responsibility to Care for the Underserved

In 1932, the Committee on the Cost of Medical Care wrote, “The quality of medical care is an index of a civilization.”27 Many people become healthcare professionals for moral, ethical, and justice reasons. Not surprisingly, virtually every faith-based organization agrees that helping the underserved gain access to health care is a moral obligation for society.28 One journal devoted to these issues is The Journal for the Health Care of the Poor and Underserved, established in 1990 and published by The Johns Hopkins University Press.

Overview of Medical Care for the Underserved

History of Government Involvement in Caring for the Underserved

The origins of the U.S. government involvement in health care for the underserved can be traced to the late 18th century. During that time the U.S. depended on the sea for trade and security. Seamen traveled widely within the U.S. coastline and often became sick at sea. Port cities were ill equipped to handle their medical needs, and this created a national problem. As a result, in 1798 Congress established the Marine Hospital Service (MHS), a loose network of marine hospitals, mainly in port cities, to care for the sick and disabled seamen. A division of the
treasury department governed the MHS, and taxing American seamen generated funds. This direct tax was one of the first to be introduced by the new republic, and was the first medical insurance program in the U.S.29

MHS hospitals were technically under the President’s control, but were actually peripherally managed by customs collectors. Local politics inevitably influenced the hospitals’ practices, and political agenda often trumped the medical needs. Lack of central control and other factors led to great disparities between hospitals in different ports. The demand for medical services always exceeded funds and resulted in a four-month time limit on hospital care for all patients. Moreover, sailors with chronic or incurable conditions were refused admission.30

Congress acted in 1870 to reorganize the MHS into a separate bureau of the Treasury Department, and made it a centrally controlled national agency with its own administrative headquarters in Washington, D.C. Standardized entrance examinations were instituted for caregivers, and medical officers, known as surgeons, who passed the exams were assigned wherever needed and given titles and pay corresponding to Army and Navy grades. MHS’ goals were clear: to create a professional, mobile health corps free from political favoritism and able to handle the emerging health needs of a rapidly growing and industrializing nation.31,b

The prevalence of underserved populations and the inadequate provision of medical care to those who could not afford to pay for it were of significant concern. The consideration of a national health insurance system in the United States was first

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a Seamen continued to pay taxes to fund the MHS until 1884, at which time proceeds from a tonnage tax on vessels entering the U.S. were used. In 1906, funds were provided by direct appropriations from Congress.
b MHS hospitals eventually closed down in 1981.
proposed in 1915 by the American Association of Labor Legislation (AALL), a relatively small organization of fewer than 3,500 members, primarily social scientists, academicians, and lawyers. The organization’s publication of a draft of a bill proposing compulsory health legislation in November 1915 immediately led to intense discussions and debates for and against compulsory health insurance.\textsuperscript{32}

The “institutional” segment of the medical profession—public health officers, hospital officials, and teaching faculty of the larger medical schools—strongly supported the concept of a compulsory (universal) insurance system. On the other hand, medical practitioners and the insurance industry’s Economic Society vehemently opposed this program, especially after the AALL proposed a specific bill. One labor leader who opposed the bill argued that higher wages, not compulsory insurance, was the solution to illness.\textsuperscript{33}

While commercial insurance companies strongly opposed the bill and resistance intensified among state medical societies, the American Medical Association (AMA) appointed a Committee on Social Insurance to investigate the issue. After the U.S.’s declaration of war against Germany in 1917, anti-German sentiment deepened opposition to compulsory health insurance because of its similarities to the German sickness insurance system (“Krankenkassen”). After the end of World War I, efforts to revive the concept met with strong disapproval, as reflected in the establishment of a strong policy against all systems of compulsory health insurance by the House of Delegates of the AMA at its meeting in New Orleans in 1920. The AMA devoted major, highly publicized efforts for many years to battling federal or state intervention in health care.\textsuperscript{34}
In 1935, Roosevelt signed the Social Security Act, thereby renewing legislative consideration of national health insurance. Over the next 30 years, bills supporting various compulsory insurance programs were submitted to Congress, but no action was taken—until July 30, 1965. On that date, President Lyndon B. Johnson signed the bill creating Medicare and Medicaid and introduced state intervention in health activities for the first time in the U.S. This opened the way for an expanding role of government in medical practice.\(^35\)

**Current Government Programs**

Medicare is the U.S.'s federal health insurance program and is available for three general groups of people: those 65 years of age or older, certain younger people with specific disabilities, and people with end-stage renal disease (ESRD) who require dialysis or a transplant. Medicare is funded by the Social Security Administration and is available to approximately 40 million people.\(^36\) Medicare has four parts: A, B, C and D. The SSA website describes each part as follows:\(^37\)

“[Medicare Part A] Hospital Insurance (HI) is the basic plan that provides protection against the cost of inpatient hospital and related post-hospital nursing care. Part A is funded out of Social Security payroll taxes. Individuals meeting eligibility requirements are automatically covered under the plan at no premium cost to them.”

“[Medicare Part B, known as] Supplementary Medical Insurance (SMI) provides protection against the cost of medical and other related services such as physician services, durable medical equipment and other outpatient services which are not paid for by Part A. It is a voluntary plan. Eligible individuals are automatically enrolled in the plan but have the right to refuse or terminate their coverage. A premium fee is charged for Part B coverage.

“[Medicare Part C, known as] Medicare Advantage provides additional care options for Medicare beneficiaries enrolled in both Medicare Part A and B. These choices include Medicare managed care organizations and private fee for service plans. These plans receive payment from the Medicare program to administer the program to enrolled beneficiaries.”
"[Under Medicare Part D,] Medicare coverage for prescription drugs will be available beginning January 1, 2006. Insurance companies and other private companies will offer plans for prescription drug coverage. Medicare beneficiaries enrolled in Part A and/or Part B will have to choose and enroll in a Medicare prescription drug program to obtain prescription drug benefits. Medicare Advantage Plans may also provide prescription drug coverage."

While Medicare is run by the Social Security Administration, Medicaid is a health plan run jointly by federal and state governments and has no affiliation with Medicare. Medicaid provides a wide scope of medical services to individuals and families who meet specialized criteria for enrollment. Medicaid services typically include pre-approved physician, optometry, and dental office visits. Radiography, laboratory expenses, prescription drugs, hospitalization, transportation for medical purposes, childhood immunizations, and addiction and mental health services are also covered services. Individuals must undergo annual recertification to maintain eligibility.

While low income is a major determining factor for Medicaid eligibility, the Medicaid program provides coverage to some, but not all, of the low-income and disabled uninsured. Medicaid covers 13% of the non-elderly and is larger than any single private health insurer. It provides health coverage based on both income and other categories of eligibility, and primarily covers three groups of non-elderly low-income people: children, their parents, and individuals with disabilities. Medicaid also assists low-income Medicare beneficiaries by paying Medicare premiums and the costs of services not covered by Medicare.
Other general eligibility criteria include pregnant women, Supplemental Security Income-dependent people,\(^a\) individuals who meet the Aid to Families with Dependent Children (AFDC)\(^b\) guidelines, certain children under 21, and the blind or disabled elderly (regardless of Medicare status). While suggested federal directives are available, each state ultimately determines how to allocate available resources; income eligibility guidelines vary from state to state and county to county.\(^44\)

In addition to Medicare and Medicaid insurance programs, the federal government funds Community Health Centers, which provide medical care to underserved populations. In the 1960s several federal programs promoted community health centers designed to provide comprehensive ambulatory care for the poor and medically underserved. Such programs included: the Office of Economic Opportunity, the Rural Health Initiative, the Health Underserved Rural Areas, the Appalachian Regional Commission, and the National Health Service Corps (NHSC). The NHSC was set up by Congress to meet the problem of the growing shortage of health personnel and the maldistribution of practicing physicians. Communities desiring the placement of a physician were required to provide clinic facilities and then apply to the NHSC for personnel. Patients were required to pay a fee, but no one could be denied care because of an inability to pay.

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\(^a\) Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues (not Social Security taxes). Eligibility requirements for the SSI include being at least 65, blind or the disabled AND having limited income or resources...

\(^b\) According to the Administration for Children and Families, U.S. Department of Health and Human Services website: "The AFDC provides transitional financial assistance to needy families. Federal and state governments share in its cost. The federal government provides broad guidelines and program requirements, and states are responsible for program formulation, benefit determinations, and administration. Eligibility for benefits is based on the state's standard of need as well as the income and resources available to the recipient." Other eligibility criteria are available on the website.
Physicians were initially sent into small communities and rural areas but during the Carter administration they began to serve in urban centers.\textsuperscript{45} These programs continued throughout the 1970 and 1980s until the Social Security Act was amended in the early 1990s to create a new category of facility under Medicaid and Medicare, known as Federally Qualified Health Centers (FQHCs).\textsuperscript{46} An FQHC, also referred to as a Community Health Center (CHC), is a...

...Federal designation from the Bureau of Primary Health Care (BPHC) and the Center for Medicare and Medicaid Services (CMS) that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved populations. FQHCs are located in or serve federally designated [underserved] areas. All FQHCs must operate under a consumer Board of Directors governance structure, and provide comprehensive primary health, oral and mental health/substance abuse services to persons in all stages of the life cycle. FQHCs provide their services to all persons regardless of ability to pay, and charge for services on a Board approved sliding-fee scale that is based on patients’ family income and size. FQHCs must comply with Section 330 program expectations/requirements and all applicable federal and state regulations.”\textsuperscript{47}

Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.\textsuperscript{48} Grants for new programs (access points) are up to $650,000.\textsuperscript{49} In addition to grants, the benefits of FQHC status include enhanced Medicaid and Medicare reimbursement, drug pricing discounts for pharmaceutical products, access to vaccines for uninsured children via the Vaccines for Children (VFC) Program and access to National Health Service Corps (NHSC) placements to provide medical, dental, and mental health provider staff, and other benefits.\textsuperscript{50}
The Social Security Act §1905(l)(2)(B) definition of an FQHC included an entity which meets the requirements of the section 330 grant program, but does not receive grant funding. This category of health centers has been labeled FQHC Look-Alikes. The FQHC Look-Alikes receive no section 330 Federal funding but are eligible for enhanced Medicaid and Medicare reimbursement, participate in the 340(b) Federal Drug Pricing program and receive an automatic Health Professional Shortage Area (HPSA) designation.\textsuperscript{51} Moreover, whereas applications for FQHC status are competitive and must be filed annually or biannually, Look-Alike status is non-competitive and can be filed at any time.\textsuperscript{52} Look-Alikes, by definition, are not recipients of PHS 330 grant funding. However, because they already meet the program requirements for this grant funding, FQHC Look-Alikes are mature applicants for PHS 330 funding. Table 5 summarizes the features of FQHCs.
Table 5. Features and Requirements of Federally Qualified Health Centers (FQHCs) 53,54,55

<table>
<thead>
<tr>
<th>Feature</th>
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<tbody>
<tr>
<td>Designated by the Bureau of Primary Health Care (BPHC) through annual grant application*</td>
</tr>
<tr>
<td>Non-profit organizations with 501(c)3 status</td>
</tr>
<tr>
<td>Governing Board of Directors will full authority over operations; majority of Board members must be users of the center</td>
</tr>
<tr>
<td>Management staff must have at least an Executive Director, Clinical Director, and Finance Director</td>
</tr>
<tr>
<td>System to bill and to collect</td>
</tr>
<tr>
<td>Sliding-scale fees, as determined by the Board</td>
</tr>
<tr>
<td>Located in Health Provider Shortage Areas and/or Medically Underserved Area/Populations</td>
</tr>
<tr>
<td>Provide comprehensive primary care services for all ages, directly or by contract</td>
</tr>
<tr>
<td>Open for minimum of 32 hours/week</td>
</tr>
<tr>
<td>Professional call coverage when closed</td>
</tr>
<tr>
<td>Serve patients regardless of their ability to pay</td>
</tr>
<tr>
<td>Enhanced Medicare and Medicaid reimbursement</td>
</tr>
<tr>
<td>Medical malpractice coverage through the Federal Tort Claims Act (FTCA)**</td>
</tr>
<tr>
<td>Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program 56</td>
</tr>
<tr>
<td>Access to National Health Service Corps 57</td>
</tr>
<tr>
<td>Access to the Vaccine for Children program 58</td>
</tr>
<tr>
<td>Must conduct annual audit that meets federal compliance requirements</td>
</tr>
</tbody>
</table>

The following must be provided directly or by arrangement with another provider:*  
- Dental services  
- Mental health and substance abuse services  
- Transportation services for adequate patient care  
- Hospital and specialty care  

* FQHC Look-Alikes are designated by the Center for Medicare & Medicaid Services (CMS) through annual renewal  
**Not required of FQHC Look-Alikes

Over 900 FQHCs throughout the U.S. account for over 52 million patient visits. 59 The range of services provided include: general primary care for newborns through geriatric-aged patients, obstetrics and midwifery, gynecology, mental health
and substance abuse services, HIV care, podiatry, optometry, oral health, and other services specific to each facility.

