Article

A call to promote healthcare justice: A summary of integrated outpatient clinics exemplifying principles of Catholic social teaching

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There is an urgent need to promote healthcare justice for patients as well as members of the healthcare team including physicians. In this article, we explain how principles of Catholic social teaching (i.e., dignity of the individual, common good, destination of goods, solidarity, and subsidiarity) are applied to health care, by featuring various types of outpatient clinics including free, charitable—direct primary care, hybrid, federally qualified health center, and rural health clinic. We describe how attempts have been made to improve the quality and access of health care by creating new medical schools (i.e., Marian University College of Osteopathic Medicine) and training programs as well as allocating government funding to alleviate the cost of training new healthcare providers through the National Health Service Corps. Finally, we suggest a few approaches (i.e., adopting new clinic models to include volunteer healthcare professionals and cross-training members of the healthcare team) to fill in current gaps in health care.

Summary: There is a need to promote justice in healthcare. In this article, we explain how principles of Catholic social teaching are applied to health care. To illustrate this, we feature various types of outpatient clinics. We also describe how attempts have been made to improve the quality and access of health care. Finally, we suggest further ways to improve healthcare reform based upon Catholic social teaching.

Keywords: Catholic Social Teaching (CST), Right to healthcare, Free clinic, Charitable direct primary care clinic (cDPC), Hybrid clinic, Federally Qualified Health Center (FQHC), Rural health clinic, National Health Service Corps (NHSC)

INTRODUCTION

There is a need to provide more adequate health care to underserved populations in the USA, especially in rural areas. In May 2017, the Marian University College of Osteopathic Medicine (Indianapolis, IN) will graduate its inaugural class of osteopathic physicians who have been educated, in part, with a focus on addressing the

shortage of primary care physicians for underserved populations. As a Catholic medical institution built on the vision and values of our Franciscan heritage—dignity of the individual, peace and justice, responsible stewardship, and reconciliation—our mission is to promote the complete healing of individuals' bodies, minds, and spirits, especially in service of the people of Indiana.

In line with Catholic social teaching (CST), as well as documents promulgated by the United States Conference of Catholic Bishops (USCCB) and the Catholic Health Association (CHA), Catholic physicians and healthcare institutions are obligated to utilize resources at their disposal to address the medical needs of all, with a preferential consideration for the poor and vulnerable. There is not; however, any one model of healthcare delivery that is specifically recommended by CST. Hence, we seek to devise novel delivery systems utilizing different types of institutional models, mission foci, and financial structures. In this article, we will explore how various types of clinics — mostly in Indiana — have fulfilled the moral obligation to meet the healthcare needs of all in line with CST. We will also suggest creative ways for future efforts to promote healthcare justice for all, such as an expansion of National Health Service Corps (NHSC)-approved sites for full medical scholarships, increased loan repayment for future healthcare providers in underserved areas, and the creation of training workshops to assist start-up clinics that support CST.

CATHOLIC SOCIAL TEACHING

When viewing health care through the lens of CST, it ought to be emphasized that there should not be one standard model of healthcare delivery; rather, each system or institutional provider should follow a set of guidelines that promote the common good, while having the flexibility to meet the specific needs of each community. That set of guidelines must be based above all on the theological virtue of love, for love is the “highest and universal criterion of the whole of social ethics” (Pontifical Council for Justice and Peace 2004, no. 204). Furthermore, Scripture

continually underlines love as the greatest commandment:

“You shall love the Lord your God with all your heart, with all your soul, with all your mind, and with all your strength.” The second is this: “You shall love your neighbor as yourself.” There is no other commandment greater than these. (Mk 12:30–31)

Through this commandment, humanity is called to cultivate a civilization of love, “for love is the only force that can lead to personal and social perfection” (Pontifical Council for Justice and Peace 2004, no. 580). This civilization of love cannot be achieved unless it is “based on the respect of the transcendent dignity of the human person” (Pontifical Council for Justice and Peace 2004, no. 132). Furthermore, each person must be considered “without exception as another self, taking into account first of all his life and the means necessary for living it with dignity” (Vatican Council II 1965, no. 27). To live with dignity, each individual should have the opportunity to reach his or her fullest potential in society. Additionally, health care should be patient-centered, allowing everyone to be an active participant in his or her own health. While each person is responsible for his or her own growth and flourishing, he or she must also work with the community to promote the dignity of all human beings. In this sense, the dignity of the individual serves as the foundation upon which each of the other principles of the Church’s social doctrine is built, especially the common good, the universal destination of goods, solidarity, and subsidiarity (Pontifical Council for Justice and Peace 2004, no. 160).