**History of Non-Governmental Involvement in Caring for the Underserved**

Centuries before Medicaid, Medicare, and Community Health Centers, physicians provided health care to people with little means to pay. In ancient Greece, physicians who trained in the Hippocratic tradition were entitled to a fee for their services, but expected to consider the patient’s financial status before determining the size of the fee, and were not to negotiate fees before treating a patient. Grecian decrees praised physicians for caring for both the poor and the rich.

Similar teachings existed in the Judeo-Christian tradition. Jewish commentary states, “a physician may not become wealthy from medical practice but is entitled to earn a good living. Medical fees should be determined by each physician and adjusted according to patient need.” Exodus 15:26 in the Hebrew Scriptures teaches that prevention of disease is the highest form of healing, and that God is ultimately the healer: "If you will listen carefully to the voice of the Lord your God, and do what is right in His eyes, and keep all of His commandments, I will put none of the diseases upon you that I have put upon the Egyptians, for I am the Lord your physician.” Christian teachings on healing and serving the poor are extensive and the primary focus of this project. They will be emphasized and explored in greater detail throughout the remainder of this paper.

Between 400-1100 AD, European medicine made little progress. Towards the end of this period, regulations were established and limited the practice of
medical care to physicians trained in one of the few medical schools in Europe. The Catholic Church taught that it was a religious duty to care for the sick. In the 12th century it opened medical schools and hospitals and oversaw the training of students and physicians. Hospitals were so named because they provided hospitality—food, shelter, and clothing—to the needy. Physicians, however, served the wealthy kings, noblemen, and merchants, and were uncommonly found at hospitals. While the majority of physicians today similarly are clustered in communities where residents have the means to pay for medical care, many physicians choose to live among and serve the poor. Hundreds of secular and faith-based medical and health care organizations send thousands of physicians to numerous regions of the globe to provide medical care to the needy.

Current Non-Governmental Models of Health Care-Delivery to the Underserved

In addition to FQHCs, physicians provide free medical care through many organizations by volunteering medical services and working at free clinics. Free clinics care for a significant number of the underserved persons in the U.S. It is estimated that free clinics raise $300 million per year in private funds, which are used to provide care for approximately 3.5 million underserved patients, generating $3 billion in health care services. Table 6 outlines the federal government’s definition of a free clinic.
Table 6. Federal Criteria for Designation as a Free Clinic

A free clinic is one that:
- Does not accept reimbursement from any third-party payer (including reimbursement from any insurance policy, health plan, or Federal or State health benefits program);
- Does not impose charges on patients to whom service is provided, OR does impose charges on patients according to their ability to pay;
- May accept patients’ voluntary donations for health care service provision;
- Is licensed or certified to provide health services in accordance with applicable law.

Based on these criteria, free clinics can be subdivided into two types: “true” free clinics and sliding scale clinics (SSC). True free clinics receive no remuneration for services provided, while sliding scale clinics receive payments from patients based on their income. From here forward, “true” free clinics will be referred to as “free clinics”; SSCs will be referred to as such. Table 7 compares basic features of free clinics and sliding scale clinics.

Table 7. Comparison of Free Clinics and Sliding Scale Clinics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Free Clinic</th>
<th>Sliding Scale Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Startup</td>
<td>Least difficult</td>
<td>Some difficulties</td>
</tr>
<tr>
<td>Revenue</td>
<td>Grants and donations exclusively</td>
<td>Grants, donations, and patient fees</td>
</tr>
<tr>
<td>Liability</td>
<td>Federal Tort Claims Act</td>
<td>Federal Tort Claims Act (FTCA) may apply</td>
</tr>
<tr>
<td>Pt’s Financial Confidentiality</td>
<td>Intact</td>
<td>Compromised</td>
</tr>
<tr>
<td>Patient-Clinic Relationship</td>
<td>Focus on patient’s needs</td>
<td>Delicate balance: providing care and demanding payment</td>
</tr>
</tbody>
</table>

Figure 1 diagrams the different major governmental and non-governmental health care programs currently available for the underserved. The categories are not exhaustive or mutually exclusive; they are intended to provide a basic organizational framework to orient the reader.
Figure 1. Basic Organizational Framework of Health Care Programs Available to the Underserved

*Includes parish nursing, hospital-sponsored outreach programs, migrant farm-worker clinics and others
**Military, State Children’s Health Insurance Program (S-CHIP)

Faith-Based Initiatives in Caring for the Underserved

The roots of Christian faith-based initiatives and the church’s involvement in caring for the sick and needy are traced to Jesus Christ’s teachings. Jesus’ followers’ devotion to His teachings has translated into the development of countless hospitals, clinics, and other charities that feed, clothe, and provide medical care to many of the world’s poorest people. Many organizations such as the late Mother

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a According to parishnursing.net, the “Parish Nurse is a Registered Nurse who acts under the Nurse Practice Act to provide Spiritual Care, and functions as a Health Advocate, a Health Counselor and Educator, a Health Promoter and Wellness Specialist to screen, assess and refer to the appropriate healthcare resource. The congregation is empowered through these activities to assume individual responsibility for health and begin the journey toward wholeness – physically, mental-emotionally, and spiritually.”
Theresa’s Sisters of Mercy, Mercy Ships, Medical Missions International, Global Health Outreach and countless other Christian organizations and charities focus on health care and exist to obey Christ’s teachings and care for the suffering.\textsuperscript{70}

The U.S. government has a history of support for faith-based organizations. Beginning in the early 19th century, many states and localities provided direct subsidies and voucher-based fees to religiously affiliated hospitals, orphanages, schools, and colleges rather than creating new public institutions.\textsuperscript{71} In the mid 20\textsuperscript{th} century, the Supreme Court ruled that public funds could be used to transport students to parochial as well as to public schools. This ruling set a precedent and led to subsequent public funding of school lunches at parochial schools, and allowed student loans to individuals attending religiously affiliated colleges and universities.\textsuperscript{72}

More recently, a section of the 1996 welfare reform legislation, Charitable Choice, gives religious congregations the right to compete with other charities for government funds without masking their religious character. Charitable Choice stipulates that the government cannot impose conditions of funding forcing a group to alter its religious character (such as praying before eating meals at a soup kitchen), but forbids the use of public funds for worship or proselytization.\textsuperscript{73}

On January 29, 2001, President George W. Bush submitted Executive Order 13199, establishing the White House Office of Faith-Based and Community Initiatives.\textsuperscript{74} The order had a simple premise: Federal funds should be awarded to the most effective organizations – whether public or private, large or small, faith-based or secular – and all must be allowed to compete on a level playing field.
Bush’s Faith-Based Initiatives are modeled after Charitable Choice. Through this order, the Bush Administration asserted the following principles:

- Faith-Based Community Organizations (FBCOs) make significant contributions to society
- The Separation of Church and State clause in the First Amendment was not intended to be an absolute separation in all circumstances, and it did not intend for all government activities to be strictly secular
- Having faith-based beliefs and convictions is associated with performing acts of social service

A recent survey by the Pew Forum on Religion and Public Life buttresses these points:75

- People with a strong religious commitment (i.e. are “faith minded”) are up to three times more likely to volunteer to help needy people than are non-faith-minded people
- Seventy five percent of Americans believe there should be government funding for faith-based organizations (the numbers drop to 38% when the organizations are Muslim and Buddhist, and 51% when Mormon)
- Many Americans find arguments in favor of faith-based funding to be compelling, and a strong majority acknowledges the contributions churches, synagogues and other religious groups make to society. Seventy two percent cite the care and compassion of religious workers as an important reason for supporting the concept of faith-based groups receiving government funding. Three-quarters think that churches and other houses of worship contribute significantly to solving America’s social problems.

Some groups have opposed these initiatives. Americans United for the Separation of Church and State oppose the faith-based legislation, and argue that forcing taxpayers to fund faith-based organizations is a “sweeping assault on the First Amendment Separation of Church and State”. They add that “In those cases where religious groups want to take tax aid to provide relief, they should first agree to run secular programs and drop all forms of religiously based discrimination from their hiring policies.”76 Some have claimed the faith-based initiatives program has failed to deliver on its promise by discriminating against effective secular programs,
and requiring beneficiaries of the services to engage in religious activities, among other practices. 77

The Anti-Defamation League (ADL) “shares the President’s appreciation for the vital role religious institutions have historically played in addressing many of our nation’s most pressing social needs, as a critical component of government funded programs.” However, the ADL believes that the implementation of the Faith-Based Initiative to date has been deeply troubling on policy and constitutional grounds, and lacks a number of safeguards. They suggest that these include: 78

- No program beneficiary is subject to unwanted and unconstitutional religious proselytizing when he or she receives government-funded social services
- Government money does not fund religious discrimination in the hiring and firing of people who deliver these social services
- Secular alternatives to social services provided by houses of worship and other religious institutions are readily available to beneficiaries. All beneficiaries are made aware of secular alternatives, and have realistic and convenient access to them
- Recipients of government funds must establish accounting systems and procedures to separate government dollars from core religious activities. Referred to as “firewalls,” these procedures ensure that taxpayer dollars are not channeled into religious activities of religious organizations. As a practical matter, the best way to establish this division is through the creation of a separate corporate structure distinguishing the religious organization from its government-funded social services program
- Recipients of government funds must comply with all the requirements and limitations imposed upon all government-funded activity by the religion clauses of the U.S. Constitution’s First Amendment, and
- Extremist, terrorist or hate mongering groups are not eligible for government funds

The distribution of government funds to any non-governmental organization—secular or faith-based—has opponents and proponents. It is one of many issues on the American landscape where worldviews collide and convictions differ, and where myriad examples of good outcomes and bad outcomes are cited. The debate regarding this issue is beyond the scope of this paper. It is raised to
demonstrate the complexity and importance of investigating effective faith-based models and assessing their approach to integrating faith and medicine.

In addition to emerging in the political arena, the faith-based movement is gaining favor and momentum in medicine. Medical journals are publishing articles on spirituality, religion and faith and their impact on health and patient care, and medical schools are implementing courses about spirituality and health. Estimates as to the number of faith-based clinics range from over 150\textsuperscript{79} to well over 200\textsuperscript{80}, accounting for millions of patient visits annually.\textsuperscript{81} A variety of formats are used by these clinics and health centers, ranging from full-time FQHCs to weekly free clinics held in schools, churches, and other sites. The next section of this paper will focus on the relationship between medicine and spirituality, religion, and faith.

**The Role of Spirituality, Religion, and Faith**

**Definitions**

Spirituality, religion, and faith are terms that conjure up a variety of thoughts and emotions in people. Many use the terms interchangeably without much thought; others believe they have distinct meanings and use them accordingly. Still others acknowledge that while the terms are not synonymous, the similarities in their connotations allow them to be loosely interchanged. Definitions of the terms follow.

*spirituality* is generally used as a broad term to emphasize the spirit, or non-material, world, and often relates to questions of meaning and hope. As reported in the Journal of American Medical Association, Hospice “defines spirituality as the personal and psychological search for meaning”.\textsuperscript{82} The National Center for
Complementary and Alternative Medicine (NCCAM) states that spirituality is “an individual's sense of purpose and meaning to life, beyond material values”.  

Meditation, generally defined as quieting the mind through stillness and/or being intentionally mindful of oneself (“self-remembering”), is commonly associated with spirituality. Unlike prayer, which is directed to God or another object of worship, meditation does not necessarily invoke a higher power or object. According to the National Center for Complementary and Alternative Medicine (NCCAM), prayer is “…an active process of appealing to a higher spiritual power, specifically for health reasons; it includes individual or group prayer on behalf of oneself or others.”

Religion has been defined as a cause, principle, or system of beliefs held to with ardor and faith. The term typically refers to a system of beliefs and practices with codified rules of behavior and formal organization, including: attending religious services; participating in various formal meetings (e.g. Bible/Holy Book studies, temple/church meetings, service-oriented activities); and performing certain rituals (praying, observing holy days and behaviors). To many, but not necessarily all, who practice it, religion is also a source of meaning and hope.

Valid religions ought to offer coherent, internally consistent answers to (at least) four fundamental questions:

- Origin: Where did I come from?
- Meaning: Why am I here on earth?
- Morality: How am I to live?
- Destiny: What happens to me after I die?

Many people believe that all religions are fundamentally the same and superficially different: they all fundamentally believe in love and goodness, but
practice these beliefs differently.\textsuperscript{89,90} However, the religions’ answers to these fundamental questions are significantly different (variability exists within religions as well). Based on this evidence, some people have argued that religions are fundamentally different and superficially the same.\textsuperscript{91} The importance of this observation and its relationship to faith and medicine will be discussed later.

*Faith* refers to the confident belief in the truth, value, or trustworthiness of a person, idea, or thing that does not rest on logical proof or material evidence.\textsuperscript{92} The author of Hebrews in the Christian Bible states that faith is “... the assurance of things hoped for, the conviction of things not seen.”\textsuperscript{93} The term “faith” is commonly used by religious and spiritual people as a reference to the transcendent. For this reason and for convenience, the umbrella term “faith” will be used for discussions pertaining to spirituality, religion, and faith (unless otherwise noted).

**Spirituality, Religion, and Faith and Medicine**

The relationship between faith and healing has been debated for thousands of years. In the Christian Bible, books written before Christ spoke of the LORD as a healer,\textsuperscript{94} and biblical figures often prayed to God for healing.\textsuperscript{95} Jesus Christ was sought by many because of His ability to heal,\textsuperscript{96} and is known as The Great Physician as a result of this gift.\textsuperscript{97}

Since its beginnings, medicine has been intimately connected with faith. In earlier times, and in some cultures today, Shaman claimed to contact and use the spirit world to perform healings. During the Middle Ages, sickness was seen to be largely a result of sin and punishment from God,\textsuperscript{98} and, as previously mentioned, the Catholic Church operated medical schools and hospitals.
Today, the impact of faith on healthcare and medicine is extensive. Many organizations in the U.S. espouse Christian teachings, ideals and values, and seek to incorporate faith into health encounters domestically and internationally. Medical Missions International (MMI), Doctors on Call for Service (DOCS), and the Christian Medical and Dental Associations (CMDA) send thousands of health care providers to many nations. These and many other similar organizations seek to provide medical care to underserved populations and to bridge the gap between medicine and faith.

The CMDA is a non-denominational, international organization based in Tennessee with approximately 17,000 members, making it the largest Christian medical organization in the world. It exists to motivate, educate, and equip Christian physicians, dentists, and respective students to glorify God through their vocations. Many members of CMDA and other similar organizations pursue medicine and dentistry because of their faith-based convictions. Peter Deckers, MD, Dean of The University of Connecticut School of Medicine, states that “medicine is God's work” in many of his talks to students and faculty. It is clear that, while faith is not necessarily a prerequisite, many people desire to bring hope, to heal others and to serve God through medicine.

Many patients express a desire to discuss faith-related beliefs and practices with their physicians, and many physicians would like to accommodate their patients’ wishes. Unfortunately, studies have revealed that while approximately 40% of physicians would like to address their patients’ faith-based needs, only 10%
Physicians cite time constraints and inadequate training to explain this discrepancy. Christina Puchalski, MD, founder and director of the George Washington Institute for Spirituality and Health in Washington, DC, characterizes traditional American medical schools as the breeding ground for physicians ill-equipped to treat patients holistically (i.e. address their faith beliefs, practices, and concerns). She identifies a problem with medical education and practice: the insatiable desire to cure and fix problems. As a result, patients are viewed as problems and reduced to the diseases afflicting them.

The fact that physicians feel ill-equipped to address their patients’ faith needs is not surprising. Until recently, no U.S. Medical School offered formal courses in faith and medicine. In the past decade, significant changes have taken place. In 1992, Puchalski taught one of three courses on faith in medicine offered nationwide. According to Fortin, in 1994 17 of the 126 accredited U.S. medical schools offered courses on spirituality in medicine. By 1998, this number had increased to 39, and by 2004, to 84 schools.

While technological advances dominated medicine in the 20th century, the “art” of medicine has re-emerged. This renewal began in the 1970s when George Engel’s Biopsychosocial Model was developed at the University of Rochester. Today, faith- based approaches are competing with the information-intensive, steely façade of modern medicine, and suggestions have been made to expand Engel’s model into a Biopsychosocial-spiritual one.
Over the past 15-20 years, medical schools have added courses on faith in medicine, and there has been a parallel increase in faith-related research, discussion, and publications in medical journals. Based on these observations, newly graduated physicians and current medical students are being taught that patients’ faith-based beliefs and practices influence their health, and that addressing them can produce multiple benefits. Performing a one to two minute faith history (commonly referred to as a “spiritual history”) at certain times, such as during a patient’s admission to the hospital, upon meeting a new patient, and during severe illness, can enhance patient satisfaction, improve outcomes, and personalize what can otherwise be a dehumanizing experience. Furthermore, taking a faith history can also serve to increase the patient’s trust in his/her physician, especially if the patients’ and physicians’ beliefs are congruent.

The incorporation of faith into medical practice has led to some concern. Critics argue that physicians are not trained in theology and pastoral care, and therefore should leave such issues to trained and licensed professionals. They further state that a fine line exists between proselytization and curious inquiry, and that the inherent power imbalance demands that patients should be safeguarded from physicians’ personal views.

Proponents argue that while the issue is certainly sensitive and potentially damaging (e.g. a physician manipulates a patient to “convert” to a particular belief system), many areas of medicine are equally sensitive. Physicians regularly inquire about patients’ sexual practices, substance abuse, child and spousal abuse, which may be the source of guilt or shame, or be illegal and a number of other potentially
explosive subjects. The medical community has decided to face the challenge and inquire about the issues directly. The means justifies the ends: the intention is to develop trust between the patient and physician, and ultimately to engender healing and wellness in the patient.

The faith or spiritual history is an integral component of a patients’ medical history. Faith histories can be ascertained via a number of published or published methods, or less formally. It is likely that patients who have little interest in faith at the time of the initial encounter are comforted by the possibility that this type of discussion can occur in the future. It is clear that physicians who respectfully inquire about patient’s faith-based beliefs and practices, at a pace and comfort level dictated by the patient, create opportunities to serve their patients better.

Definition of Faith-Based Clinics: Two Models

The term “faith-based clinic” refers to a clinic that is affiliated with a church, parachurch, or other religious institution or organization. In the following section, two models of faith-based clinics, passive and proactive, will be explored, followed by a discussion of the best practices from each. A special emphasis will be placed on proactive clinics. These terms have not been used in the literature, and, unless otherwise noted, express the author’s conceptual framework.

Faith-based clinics are diverse in their purposes, goals, missions, and visions. While they are typically located in churches, location is not the distinguishing feature.

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*a From the Greek “para”, meaning “alongside”. Parachurches are formal organizations of Christians who collaborate intra- and inter-denominationally to further the purposes of the church.
of faith-based clinics (many churches offer space for medical students and other organizations to set up medical clinics, but the clinics themselves have no faith-based component). The following paragraphs describe the general features and worldviews espoused by the staff at each type of clinic; exceptions do occur.

Passive faith-based clinics have intra- or inter-faith clergy on the Board of Directors, and are staffed by people whose faith beliefs may or may not play a significant role in their lives and/or work. At such clinics, discussions that pertain to faith may occur, but are not central to the mission of the organization, which is principally directed to affect social change. Patients who visit such clinics receive friendly care by knowledgeable individuals who are genuinely interested and care for them.

Staff at passive clinics may demonstrate outward expressions of faith, including; inquiring about the patient’s faith background (typically as part of the medical history); listening attentively and encouraging patients to continue beneficial faith-related activities; offer to pray or spend a moment in silence with the patient; and refer amenable patients to pastoral care. Physicians and staff at passive clinics believe faith-related activities (prayer, scripture reading, church attendance etc) are beneficial and should be affirmed, but not necessarily prescribed. Consequently, as a general rule, passive faith-based clinics typically do not prescribe faith-related activities.

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* Countless examples exist nationwide. For example, Medical Students at The University of Connecticut School of Medicine run a free clinic at the South Park Inn, a homeless shelter based in a church (which no longer has formal church services); Medical Students at the University of California at San Diego School of Medicine run three free clinics, two of which are in held in local churches. Neither of these programs have a faith-based component.
Proactive faith-based clinics have similarities with passive clinics, but also have fundamental differences. While both are committed to affect social change through healthcare in the persons and communities they serve, proactive clinics seek to affect *spiritual* renewal in their patients—and in themselves. The mission and/or vision statements of proactive clinics typically refer to Jesus Christ (or God) and a desire to serve Him, care for others in His name, and other similar statements. Moreover, staff at proactive clinics believe God has called them to care for the sick and suffering through medicine; they strive to demonstrate by word and deed God’s love for those people they encounter. Each of the previous characteristics are virtually always seen in proactive faith-based clinics, and less commonly seen in passive clinics.

An underlying, irrevocable belief of proactive faith-based clinics is that physical health and well-being is deeply related to and, for many people, of equal importance to spiritual health. The two are intricately woven together and require care, guidance, and nurturance. It is of utmost importance to proactive physicians to address underlying spiritual issues, and to demonstrate gently the value of faith in the patients’ lives. Proactive clinics believe that to compartmentalize the spiritual and the physical, i.e. to leave the former up to the church and the latter up to the doctor is inadequate. Addressing both simultaneously is more effective.

Proactive faith-based clinics foster an environment where non-judgmental conversations about personal faith may occur daily between physician, staff and patients. To foster this principle, staff at faith-based clinics oftentimes meet at work
before (or after) their scheduled shifts to participate in prayer meetings, Bible studies, worship sessions and other similar activities.

These unique staff meetings, which may be open to the patients, serve to teach the providers ways to integrate faith activities more comfortably into patient care. Such activities include: personal and intercessory prayer; reading and exchanging uplifting/appropriate passages from the Bible or other devotional books; and discussing God’s role and/or involvement in the patient’s life (at the patient’s comfort level and direction). Such discussions are the result of the belief that faith matters are of importance to the overall well-being of virtually all persons. These activities help prepare staff for the day ahead and remind them of their purpose and calling as Christian health care providers.

Patients at proactive clinics in turn come to expect prayer, the sharing of scripture passages, faith-related books and audiovisual materials, and other faith-related gestures at each patient visit. It is not uncommon for patients to ask for prayer during an office visit, or to remind a physician that s/he forgot to pray for/with the patient during the previous visit. Many patients take great comfort knowing their physicians have deeply held faith beliefs and integrate these beliefs into their practices. Moreover, it is not uncommon for patients who desire spiritually-influenced medical care to travel significant distances to visit physicians with similar beliefs. Likewise, health care providers often choose to leave well-paying private practices (or choose not to accept them in the first place), usually receiving 30-40% less pay to work in these clinics.¹³⁷

¹³⁷ One nurse was so inspired by the work being done at Lawndale Christian Health Center (LCHC), a faith-based health center in Chicago, she went to considerable lengths to secure a job there: when her
Proactive clinics highly regard the integral relationship between faith and medicine, and thereby regularly prescribe and participate with their patients in faith-related practices routinely. The goal is for an equal exchange to occur between the patient and physician.

**Religious Validity and Medicine Revisited**

Earlier in this paper, it was argued that all valid religions ought to provide coherent and internally consistent answers to the four fundamental questions of origin, meaning, morality, and destiny. It was further claimed that two general perspectives regarding world-religions exist: that religions are fundamentally the same and superficially different, or that religions are fundamentally different and superficially the same. This claim is now extended and applied to faith-based clinics.

Passive faith-based clinics hold to the worldview that religions are fundamentally the same; that faith beliefs and practices that do not harm others are essentially equivalent and good; that similarities between religions ought to be emphasized; and that differences, though acknowledged, should be essentially ignored.

While it is important for people who are working towards a common goal to focus on similarities, this author suggests that it is imprudent to ignore the differences (and even worse to deny their existence). Doing so fails to acknowledge that religious conviction plays a major role in many physicians’ decision to pursue

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job application to LCHC was declined due to budget constraints, she quit her previous job anyhow to work at LCHC *for free*. Her persistence and passion paid off: the administration were so moved by her commitment, they hired a short time later.
medicine. To say to such physicians, “Keep your religious beliefs to yourself” (i.e. your religious beliefs have no place in the practice of medicine and/or the public sector), is to strip the physician of the impetus that led him/her to medicine in the first place. It reduces such a physician to an emotionless automaton, and ignores the significance of faith in his or her life.

The motivation behind those people who wish to separate faith from medicine movement is autonomy. Patient autonomy is the predominant principle guiding medical decision making. Physicians who incorporate their religious faith are considered by some to proselytize their patients and thereby threaten patient autonomy.

The term proselytization is typically used in reference to religious extremists who strive to convert others to their religious views. The Merrian-Webster dictionary’s definition of proselytize is “to induce someone to convert to one’s faith; to recruit someone to join one’s party, institution, or cause.” According this definition, any person who persuades others to change their currently-held beliefs is a proselytizer.

By logical extension, it can be argued that physicians who engage in health promotion and disease prevention strategies, such as smoking-cessation and exercise counseling, are proselytizers. As are lawyers, politicians, civil-rights workers and virtually everyone else committed to bring about change. These latter individuals make their living recruiting others to join their causes, and are often praised for it. Proselytization, depending on the method of induction used, is not necessarily a

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*a The Christian Medical and Dental Associations have 17,000 + members whose Christian faith is foundational to their vocations.
threat to autonomy. Clearly, a fine line exists between open-minded, two-sided
dialogue about an issue and one-sided, close minded dogma. This fine line will now
be explored.