CST defines the *common good* as “the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily” (Vatican Council II 1965,

26). For humanity to achieve this fulfillment, the common good requires a set of demands to be met, including education, employment, the commitment to peace, and access to basic health care (Pontifical Council for Justice and Peace 2004, no. 166). Participating in society is considered both a right and a duty. When illness prevents individuals from doing so, the pursuit of attaining the greatest common good is hindered; therefore, health care should be equally accessible to each human person, allowing for the flourishing of society as a whole (Catholic Health Association 2007). This is reinforced through the principle of the *universal destination of goods*.

The Church proclaims that the goods of God's creation are meant to be shared equitably amongst all humankind. However, this does not mean that "everything is at the disposal of each person or of all people," nor does it abolish private property; rather, it requires that "ownership of goods be equally accessible to all" so that each person may "have access to the level of well-being necessary for his full development" (Pontifical Council for Justice and Peace 2004, nos. 172–3, 176). The universal destination of goods asserts that humanity should focus on removing the barriers that inhibit the growth of the most vulnerable of society, the poor and marginalized, through the practice of Christian charity. This includes "the hungry, the needy, the homeless, those without health care and, above all, those without hope of a better future" (Pontifical Council for Justice and Peace 2004, no. 182). In this regard, healthcare systems have a duty to protect the needs of the poor and vulnerable by providing care to, and advocating for, underserved populations, putting into practice the virtue of *solidarity*.

Solidarity is described by Pope St. John Paul II as "a firm and persevering

determination to commit oneself to the common good. That is to say to the good of all and of each individual, because we are all responsible for all" (John Paul 1988, no. 38). He continues:

In the light of faith, solidarity seeks to go beyond itself, to take on the specifically Christian dimensions of total gratuity, forgiveness and reconciliation. One's neighbor is then not only a human being with his or her own rights and a fundamental equality with everyone else, but becomes the living image of God the Father, redeemed by the blood of Jesus Christ and placed under the permanent action of the Holy Spirit. One's neighbor must therefore be loved, even if an enemy, with the same love with which the Lord loves him or her; and for that person's sake one must be ready for sacrifice, even the ultimate one: to lay down one's life for the brethren. (John Paul 1988, no. 40)

Humanity pursues the virtue of solidarity when each person is cared for by the others purely out of love and charity. In this sense, both solidarity and charity are necessary to help society strive for the common good. This goal can be more readily pursued through health care that is equally accessible to all persons regardless of socioeconomic status, race, ethnicity, gender, or existing health conditions. Additionally, the quality of health care should not be dependent on these factors. For this to occur, healthcare providers, charitable organizations, and the government must collaborate to work towards the greatest good. As this collaboration strives for the common good, it is necessary that it adheres to the principle of subsidiarity.

Subsidiarity states that political decisions and matters should be handled by the lowest (most local) social entity that can "properly perform the functions that fall to them without being required to

hand them over unjustly to other social entities of a higher level” (Pontifical Council for Justice and Peace 2004, no. 186). This ensures that each individual is granted the opportunity to contribute to and fulfill his or her duty to participate in his or her community. Additionally, it allows the specific needs of each community to be met more fully by providing flexibility rather than imposing a singular societal structure.

HEALTH CARE AS A SOCIAL GOOD

It is with the above principles of CST in mind that the U.S. bishops (USCCB 2010) and the CHA, as well as the Catholic Medical Association, the National Catholic Bioethics Center, and a host of individual Catholic healthcare workers, moral theologians, and bioethicists, have sought to define specific guidelines for continual healthcare reform within the U.S. in order to promote the common good mandate of equitable access to quality healthcare services for all. The CHA (1992, 2007), for example, asserts that all human persons have a fundamental “right to basic and comprehensive health care.” They also emphasize the CST principle that there be a “preferential option for the poor.” The USCCB (1981, 1993) also acknowledges the need for greater *economic efficiency* in the healthcare system. The CHA recommends promoting “the efficient and cost-effective use of facilities, equipment and services while minimizing unnecessary administrative expenses; be highly efficient, avoiding waste or mismanagement of financial, material and human resources” and to “not spend resources on care that medical judgment determines to be futile” (CHA 2007). This aligns with the Franciscan value of “responsible stewardship” that characterizes the mission of Marian University and,