**The Purpose of Proactive Clinics**

In recent years, many abstracts and papers have been published regarding the
health benefits associated with church attendance and involvement in a supportive,
faith-based community. Such benefits are very important to proactive clinics,
but no more important than the spiritual renewal, which is a necessary component of
overall (physical and spiritual) wellness. Proactive clinics seek to honor and respect
their patients and to facilitate them in their spiritual journeys.

The purpose of proactive clinics is to restore patients to physical and spiritual
wellness. Doing so precludes the use of manipulative, coercive methods, which are
unacceptable not only from medicine and society’s perspectives, but from a spiritual
perspective as well. The use of guilt-laden techniques to convince others of one’s
beliefs have no place in proactive clinics, for both moral and practical reasons: such
methods contradict the very essence of wellness, which frees the individual to make
healthy choices. Proactive clinics do not push faith, but instead are pushed by faith.

**The Patient Encounter**

During the medical history component of a patient-physician encounter, a
spiritual history is obtained and it is established whether the patient wishes to discuss
spiritual matters with his/her physician. For example, a physician may ask the
patient, “Does faith play a role in your life?” Affirmative responses allow for
additional questions: “Is your faith involved in your health in any way?” followed
by, “Do you attend church or meet with a community of like-minded people who share your faith and/or religious beliefs?” Lastly, “How would you like me to address these issues?” In this series of questions, the physician gauges the patient’s interest and can act accordingly, always considering the patient’s comfort level and interest.

It is conceivable that individuals who have been traumatized by past faith-related events (e.g. physical or sexual abuse, shame) have those feelings stirred up by an inquisitive physician. Many primary care physicians are unaccustomed to taking detailed faith-histories, and may fear that doing so will offend the patient. On the other hand, physicians who do inquire about such issues usually find that they develop a deeper rapport with their patients. The following sections discuss the mission and methods of existing faith-based clinics.

**Current Faith-Based Programs: Best Practices**

A variety of different, faith-based clinics exist throughout the United States. In the following section, examples of passive and active faith-based clinics will be discussed, with a more in depth exploration of proactive faith based clinics. The best practices will be applied to the development of a faith-based clinic in Hartford, Connecticut—The Christian Medical Fellowship Health Center, CMFHC.

**Proactive Clinics**

In the proactive faith-based clinic community, the Lawndale Christian Health Center (LCHC) in Chicago is widely known and considered by many to be the gold standard for a faith-based Federally Qualified Health Center (FQHC). The LCHC
began as a free clinic and has grown significantly in its 20+ year history. The LCHC’s mission statement is as follows:

Lawndale Christian Health Center (LCHC) is a not for profit health center founded in 1984. Our mission is to show and share the love of Jesus Christ to the Lawndale and Garfield Communities by providing wholistic [sic], affordable, and quality health care services.

LCHC is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and is recognized as Federally Qualified Health Center (FQHC) by the U.S. Department of Health and Human Services’ Bureau of Primary Health Care. LCHC is a faith-based FQHC in one of Chicago’s poorest communities that began as a small church in the 1970s. The church expanded and incorporated a free clinic, which cared for its first patient in 1984. Twenty one years later, LCHC’s staff of 275 provides over 100,000 patient-care visits annually.

Initially, the LCHC cared for patients who lived locally. Today, individuals travel from miles away to Lawndale for their healthcare needs. They do so because of the personal, sensitive care they receive by Lawndale’s physicians, who actively incorporate their Christian faith into their practice of medicine. Lawndale’s physicians receive great satisfaction from being a part of the faith-based environment at the Center, as evidenced by the fact that they accept salaries that are 60-70% of their market value (the other 30-40% is invested in the health center, which now includes a gymnasium, fitness center, and health and faith-related educational programs). Moreover, the 50 full-time physicians at the LCHC routinely pray with and for their patients and refer them to pastoral services, as necessary. Many people in the faith-based health center community consider LCHC to be the prototypical faith-based health center and aspire to emulate it.
Esperanza in Philadelphia is another well-known faith-based FQHC that opened its doors shortly after the LCHC. (Unless otherwise noted, information about Esperanza was obtained from its 2005 Annual Report, which is available on its website.) Esperanza’s Mission Statement is as follows:

Compelled by the love of God in Christ Jesus, in cooperation with the Church and others, Esperanza Health Center is a multi-cultural ministry providing holistic healthcare to the Latino and underserved communities of Philadelphia.

Esperanza, Spanish for “hope”, began in 1987 when a number of medical professionals from inner city churches realized the unmet health needs of the Latino community in North Philadelphia. They formed a small, walk-in clinic in Philadelphia’s Latino commercial district, and word spread that Esperanza provided bilingual/bi-cultural care. The site soon became insufficient to support the growing number of patients, and two years later the clinic moved to its present, more accommodating, location.

Today, Esperanza serves over 3,000 patients annually through 12,000 medical care visits, and like LCHC, is accredited by JCAHO and is recognized as an FQHC. Esperanza provides urgent care services and comprehensive primary care services, including: gynecological services, family planning, adult and pediatric vaccines, preventive services, and social services. Obstetrics, lab work, and radiology services are provided by referral. Esperanza also provides HIV treatment and prevention services, and integrates bilingual mental health counseling and social work services.

Esperanza’s Women’s Health Program is an integrated team of medical care, mental health and social service providers serving women with special needs.
Esperanza’s Chaplaincy Program involves a full-time, on-site chaplain who works alongside physicians and the clinical staff, and is available to speak with any patient about spiritual concerns or to pray with patients who desire prayer. Over 300 patients per year receive chaplain prayer or pastoral counseling. Moreover, new Bibles are also provided to patients in need.

Esperanza serves the community by providing health screening and education at local community events and churches. It also partners with “welfare-to-work” programs and has helped nearly a dozen women obtain clerical positions.

Esperanza plans to expand over the next two years, and has received federal funding to open a new clinic across the street from its original, walk-in clinic. The new site will provide dental services, hospital services (i.e. privileges for its physicians at nearby Temple University Hospital), pharmacy, nutritional services, expanded counseling services and expanded hours. It is projected that by 2008, Esperanza will increase from 3,000 patients and 12,000 patient visits to 8,250 patients and 30,600 patient visits.

Income for 2005 came from a number of sources: $1.61 million (68%) from medical revenue, $533 thousand (22%) from grant revenues, and $228 thousand (10%) from contributions, for a total of $2.37 million. Expenses for 2005 were: $1.70 million (73%) for Program, $595,000 (25%) for General and Administrative, and $25,000 (1%) for Fundraising, for a total of $2.32 million.

Esperanza’s attending physicians are all Christians, and they believe in and adhere to the organization’s mission statement. A number of non-Christian volunteers including residents, medical students, nursing students, medical records
clerks, and welfare to work program volunteers also donate their time to Esperanza.\textsuperscript{145} The proactive nature of Esperanza is characterized by the following statements in its annual report:

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"Through the example of Christ, we want to care for our patients holistically, being concerned not only with the presenting physical health needs, but also the spiritual, emotional and social factors that contribute to overall health... In all our plans, we’ve tried to keep Christ first in everything we do and to stay committed to our core values – compassion, excellence, commitment, wholeness and service... Compelled by the love of Christ, we strive to make a difference in our city, family by family... The Esperanza medical provider staff is a group of committed individuals who see their vocation as a calling rather than a career. Each person comes to Esperanza with a special concern to serve the people in this community with care that is holistic – physically, spiritually and psychologically. In addition to the medical care they provide, these dedicated individuals spend time in devotions with the staff and in prayer for and with patients. They are able to take time with patients who have a particular extra need—all at a salary that is much less than if they were to work in the larger, profit-driven healthcare facilities. The entire staff at Esperanza works to provide a caring environment, where patients are treated with dignity and respect... Esperanza takes time to personally care because, to the staff, it’s not just a job, it’s a calling."
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**Passive Clinics**

The San Diego Health and Faith Alliance (SDHFA) is an interdenominational organization with the following mission statement:

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The mission of the San Diego Health & Faith Alliance, in collaboration with faith-based and community service organizations and local educational institutions, is to arrange for the provision of health care and counseling services, free of charge, to the needy of San Diego County through innovative and integrated team-training experiences for future physicians, nurses, pharmacists, family therapists, chaplains, and other helping professionals.\textsuperscript{146}
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SDHFA has several goals: “First and foremost [SDHFA is] an organization that facilitates professional training programs... [it] exists to develop and enable an innovative team-training experience for future physicians, nurses, pharmacists, therapists, and those who provide pastoral care”. SDHFA partners with students and
professionals from “accredited universities with certified training programs in the healing arts.” Other goals are summarized in the following paragraphs.

SDHFA is committed to train team members and provide health care services at faith-based organizations, non-public schools, and community service agencies that agree to serve as hosts. SDHFA believes that local faith communities are trusted points of entry and offer the benefit of pastoral care in the patients’ own faith-based community.

Furthermore, each host site is encouraged to form a health cabinet (comprised of parishioners/clients of the agency’s services) to assess the community’s health care needs, which are then reviewed by a nurse-liaison, who in turn develops a plan to meet those needs, as possible. Outcomes studies are performed annually and adjustments in services made accordingly—a process referred to as “Community Oriented Primary Care” (COPC).

SDHFA also incorporates the use of student nurses to perform screenings, administer immunizations and patient education. Marriage and Family Therapists (MFTs) travel to host congregations and provide counseling services. Residents from the University of California at San Diego Combined Family Medicine-Psychiatry program rotate through the host sites and care for the patients, and serve as back-up for the nurses and MFTs. Pharmacy students and Clinical Pastoral Education students will also be part of the professional team.

Shepherd’s Hope in Orlando, Florida is another passive faith-based clinic. Founded in 1997, Shepherd’s Hope is a network of free clinics that provide medical care to Orlando’s uninsured communities. Its Mission Statement is as follows:
Shepherd’s Hope is a faith-based organization of volunteers providing access to health care for the uninsured.\textsuperscript{148}

Shepherd’s Hope links local schools, churches, and hospitals to form partnerships, each of which serves an underserved community. Each partnership, or health clinic, is sponsored by one or two churches (a total of twelve churches representing several Protestant denominations as well a Catholic parish), which provide funding and the majority of the clinics’ professional and general volunteers. Local Latino churches provide volunteers and translators.\textsuperscript{149}

Seven of the eight clinics are located on school campuses, and the remaining clinic is held at a church. All eight clinics are within a 15-20 mile radius; each one is open approximately two evenings per week. Evaluation and treatment for a variety of basic, primary care services (e.g. upper respiratory infections, skin disorders, gynecological concerns, and urinary tract infections) are provided on site. Laboratory and radiology services are donated by local hospitals, which form the third member of the partnerships.\textsuperscript{150}

Patients at Shepherd’s Hope are predominantly the working poor, with incomes <200\% of the Federal Poverty Limit (FPL), who fail to qualify for government aid. Shepherd’s Hope does not serve as a permanent primary medical home for patients; does not provide emergency services; and, does not provide obstetrical or well baby care. Once patients have been treated, Shepherd’s Hope helps find them a permanent medical home, whenever possible.\textsuperscript{151}

Shepherd’s Hope accepts all volunteers who are “open to training”. No statement of faith is required to volunteer—a number Jews and Muslims comprise
the 1,200 who donate their time, accounting for nearly 23,500 volunteer hours valued at nearly $1.25 million. Volunteers may pray with/for patients who request it, or may refer patients for pastoral care. Overall, the primary goal of Shepherd’s Hope is to serve and heal the sick.152

Passive and proactive faith-based clinics serve their communities in unique ways and have similarities and differences. Table 8 compares major features of passive and proactive faith-based clinics.

Table 8. Comparison of Passive and Proactive Faith-Based Clinics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Passive Faith-Based Clinics</th>
<th>Proactive Faith-Based Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Inter-faith members</td>
<td>Intra-faith members</td>
</tr>
<tr>
<td>Employee characteristics</td>
<td>Interfaith, open to faith</td>
<td>Christian faith</td>
</tr>
<tr>
<td>Volunteer characteristics</td>
<td>Interfaith, open to faith</td>
<td>Christian faith, open to faith</td>
</tr>
<tr>
<td>Mission/Vision Statements</td>
<td>Emphasis on social change</td>
<td>Emphasis on social change and spiritual renewal; specifically refer to Jesus Christ or God</td>
</tr>
<tr>
<td>Medical Care</td>
<td>A critical component</td>
<td>A critical component</td>
</tr>
<tr>
<td>Spiritual Care</td>
<td>An important component</td>
<td>A critical component</td>
</tr>
<tr>
<td>Prescribe Faith-Activities</td>
<td>Infrequently</td>
<td>Frequently</td>
</tr>
<tr>
<td>Physicians pray with/for pts</td>
<td>Infrequently</td>
<td>Very Frequently</td>
</tr>
<tr>
<td>Pastoral referrals</td>
<td>Frequently</td>
<td>Very Frequently</td>
</tr>
<tr>
<td>Faith-based education on site</td>
<td>Infrequently</td>
<td>Frequently</td>
</tr>
<tr>
<td>Staff participate in faith-related activities (e.g. prayer) together</td>
<td>Infrequently</td>
<td>Very frequently</td>
</tr>
</tbody>
</table>
Bringing it Home to Hartford, CT

Overview of Hartford and Health Indicators

According to the 2000 U.S. census, Hartford’s population was just under 125,000. The city’s per capita income was $24,080, and approximately 30% of its residents live below the Federal Poverty Level. Consequently, among cities with greater than 100,000 residents, Hartford is the second poorest city in America.153

The city’s public health is under the control of the Hartford Department of Health and Social Services. Since 1997, the Institute for Outcomes Research and Evaluation at Hartford Hospital has prepared the Hartford Health Survey (HHS) for the Hartford Health and Human Services Department.154 The HHSs are done every three years and inquire about a number of different health-related categories. Table 9 compares selected results from the three editions of the HHS (1997, 2000, and 2003) and the 2000 U.S. Census data.
Table 9. Selected Data from Hartford Health Survey and 2000 U.S. Census

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Household Income</td>
<td>$24,193</td>
<td>$20,349</td>
<td>$21,632</td>
<td>$24,820</td>
</tr>
<tr>
<td>Black</td>
<td>30%</td>
<td>37%</td>
<td>33%</td>
<td>36%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>30%</td>
<td>32%</td>
<td>29%</td>
<td>41%</td>
</tr>
<tr>
<td>White (non Hispanic)</td>
<td>31%</td>
<td>24%</td>
<td>34%</td>
<td>18%</td>
</tr>
<tr>
<td>Asian/Pacific</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.6%</td>
</tr>
<tr>
<td>Population of ≥2 races</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>3.2%</td>
</tr>
<tr>
<td>Gender: Female %</td>
<td>69%</td>
<td>69%</td>
<td>67%</td>
<td>52%</td>
</tr>
<tr>
<td>% of adult pop 65+ years</td>
<td>14%</td>
<td>17%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>High School Completion</td>
<td>74%</td>
<td>72%</td>
<td>76%</td>
<td>61%</td>
</tr>
<tr>
<td>% at/below FPL</td>
<td>24%</td>
<td>34%</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>Unemployment Rate</td>
<td>9.3%</td>
<td>7%</td>
<td>8%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 10 compares the regular place of healthcare for the 2003 and 2000 HHSs (this information was not obtained in 1997).

Table 10. Regular Place of Health Care for Residents of Hartford

<table>
<thead>
<tr>
<th>Place</th>
<th>2003 HHS</th>
<th>2000 HHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s Office</td>
<td>62%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospital Clinic</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Community Health Center</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Other Sites</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>No Place Named</td>
<td>7%</td>
<td>--</td>
</tr>
</tbody>
</table>

While the HHS data provide valuable demographic information and a sense of the city’s health care and other needs, the surveys do have significant methodological problems. Selection bias is the survey’s most significant problem: subjects in the study were required to be literate in English or Spanish, have
telephone service, have a valid address (to which the survey was mailed), and to complete the survey and mail it back.

This selection bias must be taken into consideration when interpreting the data, and probably resulted in an under-representation of the population using emergency departments (ED) as the primary source of care. Underserved populations regularly use Emergency Departments as their sole or primary mode of health care. In one cross-sectional study of patients at EDs in the Midwest, 56% had primary care physicians (PCPs), 66% stated that the ED was the only place they knew to go for their present problem, and 27% reported that they depended on the ED for all medical care. Of those patients with a PCP, 47% rated the ED better for unscheduled care. While the HHS and the ED study are measuring different variables, the magnitude of the number of patients who use the EDs as primary source of care suggests that people most likely to use EDs as a regular source of care were not included in the HHS.

Moreover, based on comparisons between the HHS and the U.S. Census data, high school-educated, African American women filled out a disproportionate number of HHS surveys. It is likely that such women would be more inclined to know the importance of routine care, would be more likely to know where to access it, and have the means to obtain it. The survey inadequately accounts for those persons who did not complete the surveys, such as the homeless, non-English speakers, and others. These flaws may attribute to the underestimation of ED visits (and perhaps overestimation of primary care office, “doctor’s office”, visits) by the subjects.
Hartford’s underserved residents have a few options to meet their health care needs. Facilities include two hospitals (Hartford Hospital (HH) and St. Francis Hospital (SF)), two FQHCs (Charter Oak Health Center, and Community Health Services), many private practices primarily located around the hospitals and serving non-Hartford residents, and two medical-student-run free health clinics.

Both hospitals provide medical care and other services to Hartford’s underserved. Saint Francis has a “free bed fund” for uninsured patients receiving medically necessary services who cannot afford to pay. HH has taken extensive steps to mitigate the disparity in mortality rates between underserved and adequately-served women diagnosed with breast cancer.

For example, recently it was observed that women living just a few blocks from mammography sites in the city were not getting mammograms. In response, HH deployed mobile vans with mammography equipment to churches, community centers, senior centers, and other “friendlier” sites where the equipment would be off-loaded and used by trained professionals to screen women. In addition, the Connecticut Breast and Cervical Cancer Early Detection Program is a state-sponsored outreach program that provides mammograms and cervical cancer screening to the underserved women of the greater Hartford area.

Charter Oak’s main facility is located at 21 Grand Street and provides the comprehensive medical services required of FQHCs. The Connecticut Primary Care Association (CTPCA) website describes this FQHC:

“Charter Oak Health Care was established in 1978 and began offering health care services in 1979. Founded by community residents and leaders, Charter Oak serves patients from throughout southern Hartford and surrounding neighborhoods... The Center provides comprehensive primary medical,
dental and behavioral health services to people in all life cycles. The patient population is diverse: 20% Black, 5% White; 59% Hispanic; and 16% unreported/unknown... Charter Oak serves more than 8,700 people from the greater Hartford area. Providing “one-stop-shopping” in a culturally appropriate and sensitive atmosphere, Charter Oak is committed to financially and physically accessible health care for both young and old alike... Among the special services offered by Charter Oak are: elderly health services, health care for homeless individuals, and school-based health care. The Center is also a clinical training site for medical, nursing, nurse practitioner, dental hygiene, dental assisting and medical assisting students. On staff are physicians, family nurse practitioners, physician assistants, dentists and psychologists.160

Charter Oak’s many satellite sites provide a range of services provided by visiting nurses, primary care services by physicians, and health care screenings. Table 11 lists the different satellite sites and the services they provide.161,162,163
Table 11. Charter Oak Health Center and Satellite Facility Services

<table>
<thead>
<tr>
<th>Charter Oak Facilities</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Grand Street (Primary site)</td>
<td>Full Status FQHC</td>
</tr>
<tr>
<td>401 New Britain Avenue</td>
<td>Primary care services with one full time physician</td>
</tr>
<tr>
<td>Connecticut Children’s Medical Center</td>
<td>Primary care and behavioral health services</td>
</tr>
<tr>
<td>Albert I. Prince Regional Vocational Technical School</td>
<td>School-based clinic serving students, open Thursdays</td>
</tr>
<tr>
<td>San Juan Golden Age</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>Elderly St. Elizabeth House</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>La Casa Elderly</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>Underwood (Elderly)</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>Bacon Congregate (Elderly)</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>Fox Manor (Elderly)</td>
<td>Provides screenings for the elderly</td>
</tr>
<tr>
<td>McKinney Shelter</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>Open Hearth Homeless</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>Immaculate Conception Homeless Shelter</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>Loaves and Fishes</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>House of Bread</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>Mercy Housing and Shelter</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>YWCA Homeless Care</td>
<td>Visiting nurse services, health care for the homeless</td>
</tr>
<tr>
<td>South Park Inn</td>
<td>Health care for the homeless, referral site for the University of Connecticut student-run free clinic</td>
</tr>
</tbody>
</table>

Community Health Services (CHS) is located at 500 Albany Avenue and primarily serves the city’s north end. CHS employs nine full-time physicians, four dentists, four Advanced Practice Registered Nurses, five behavioral health counselors, two dental hygienists, and one certified nurse midwife. CHS provides its full spectrum of services to 14,000 patients, which account for 63,000 patient-visits each year. The insurance profile for these patients is 40% uninsured, 40% Medicaid,
10% Medicare, and 10% various indemnity plans. According the CTPCA website:

"CHS has available a full services pharmacy on-site and a medical laboratory available to CHS patients. CHS offers social services, case management, outreach services, assistance to help qualified uninsured patients to apply for Medicaid and Husky program services, as well as Food Pantry and Clothing Bank for families in need... CHS accepts most forms of insurance including Aetna, Anthem Blue Cross, Cigna, ConnectiCare, CHNCT, Medicaid, Medicare and HealthNet. We also provide services to patients who are uninsured regardless of their ability to pay for services...CHS is open Monday through Friday from 8:30 a.m. to 5:30 p.m. Extended hours are available on Mondays and Wednesdays until 6:30 p.m... The racial/ethnic composition of the CHS service area is 2% Caucasian, 62% African-American and 36% Latino. Approximately 70% of patients served by CHS are on Medicaid. Languages offered within CHS are English, Spanish, Romanian, Haitian Creole, Bosnian, Russian, Albanian, German, and French."165

Two Medical Student-Run Free Clinics exist in the city: The South Park Inn free clinic and the South Marshall Salvation Army free clinic. The South Park Inn serves the residents of the South Park Inn Homeless Shelter by providing non-emergent, acute medical care. The clinic is open two evenings per week for general medical care and about once per month for women’s health care needs. According to the University of Connecticut School of Medicine website:

"[Since it first opened in 1987,] the clinic has served over 750 patients per year, providing primary care, counseling and information for the community of the South Park Inn Shelter, in Hartford's south end. The clinic is open weekly and is staffed by hundreds of student volunteers and supervised by community physicians who donate their time. Every Tuesday and Thursday evening, clinic volunteers see 10 to 15 shelter residents ranging in age from 1 to 80 years old, with medical problems, concerns about safety, and hygiene. The primary goal of the clinic is to provide much-needed medical attention to the residents of South Park Inn, while providing an opportunity for medical students to become familiar with the special needs of a homeless population. The clinic is equipped to diagnose and treat minor medical and psychiatric

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164 Connecticut’s state health insurance for children is known as HUSKY, which has two parts: Part A and Part B. HUSKY Part A is Medicaid (Title XIX), Part B is the S-CHIP program (Title XXI).
problems and refer patients to area hospitals and support services when required."

The South Marshall Clinic serves Hartford by providing non-emergent, acute medical care to the city’s pediatric population. According to the University of Connecticut Health Center website:

“The Salvation Army Marshall House is a homeless shelter in Hartford which houses single parent families, dual parent families, married couples, single women, and adolescents cared for by the Department of Children and Families (DCF). The Salvation Army Marshall House provides a free medical clinic for the residents of its shelter and is staffed by volunteers from the University of Connecticut School of Medicine. The clinic benefits the children and adolescents living at the shelter and to serve as a learning experience for UConn medical students. The clinic is open one evening a week on alternating Mondays and Wednesdays from 7 to 9:30 p.m. The clinic is staffed by two medical students and a teaching physician. On a typical night, three to five pediatric and adolescent patients are seen. The student volunteers…take the patient's history and perform a physical exam, then present the case to the attending physician. The physician helps them form a differential diagnosis, and then together they examine the patient and decide on appropriate diagnosis and treatment.”

Despite the number of health care facilities in Hartford, the area is in great need of primary medical care providers and facilities. Using state and federal criteria, there is an inadequate number of health care providers available to the city’s residents. This determination is made by the Connecticut Department of Public Health (DPH) in collaboration with the United States Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), and Bureau of Health Professions, Shortage Designation Branch to identify medically underserved areas in CT. Such areas qualify for a federal designation as a Medically Underserved Area or Population (MUA and MUP, respectively), or a Health Provider Shortage Area (HPSA).
HPSAs can be designated as underserved areas for primary care, dental, or mental health care. Under the primary medical care category, Hartford County has nine HPSA designations, four of which are in the city of Hartford.\textsuperscript{169} HPSA designation requires three basic criteria, as outlined in Table 12.\textsuperscript{170}

**Table 12. Criteria for Health Provider Shortage Area (HPSA) Designation**

1) The area is a rational area for the delivery of primary medical services;
2) A population to primary care physician ratio of at least 3500 to 1 or a ratio greater than 3000 to 1 with unusually high needs for primary care services or insufficient capacity of existing primary care providers;
3) Primary care in the contiguous area is over-utilized, excessively distant or inaccessible to the population of the considered area.

MUA/P criteria are different. On October 15, 1976, the Index of Medical Underservice (IMU) was published in the Federal Register. The IMU is a scale used to designate MUAs and MUPs, and involves four variables, outlined in Table 13.

**Table 13. Criteria for Medically Underserved Area/Population (MUA/P) Designation**

1) The rate of primary medical care physicians per 1,000 population (obtained by determining the current number of full-time equivalent [FTE] primary care physicians [PCPs] providing patient care in the service area and their locations of practice)
2) Infant Mortality Rate (IMR)
3) Percentage of the population with incomes below the poverty level
4) Percentage of the population age 65 or over.

The value of each of these variables for the service area is converted to a weighted value, according to the established criteria. The weighted values are scaled from 0 to 100, where 0 represents completely underserved and 100 represents best served, or least underserved. Under the established criteria, each strictly-defined service area found to have an IMU of 62.0 or less qualifies for designation as an
MUA. MUP determination involves the same process as the MUA determination, with slight modifications.171

Whereas MUA/P data in Hartford County and many other locations have not been updated in over a decade, HPSA data is updated many times per year and is more commonly used as part of the criteria to qualify an area for particular federal benefits, such as National Health Service Corps placement, enhanced Medicare reimbursements, Community Health Center grants, and other federal or state programs. More than 34 federal programs currently depend on HPSA designation to determine eligibility or as a funding preference.172

HPSA designation is also an indicator of the availability of primary care and preventive services in a region. A foundational, underlying assumption of medicine is that routine, preventive care improves quality of life, reduces morbidities and mortalities, and prolongs life-expectancy. Inadequate access to medical care results in the opposite. Individuals living in HPSAs receive inadequate medical care on average. As a result, the negative, irreversible consequences of chronic diseases are more common in HPSAs.

In Hartford, the 2003 HHS reports that the top five reported medical conditions in the city were hypertension, depression, asthma, diabetes, and heart disease. Women’s health needs, including gynecological services and family planning, are also prevalent in Hartford.173 Chronic illnesses demand routine care to prevent myriad complications, which are both costly and detrimental to quality of life. Hartford is in need of additional health care facilities to care for its residents.
While Hartford does have some religiously affiliated health care facilities located within homeless shelters (Charter Oak has several satellite sites that are affiliated with the Catholic Church and/or St. Francis Hospital, e.g. House of Bread, Immaculate Conception and others), no proactive faith-based clinics exist in the city. The combination of medical need and the lack of emphasis on the role of faith in health care by existent facilities have led several Christian physicians and students in the Hartford area to work together to open a faith-based health center in the city.

**The Christian Medical Fellowship: Opening a Health Center**

Christian Medical Fellowship (CMF), a Hartford-based non-profit organization, has spearheaded the effort to open a faith-based medical center in Hartford. CMF is a nondenominational Christian organization of individuals interested in health care. Founded in the mid 1990s by a Hartford-based Obstetrician-Gynecologist, CMF’s mission is “to promote spiritual growth and fellowship, to show love and compassion, and to proclaim the goodness of God within the health care community.” CMF is involved in international, national, and local projects. Internationally it leads medical teams to Haiti, Siberia, and Nigeria. Nationally, CMF has chapters in Hartford, New Haven, and Florida. Locally, it holds monthly fellowship meetings, health fairs, Christmas-caroling, and other events.

CMF has identified a variety of expressed and observed needs of patients and health care providers in the local community. Chief among patient needs are routine and preventive services, women’s health, non-emergency acute care, and medical care in the context of a faith-based and spiritually friendly environment.
Physicians have a different yet related set of needs. Through personal experience of its members, interaction with other physicians and medical students, and involvement with the CMDA, CMF leaders know that many students’ and health care providers’ are motivated to study medicine because of their religious convictions. A substantial number of individuals enter the medical profession because they want to serve God by caring for the infirm. Physicians who are involved with CMF recognize that traditional medicine inadequately addresses patients’ faith-based needs. Moreover, the rigors of medical training can have the opposite effect: it often hardens and desensitizes physicians to the pain and suffering of their patients. As a result, many students and physicians with abundant compassion in the early phases of medical training lose sight of their original vision.

To combat this tendency, many physicians attend contemplative retreats, read books and journal articles that touch on the spiritual side of medicine, and try to reconnect in other ways with their once-held convictions. Periods of renewal and recommitment may be short-lived, however, and physicians may find themselves mentally right back where they started. This cycle is familiar to many physicians.

CMF and its members believed that periodic retreats and intermittent spiritual practices can bring about change, but only temporarily. CMF, therefore, believes that by promoting individual faith, community outreach, and international missions, it can instill a spiritually enhanced way of life.

CMF desires to bring about a transformation in health care—in the lives of patients and providers, as seen in the people involved with Lawndale, Esperanza, and other similar faith-based health centers around the country. With this vision in mind,
CMF formed a committee to plan the implementation of a faith-based clinic called the Christian Medical Fellowship Health Clinic (CMFHC). The Christian Medical Fellowship Health Center (CMFHC), a proactive, faith-based, affordable health center in Hartford, would address the community’s needs in the context of the CMFHC’s mission and vision statements:174

*Mission:* The Christian Medical Fellowship Health Center is a nonprofit organization established to demonstrate the love of Jesus Christ by providing affordable, holistic and quality health care services to people in the greater Hartford community.

*Vision:* CMFHC will provide comprehensive women’s health services regularly and envisions a future where:
1) Comprehensive health care services are provided to men, women, and children in a spiritually-friendly environment honoring to Jesus Christ;
2) Patients have their physical, emotional and faith-related needs addressed;
3) Patients are educated about health promotion and disease prevention;
4) Patients take ownership of CMFHC;
5) Volunteers and staff are encouraged and enabled to integrate their Christian worldview into their daily interactions with others;
6) All involved discover God’s general and specific purpose for their lives.

The CMFHC is committed to provide affordable primary care and women’s health services to underserved individuals and families in the Hartford area with a special focus on faith-based concerns of patients. “Affordable” means that CMFHC will be a free clinic or one where cost is not prohibitive to any recipients. No such model of a faith-based free clinic exists in the city. The CMFHC will distinguish itself from other free clinics, FQHCs and any other health care facility through excellent medical care *and* through spiritual care of both its patients and its staff.

The three year plan for CMFHC involves two phases. Phase One is the free clinic, which will be functional for the first twelve months. Phase Two is the sliding scale clinic, which will be functional within 12-36 months. Phase Three is the
transition into an FQHC Look-Alike or a full FQHC. Phase Four is the development of a faith-based residency fellowship program that trains physicians, residents, medical students and other health care professionals to incorporate their faith into patient care. These are some of the long-term goals of the CMFHC; analysis of these phases is beyond the scope of this paper. Moreover, this progression, while not unusual, is not the only road to becoming an FQHC; no “typical” progression exists. The direction the CMFHC takes is dependent on a number of variables, including: fundraising, developing a volunteer base, and procuring an adequately-sized site.

In addition to being a fully-functioning primary care medical facility, CMFHC will be a proactive faith-based clinic. Physicians will be encouraged to explore and address the faith-related issues related to their patients’ wellbeing. Patients will be encouraged, at their own pace and comfort, to talk about their faith, to talk about God’s role in their health, to pray and/or receive prayer, and to discuss anything else that they believe affects their wellbeing. CMFHC will encourage research in the area of faith and medicine. It will train interested physicians how to engage patients in thoughtful, non-threatening conversations about spirituality, religion, and faith and their impact on health and wellbeing. CMFHC will be a health center whose doors are open to all in need.

It is important to emphasize that the vision, or “ends”, of the CMFHC are more important than the means through which they are achieved. It is conceivable that the CMFHC will accomplish it mission and vision during Phase One, which is currently acceptable to the Board of Directors.
Several legal requirements must be met before any organization can open a medical clinic. The State of Connecticut’s Department of Public Health (DPH) requires that free clinics complete a licensure application,\textsuperscript{175} obtain a certificate of insurance for workman’s compensation and for general and professional liability, and provide proof of malpractice insurance for each volunteer physician.

The licensure application, which is available through the CT DPH website, inquires about the name of the facility, services provided, and other questions.\textsuperscript{176} The workman’s compensation insurance and liability insurance can be obtained through an insurance company or broker. The liability insurance is for general liability, not specifically medical liability, known as malpractice insurance.

Malpractice insurance for volunteer physicians is available through the federal government for those who satisfy a number of basic eligibility requirements. Once these requirements are met, the clinic volunteers are deemed federal employees and qualify for medial liability coverage under the Free Clinic Federal Tort Claims Act (FTCA).\textsuperscript{177} The National Association of Free Clinics (NAFC) has collaborated with a consulting group, The Triton Group, LLC, to assist free clinics access the FTCA coverage.\textsuperscript{178} The CMFHC appears to satisfy the qualification criteria and is submitting an application for FTCA coverage.

In addition to the DPH’s requirements, the State of Connecticut’s Office of Health Care Access (OHCA) requires that certain facilities, including ambulatory care centers, obtain a Certificate of Need (CON) prior to developing a new clinic:

\textsuperscript{a} Per the Federal Government’s Bureau of Primary Health Care: in addition to volunteering at a free clinic or a clinic-sponsored off-site event or program, the health professional: cannot receive compensation for provided services from patients directly or from any third-party payer; must be licensed or certified to provide health care services; may receive repayment from a free clinic for reasonable expenses incurred in service provision to patients, and other criteria.
Certificate of Need ('CON') authorization is required when a health care facility proposes; a medical equipment purchase, establishment of new medical or expanded service or a reduction or termination in services. Connecticut health care facilities, including ambulatory care centers and outpatient behavioral health programs need to obtain a CON prior to developing, expanding or closing certain services and expending more than $1 million on a capital project. Additionally, any person is required to obtain a CON if he/she proposes to acquire major medical with a capital cost in excess of $400,000. Effective July 1, 2005, CON approval, regardless of cost, is required for anyone acquiring, purchasing, or accepting donation of a CT scanner, PET scanner, PET/CT scanner, MRI, cineangiography equipment, a linear accelerator or similar equipment utilizing new technology that is being introduced to the state.¹⁷⁹

Organizations seeking a CON must initially submit a Letter of Intent (LOI), which is available on the OHCA website.¹⁸⁰ The LOI requests basic information such as the organization’s name, services provided, location, and funding. Once the LOI is accepted, OHCA sends the organization a customized CON to complete and submit within a designated filing period. The applicant is also assigned an analyst and given a docket number for the proposal. For a small fee, the OHCA furnishes applicants with a guide to help them complete the LOI and CON.¹⁸¹ The CON application and approval process:

“...consists of a review of the application, a public hearing process, and a decision. The application submitted to OHCA must include the following components [see Table 12] as required under Section 19a-637 C.G.S, which relates to OHCA’s considerations in deliberations and written findings. The application is deemed complete when the Applicant successfully addresses each of these requirements.

Table 14 is adapted from the OHCA website and lists the required components of the application.¹⁸²
Table 14. Required Components of the Certificate of Need Application

- The relationship of the proposal to the Applicant’s long range plan
- The financial feasibility of the proposal
- The impact on the Applicant’s rates and financial condition
- The impact on interests of consumers
- The impact on payers for such services
- The contributions of the proposal to the quality, accessibility, and cost effectiveness of health care delivery
- Competency of facility managers
- Sufficiency of rates
- Changes in the Applicant’s current utilization
- Teaching and research responsibilities of the Applicant
- The efforts of the Applicant in improving productivity and containing costs
- Any other factors deemed relevant by the Office

While certain aspects of Table 14 will be discussed throughout the remainder of this thesis, an exhaustive, point-by-point analysis requires careful consideration by the CMF Board of Directors and the CMFHC Committee, and is beyond the scope of this paper—and may not even be necessary. Waivers and exemptions for the CON are available to qualifying applicants. It is unclear whether a CON is required by the CMFHC, which plans to submit the CON Determination Form in lieu of the LOI:

A CON Determination is submitted if an Applicant is unsure if a CON is required for a proposed project. The CON determination form (Form 2020) describes the proposal and is submitted to OHCA for review. Based on that information, OHCA determines if a CON is required. If a CON is required, the CON Determination Form can be considered a completed LOI. 183

Once the applications are approved, the site is approved by the fire marshal, and the clinic passes a general inspection by the DPH, the clinic can open. The process typically takes about three months.

In addition to state laws regarding opening an outpatient free clinic, a number of basic factors essential to the startup and operation of any free clinic must first be considered and prioritized. Such considerations are listed in Table 15.
Table 15. Major Factors to be Addressed to Open a Free Clinic

| Services to be provided          |
| Location of the facility        |
| Accessibility of the facility to staff and patients |
| Safety concerns within and without the clinic neighborhood |
| Structure of the Clinic (mobile unit, temporary, permanent etc) |
| Ownership of the facility       |
| Volunteer recruitment: strategies, criteria |
| Fundraising                     |
| Hours of operation              |
| Medical-legal issues            |
| Medical records                 |
| Quantification of Services      |
| Patient Tracking                |
| Sustainability                  |

The issues related to opening a free clinic require professional guidance and consultation. A number of organizations, as well as free clinics themselves, are available to help with the process. The Christian Community Health Fellowship (CCHF)\(^{184}\) is a non-profit organization in Chicago that assists interested persons and/or organizations open faith-based medical clinics. The CCHF sponsors conferences and compiles best practices models from different faith-based clinics around the country.

In the next section, the *Best Practices and Principles*, models from the CCHF and from various clinics around the country will be described. These principles will be applied to Hartford and the CMFHC in the subsequent section of the paper, *The CMFHC: Developing a Model Based on Best Practices*, resulting in a unique model. When the best practices are generalized and/or relatively universal among clinics, they will be discussed briefly in the Best Practices and Principles section. Greater detail will be included in CMFHC Model section.
Best Practices and Principles

Services Provided

A saying exists in the free-clinic community: “If you’ve seen one free clinic, you’ve seen one free clinic.” This quotation captures the diversity in services provided and the unique means through which that care is provided at each free clinic. Perhaps the first two questions a potential clinic must answer are: “What services will we provide?” and “What is our target population?”

Free clinics provide a vast array of services through a variety of means. Some clinics see patients strictly on a walk-in basis, others require appointments, and others have a combination of the two. Walk-in clinics chiefly provide acute, non-emergent care (“episodic care”) and provide referrals to other specialized or better-equipped facilities. Other clinic models provide walk-in services and range of routine and preventive services. Basic services in addition to acute, non-emergent care include chronic disease prevention and care (e.g. blood pressure and diabetes screenings and management), subspecialty medical care (e.g. eye care), dental care, counseling services, pastoral care, disease prevention and wellness education services, and other services. Many clinics hire or have volunteer translators in order to meet the needs of non-English speaking patients, particularly in urban areas. “Language Line” is a service provided by AT&T and offers translation services in 150 languages.

The qualification criteria for patients to receive care are generally based on low income, but certain clinics have additional criteria such as employment (for the

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*Donors with special interests often influence the services provided with directed gifts.*
able-bodied). Table 16 lists examples of qualification criteria for a handful of faith-based clinics around the U.S.

**Table 16.** Selected Faith-Based Clinics and the Qualification Criteria for Patients Seeking Care

<table>
<thead>
<tr>
<th>Facility</th>
<th>Qualification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Church Health Center, Memphis, TN&lt;sup&gt;186&lt;/sup&gt;</td>
<td>Residents of the local county who: are children under 18, the employed with low income and no health insurance, the elderly, and the homeless.</td>
</tr>
<tr>
<td>Cross Over Ministry, Richmond, VA&lt;sup&gt;187&lt;/sup&gt;</td>
<td>The homeless and individuals who do not have access to traditional medicine</td>
</tr>
<tr>
<td>Health and Hope Clinic, Pensacola, FL&lt;sup&gt;188&lt;/sup&gt;</td>
<td>The economically disadvantaged patients residing in the greater Pensacola, FL area</td>
</tr>
<tr>
<td>Siloam Health Center, Nashville, TN&lt;sup&gt;189&lt;/sup&gt;</td>
<td>The uninsured, people who have difficulty accessing medical care</td>
</tr>
</tbody>
</table>

**Location and Accessibility**

Location and accessibility of the clinic to patients and staff are main concerns. Most faith-based clinics serve urban areas and must locate an adequately sized building in an accessible part of the town. The ideal scenario is one in which the respective needs and assets of two (or more) organizations complement one another. For example, a company or organization may have the asset of extra space in its building. The company can increase its revenues by renting the space, or it can boost its public image by donating the space to a charitable organization. Being affiliated with the charitable organization may serve as an asset to the company.

Because the target population relies heavily on public transportation, it is imperative that the health center be located near the city’s primary mode of public transport, which is the bus line in Hartford. Furthermore, the facility should be wheelchair-accessible to accommodate handicapped patients.
Safety Concerns

Impoverished areas have higher crime rates and may warrant securing the facility during office hours with guards. While every volunteer has to take on some risk associated with working with the underserved, minimizing those risks should enhance volunteer retention and recruitment, and contribute to the wellness of the patients who visit.

At the same time, many volunteers at faith-based clinics live by faith and trust in God’s care in spite of their potentially harmful surroundings. An example of this is Chicago’s Lawndale Christian Health Center’s (LCHC). Staff and volunteers at LCHC are currently revered in their community, but this did not come without a cost. LCHC’s founder (a Caucasian pastor who first planted Lawndale Christian Church, which is across the street from LCHC) developed a love for the poorest of the poor in Chicago while in college studying to become a pastor. He felt called by God to leave his comfortable suburban roots, plant a church and live among the poor in the Lawndale community, which was inhabited exclusively by impoverished African Americans and Latino minorities. His home was broken into no fewer than a dozen times during his first couple years living in the community, but he was not deterred, and his new bride persevered with him. His devotion and commitment to the mission and vision of Lawndale, and his unwavering faith in God created a trusting environment that set a standard that continues to sustain the health center today. The challenge for CMFHC is finding the right balance between meeting the community’s deepest needs while generating and retaining a solid volunteer base.
Clinic Structure and Ownership

Free clinics across the nation utilize space in churches, schools, community centers, hospitals, other buildings, and traveling buses. Some free clinics utilize a combination of these facilities and rotate sites. Others locate in a permanent facility permanently and are given control of specific space, allowing them to store equipment and secure records. Still others must set up and break down the clinic’s temporary exam rooms, pharmacies, and waiting areas in between clinic sessions.

It has been theorized that setting up a clinic at a church may turn away people who have had bad experiences at churches, are intimidated by churches, or feel they would not “fit in” because they are of another faith. On the other hand, many churchgoers feel comforted and cared for in churches, leading to the suggestion that people who have an aversion to medical clinics and hospitals may feel much more comfortable visiting a church-based clinic.

The rotating (or traveling) model is beneficial in that it allows for physicians to travel to the patient by setting up temporary sites in a number of neighborhoods. The novelty of having the “doctors” come to town every few weeks or months may generate interest among the people who would otherwise not travel to see a physician for routine (or other) care. A few downsides of temporary/traveling clinics include the significant set-up time, marketing strategies, and the logistics of coordinating traffic, directions, parking, and other intangibles. These details are particularly important when it comes to recruiting and retaining volunteers, as well as continuity of patient care.
In any case, the type of physical space is less important than the trust that is established between the caregivers and the community. When LCHC first opened, the leaders knew that thousands of potentially uninsured people lived in the community. Upon opening the clinic, however, only two dozen or so patients came each week and this went on for a substantial period of time. Subsequently it was discovered that people in the community did not know the staff, and hence did not trust the clinic. Unless LCHC addressed the fear issue and demonstrated its trustworthiness, the clinic would not fulfill its potential.

Steps were taken to generate trust between community members and the clinic, and between community members themselves. The LCHC created an atmosphere of trust through specific steps: placing some of the poorest community members on their Board of Directors, listening to their needs and concerns, and taking steps to address them; networking with area churches and community leaders; and hosting health fairs and other community activities. Not until the walls of fear were razed and replaced with trust did growth occur.

Over time people who rarely ventured outside their homes because of the violence were now congregating at the Lawndale Christian Church and health center and contributing “sweat equity”—building new roofs, painting, cleaning and other jobs. The people in community realized the health center was effectively theirs, and they were taking responsibility for it—they were taking ownership of it.

Volunteer Recruitment

Volunteer recruitment for non faith-based clinics has no restraints. At the South Park free clinic in Hartford, which is run by medical students at the University
of Connecticut School of Medicine, any student at the school and any physician in
the community who wishes to volunteer his or her time is welcome to do so.

Volunteer recruitment at passive faith-based clinics is moderately variable. In the SDFHA model, professionals and staff at the free clinics need not have any faith commitment. That the facility is “faith-based” has no practical impact on the work they do. Professional staff at SDFHA are students and professionals from local academic institutions who rotate through the clinic(s) and gain valuable experience in their respective domains.

In contrast, at Shepherd’s Hope the vast majority of professional volunteers are recruited from Christian churches, with a few coming from synagogues or mosques. While no statement of faith is required by the volunteers, the pool of people from which they obtain volunteers is almost exclusively from Christian churches.

At Lawndale and Esperanza, the entire professional staff are Christians who are devoted to the organization’s mission statement. The mission is such an important, integral part of the work they do that applicants who do not adhere to it would compromise the clinic’s core values.

**Fundraising**

Funds come from a variety of sources in all faith-based and non-faith based clinics. While all clinics and health centers utilize externally generated funds to some degree, free clinics are more dependent on them (external funds are those not generated via patient self-pay or a third party payer, e.g. insurance payments). For example, the Cross Over Ministry’s clinic does not charge patients for office visits,
but does accept donations: patients contributed $100,000 to the clinic in 2005. Cross Over's budget comes from diverse sources: 30% is from individual contributions, 30% from foundations, and the remainder from corporations, local churches, businesses, and patients.\textsuperscript{191}

Similarly, The Church Health Center’s donors include more than 200 congregations (churches of all denominations and synagogues) as well as individuals, businesses, groups and foundations. Donations are its primary source of funding, providing almost its entire annual budget.\textsuperscript{192} Non-cash gifts including furniture, medical equipment, carpeting, paint, supplies and other items can be solicited from corporations, charitable organizations, and individuals.

**Hours of operation**

Hours of operation are dependent on two primary variables: the number of volunteers and funds available (it is anticipated that demand for services will always outweigh supply). In the early stages of most free clinics, office hours are typically in the evenings. Transition into daytime hours may be initiated once the volunteer pool expands, external funds are procured, and the patient population demands it. The CMFHC plans to have night hours initially, two to three times a month, as possible.

**Medical-Legal Issues**

Physicians solicited to volunteer at the clinic typically have the same first question, “Will I have liability coverage?” Volunteer physicians who satisfy a number of basic eligibility requirements, such as working at a free clinic and not receiving payment from a third party for services provided, are deemed federal
employees and qualify for medical liability coverage under the Free Clinic Federal Tort Claims Act (FTCA). Moreover, while many states do make liability provisions for volunteer physicians who practice in sliding scale free clinics, the specific coverage varies from state to state. Physicians’ malpractice insurance coverage also vary and may or may not cover volunteer work done at free clinics.

Medical Records, Quantification of Services, and Patient Tracking

Wayne Detmer, MD, Medical Director of LCHC emphasizes that only through accurate measurement of important information can a health center (or any organization) learn from its mistakes, predict trends, know what changes to make and why, and prevent problems before they occur. He states, “If it is important, measure it!”

Quantification of patient services and patient tracking can be achieved through simple or sophisticated means. The South Park student-run clinic provides episodic care to Hartford’s homeless and uses a combination of paper charts, log sheets, and a basic software program to collect and organize patient information including: basic demographical information; employment status; previous medical care received and by whom; status regarding certain infectious disease such as Tuberculosis, viral hepatitis, and HIV; substance abuse history; and other relevant medical and social history. South Park also records diagnoses, treatments, medications distributed, and follow-up plans. Other clinics utilize more sophisticated electronic medical records that allow for more detailed data collection.

\* In addition to volunteering at a free clinic or a clinic-sponsored off-site event or program, the health professional: cannot receive compensation for provided services from patients directly or from any third-party payer; must be licensed or certified to provide health care services; may receive repayment from a free clinic for reasonable expenses incurred in service provision to patients, and other criteria.
and reports. This information will provide physicians a framework to understand their patients and will help them provide more appropriate patient care.

These data and reports also help fund the care that’s provided. Foundations and other donors to organizations oftentimes want documentation of how effectively the recipient utilizes the funds. No uniform method of delivering information to donors exists; instead, many donors request specific data and it is up to the clinic to furnish the information in the way the donor desires it. For example, a foundation interested in funding women’s health initiatives may request data on the number of women seen, their ages, and their diagnoses—a relatively simple parameter. On the other hand, the foundation may desire data on more detailed information. Either way, the technological sophistication of the clinic may dictate the grants it can or cannot receive.

In addition to these considerations, startup costs, maintenance, access to technical support, and the realistic need of such systems are important to consider prior to deciding which system is best for a clinic. In short, a sophisticated electronic system may not be necessary for clinics providing episodic care only, but may be more appropriate for facilities with donors who require more detailed reports of services provided and outcomes.

**Quality Control**

Quality control is achieved by a number of methods. Patient satisfaction surveys can be used to assess a variety of parameters ranging from office management issues (e.g. patient wait time) to the patient-physician relationship (e.g. time spent with the patient; willingness of the physician to answer questions; patient
comfort level when the physician inquired about sensitive issues). Such feedback can be used to improve the qualitative aspects of patient care.

In addition, physicians, residents, and students who volunteer in the clinic can share experiences and discuss the means by which they addressed their patients’ faith-based needs. Pre- and post-tests can be administered to determine the volunteers skill at eliciting faith-based histories and addressing related needs. Moreover, donors giving directed funds might require certain reports, which can serve as quality control checks.

**Best Practices: The Bottom Line**

It is important that the planning committee achieves its intended purpose(s). Donors, grantors, volunteers, and patients are drawn to well-organized organizations that accomplish their goals. It is better to under-promise and over-deliver than vice versa. This is best accomplished when the purposes are clearly defined and reasonably attained.

**The CMFHC: Developing a Model Based on Best Practices**

Prior to discussing the application of the *Best Practices* to the CMFHC, it is important to describe what a typical patient will experience when he or she visits the CMFHC (and most other proactive faith-based clinics). While patients who visit the CMFHC will receive quality medical care not unlike other health care facilities, the uniqueness of the CMFHC and other proactive faith-based clinics lies in the emphasis on the person’s spiritual wellbeing. Physicians at the CMFHC believe that a patient’s spiritual history is as important as his/her medical history.
A review of patient records at typical primary care physicians' offices will reveal that most, if not all, physicians document the faith background of their patients. What physicians do with this information is vastly different between proactive faith-based clinics and the typical non-faith-based facility. Whereas non-faith-based facilities utilize the information more often as the patient's wellbeing declines (i.e. they contact the patient's minister or religious leader or engage in deeper conversations or prayer with patients in cases of severe/terminal illness), proactive faith-based clinics use the information whenever possible to encourage the patient, pray with the patient, help the patient see the condition through the perspective of a loving, caring God, and other means. Physicians and staff at proactive clinics believe that the role of faith permeates all facets of life, in sickness and health alike.

CMFHC physicians also understand that some studies reveal that as low as 10% of patients wish to discuss spiritually during a routine visit. Physicians and staff will are not to force or coerce a patient to discuss faith-related matters against the patients' wishes. The bottom line is that the CMFHC intends to offer a service to patients who desire it.

Once a patient indicates verbally, through body language, or any other means that he or she does not wish to continue to discuss the issue, the physician is to honor the request for the given visit. However, it is assumed by the CMFHC that life's vicissitudes influence all persons and their desire to discuss matters of faith (and other topics). Physicians at CMFHC believe that faith is such an important component of wholeness that physicians at the CMFHC will be encouraged to
inquire about the patients’ current faith-based circumstances during future visits, and to proceed accordingly.

Services Provided by the CMFHC

The CMFHC plans to provide episodic women’s health and gynecological care initially. Once a stable volunteer base of physicians is established, other services such as episodic pediatric and adult care will be provided. CMFHC also plans to have pastoral counselors on hand at each session and offer educational programs and seminars. Volunteer recruitment, which will be done primarily via word of mouth and by contacting local churches, will dictate the programs and services provided.

Language Interpreters

The significant Hispanic population in Hartford demands that the CMFHC have Spanish translators available to care for this community. The CMFHC will recruit such translators from local churches and by word of mouth. Patients who speak other language will be handled on a case by case basis, and AT&T’s Language Line can be consulted.

Location and Accessibility for the CMFHC

The CMFHC developed a needs/assets relationship with another local non-profit organization in Hartford, La Casa de Puerto Rico, which assists Latino women obtain employment. La Casa is going through financial difficulties and needs to gain greater credibility among its donors and grantors. La Casa has offered a portion of its building to CMFHC. The space is handicapped accessible, has a waiting area,
small kitchen, bathroom, common area, and three large rooms, which will serve as examination rooms. Sufficient parking space is available as well.

By donating extra space in its centrally-located building to the CMFHC, La Casa demonstrates that it is providing a service to the community. Moreover, CMFHC’s target population, the underserved minorities in Hartford, includes members of the Latino community. La Casa’s underserved clients, their family members or friends may become patients of the CMFHC.

Phase One of the CMFHC will be in this office, which is accessibly located two blocks from Hartford Hospital on Main Street in Hartford. La Casa is located in a federally designated HPSA, and therefore is eligible for federal grants (a key consideration if CMFHC stays in the same location and wants to become an FQHC). Moreover, the proximity of the site to Hartford Hospital ensures its accessibility to both patients and professional volunteers.

Safety Concerns for the CMFHC

La Casa and CMFHC share a common entryway, but have separate entrances into their respective offices. Security has not been a significant problem for La Casa, and so is not expected to affect the CMFHC. Security systems and guards will be used if necessary.

Clinic Structure and Ownership for the CMFHC

For CMFHC, Phase One will be a walk-in free clinic at La Casa, a permanent site. Walk-in free clinics are relatively simple to manage because of their small size and limited services. Moreover, the arduous process of collecting payments is not an
issue at free clinics. Patients know the focus is on them, regardless of their ability to pay.

Phase Two is a sliding scale clinic (SSC), which, compared to a free clinic, has advantages and disadvantages. One suggested advantage of SSCs is that a percentage of patients who pay for the care they receive more greatly value the treatment and remain adherent to the prescribed medications, and that patient fees are necessary to ensure the sustainability of treatment programs. It is further argued that SSCs tend to instill in patients a sense of financial responsibility and pride. On the other hand, several studies have indicated that for certain diseases, such as HIV, adherence rates to medications are improved when the medications are provided free of charge.

A second advantage is that SSCs generate revenue for the clinic and thereby decrease the burden of relying on external funding sources. A disadvantage of sliding scales is that patients are asked to divulge personal, oftentimes unverifiable financial information in order to determine the amount they are to pay for services provided.

Transition from Phase One to Phase Two is partly dependent upon the Committee’s willingness and ability to make a decision regarding what to do about outstanding balances. Table 17, adapted from the Health Resources Services Administration website, lists a number of questions that should be addressed prior to opening or transitioning to an SSC.
Table 17. Questions to be Asked Prior to Opening or Transitioning to a Sliding Scale Clinic

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Should it set up payment plans, insist on full payment, or write off balances?</td>
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<tr>
<td>Write them off? Other related questions include:</td>
</tr>
<tr>
<td>When and how should patients hear about sliding fee scales?</td>
</tr>
<tr>
<td>Does the committee prefer/recommend a system that addresses payment issues before or after treatment?</td>
</tr>
<tr>
<td>How does the committee decide what is appropriate and affordable?</td>
</tr>
<tr>
<td>Should verification of income be required? How often?</td>
</tr>
<tr>
<td>Has there been community dialogue about what is affordable?</td>
</tr>
</tbody>
</table>

While different clinics’ answers to these questions are highly variable, they have definite consequences and set the tone for the clinic. One philosophy is that the clinic should play a role in teaching patients about financial and personal responsibility, which will then theoretically spill over into other areas in the lives (this model assumes a lack of either or both qualities in the first place, which may or may not be accurate). Another philosophy is that these underserved patients have been neglected and looked down upon for most of their lives, and that they need to be lavished with the care and attention they inherently deserve as persons with human dignity.

These models are not mutually exclusive; a delicate balance exists between them. While the CMFHC acknowledges that the type of service provided dictates whether charging a sliding scale fee or offering treatments free of charge is most effective, it has not yet answered these questions and balanced patient responsibility with charity. The CMFHC does espouse a “both-and” approach as opposed to an “either-or” philosophy to this particular issue: it hopes both to foster responsibility in its patients and at the same time not to take on a paternalistic role.
Volunteer Recruitment for the CMFHC

Sustainability of CMFHC is dependent on its ability to fundraise and recruit volunteers, which in turn will dictate the hours of operation. The committee has created a list of health care professionals whom they believe would be committed to the mission statement, and will invite them to participate.

It is CMFHC’s hope that patients will partner with CMFHC by contributing to it with their time, treasure and talent. In Chicago, much of LCHC was built, cared for and cleaned by the community, which did not have the finances to hire others to complete these jobs. LCHC has become a source of pride and achievement by all who have been touched by and benefited from it.

CMFHC does not anticipate having difficulties recruiting patients to the clinic. Its relationship with La Casa avails it to many potential patients. Other patient recruitment methods include informing local churches and other houses of worship, posting fliers, and informing local emergency departments, which can direct patients to the CMFHC for future healthcare needs.

Fundraising for the CMFHC

Sustainability is the bottom line of fundraising. Free clinics are dependent on external funding even though they are allowed to accept contributions from patients who would like to give to the clinic’s general fund, as allowed by the Free Clinic Federal Tort Claims Act (FTCA, as described in the Legal Issues section below).

Ideally, external funds are donated in a long term (or renewable) commitment established between donors and the clinic. Shepherd’s Hope’s three-way partnership is sustainable because the church, school and hospital all contribute their assets
(volunteers and funding, physical space, and diagnostic services, respectively) to cover the clinics needs. This system is highly sustainable. If more volunteers are needed, another church can be called on to donate its assets, and so on.

Fundraising is one of the most challenging aspects of opening a free clinic. As a result, it has been suggested that Board Members lead by example and be the first to contribute sacrificially, and to communicate with family members, friends, and others through phone calls, letters and in person about the organization’s mission and vision. Eventually, Board Members should specifically ask their contacts if they are interested in contributing financially to the cause and follow up with them.

The president of CMFHC has met with various private faith-based foundations and philanthropists, discussed its mission and vision, and applied for grants. Currently, CMFHC receives support from several financially secure Hartford-area churches, has made arrangements with Hartford’s Aetna Insurance Corporation to supply furniture, and has received cash and non-cash pledges from other charitable organizations.

Medical-Legal Issues for the CMFHC

The complexity of medical-legal issues demands the expertise of professional counsel. Organizations that provide free legal consultation to non-profit organizations exist in many cities. The Connecticut Urban Legal Initiative (CULI), a Hartford-based non-profit organization affiliated with the University of Connecticut School of Law, is one such organization. The CMFHC has discussed its goals with CULI, which has agreed to assist CMFHC with its legal concerns.
CMFHC anticipates using a system like South Park’s which will allow the clinic to run helpful reports on a number of variables (e.g. numbers of patient visits, conditions treated, medications used etc). A system that quantifies outcomes such as blood pressure, glycosylated hemoglobin (known as A1C scores) for diabetics, asthma exacerbations and associated hospitalizations, and other commonly occurring illnesses will also be sought. The data can be used to implement quality improvement controls, where necessary, and to demonstrate to potential donors that the clinic is providing quality medical care.

Quality Control for the CMFHC

Patient satisfaction surveys will be used to obtain patients’ feedback and suggestions. The data from these surveys can also serve as quality control measures, and favorable data can be used to recruit other donors and volunteers.

Lastly, in agreement with its vision to educate patients and caregivers, the CMFHC plans to have physicians, residents, and students who rotate through the clinic evaluated with pre- and post-tests to determine their skill at eliciting faith-based histories and addressing related needs. Students, residents, and physicians with experience in caring for people’s spiritual needs will learn from one another, will have journal clubs and read related articles. The CMFHC will also invite physicians skilled at eliciting faith histories and caring for patients’ faith-related needs for workshops and lectures. It is a desire of the CMFHC to research and publish articles pertaining to the role of faith in medicine.
The CMFHC: What Else Needs to be Done?

Community Networking

CMF needs to make greater inroads in the local community and begin the process of developing trust among the people it intends to serve. One strategy of doing so is to invite community members to join the steering committee as soon as possible. The purpose of the steering committee is to guide and direct the day-to-day activities of the health center, determine what services it will provide (based on the community’s needs), and to recruit volunteers to care for, clean and take ownership of the facility. The LCHC epitomizes the impact a committed community can have on a cause.

Transitioning from Phase One to Phase Two

The circumstances under which the CMFHC should transition from Phase One to Phase Two, or whether it should transition at all, also need to be determined. Answers to the questions in Table 17 will likely be made once the community accepts the purpose of the CMFHC and takes ownership of it.

Sustainability

The sustainability of the CMFHC is dependent on several factors: the recruitment of volunteers (physicians, residents, students, nurses, front office, pastoral counselors and others), procurement of funds through donors and grants, and the willingness of the community to take ownership of the health center. The CMFHC must make necessary adjustments and compromises for these critical factors to be established.
Conclusion

The CMFHC has taken many forward steps forward in its goal of opening a proactive faith-based medical center in Hartford. Eager physicians have been recruited, a site has been obtained, negotiations with potential donors are being conducted, and applications for licensure are being filed with appropriate authorities. It is the hope and prayer of the CMFHC Committee, the CMF Board of Directors, and many physicians and students who have expressed interest in this project that the blessings bestowed on those involved overflow into the lives of the underserved in Hartford. It is appropriate that this thesis conclude with two quotations from Jesus, as recorded in two of the Gospels, Luke 12:48 and Mathew 25:40: "From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked" and "I tell you the truth, whatever you did for one of the least of these brothers and sisters of mine, you did for me."
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