as we will see below, is operationalized in the management of medical and financial resources in the various types of clinics described. The complementary principles of *individual and social responsibility* are reflected in the CHA’s further recommendation that the financial burden of providing essential healthcare services be “fairly and equitably” distributed “among all members of society, not unjustly allocating that burden to any selected element including employers, providers and individuals.” (CHA 2007). *Quality health care* is also emphasized by the CHA’s recommendations to “standardize the use of information technology throughout the health care system to improve clinical coordination and reduce medical errors” and to “expand evidence-based medicine to improve safety and continually improve outcomes,” as well as to “prioritize patient safety by minimizing the systemic causes of errors” (CHA 2007). We will show below how various types of clinics have sought to provide quality health care in service to the poor and vulnerable by means of the responsible stewardship of resources in line with their mission.

The CHA and USCCB’s parallel calls for an efficient healthcare system to deliver quality care to all human persons, especially the poor and vulnerable, reflects the “consistent ethic of life” promoted by the late Joseph Cardinal Bernardin, who contends that ethical consistency requires that those who defend an inviolable “right to life” cannot stop their moral concern at birth but must equally emphasize the need to promote “quality of life,” especially for “the powerless among us” (Bernardin 2008, 79). Fulfilling this moral mandate requires us to recognize that, while healthcare resources in the U.S. are limited, they are by no means *scarce* (excepting certain resources such as vital organs for transplant); Bernardin thus diagnoses the basic problem of healthcare access in the U.S. as

“managerial” (Bernardin 2008, 82). This is where the complementary CST principles of *solidarity*, *stewardship*, and *subsidiarity* come into play insofar as the responsibility for ensuring healthcare access for all is incumbent upon all members of society: as individuals who are the primary stewards of our own health, as healthcare professionals to find ways of delivering health care to all through creative local means in accord with subsidiarity, and on the part of government when more local efforts fail and there is a need, based on solidarity, to redistribute state and national resources to fulfill this requirement of the common good (Bernardin 2008, 224–5).

At this point, the question arises of whether the principles of CST entail that healthcare access be recognized as a fundamental *right* or whether it is some other type of good that nevertheless makes moral demands upon individuals and society as a whole. We do not need to take a formal position on this vexed question for the purposes of this paper; although one of us has argued previously in favor of there being a natural right to health care (Eberl et al. 2011). At the very least, CST requires that we view health care as an essential *social good*, which merits the investment of public resources just as we invest in police, military, and fire protection; safety in road, sea, and air travel; and clean drinking water (Craig 2014).

Although Cardinal Bernardin (2008, 224) denotes the common good to mandate a “right to health care,” as explicitly affirmed in Pope St. John XXIII’s encyclical *Pacem in terris* (John 1963, 11), the fulfillment of such a right does not entail any particular model for ensuring healthcare access and delivery. Bernardin stresses only that such a system must provide for *universal coverage* that is both *person-centered* and *community-based* (Bernardin 2008, 244); hence, “no system

of health care is an end in itself” (Bernardin 2008, 277). The broadly stated values that Bernardin recommends to guide any model for healthcare delivery within a morally just system are as follows:

- (1) Health care must be a service.
- (2) The common good must be served.
- (3) The needs of the poor must have special priority.
- (4) There must be responsible stewardship of resources.
- (5) Health care should be provided at appropriate levels of organization (Bernardin 2008, 277–8).

It is with this background—particularly the fifth value—in mind that we will explore various practical examples of healthcare providers fulfilling the common good mandate to provide services primarily to the poor and vulnerable at local levels.

MODELS OF HEALTHCARE DELIVERY

There are various models of healthcare delivery that have been created which exemplify principles of CST (Table 1). Most of these charitable clinics, including other outstanding clinics not featured in this summary, are initiated by concerned individuals who have noticed a significant healthcare need especially for the poor and vulnerable in their local community. Often, this is precipitated by socioeconomic factors such as employment status (e.g., economic recession decreasing job opportunities, the influx of immigrant workers due to increasing job opportunities, etc.). Prior to the implementation of the Patient Protection and Affordable Care Act (PPACA), which expanded Medicaid coverage to individuals with a household income less than 133 percent of the federal poverty level, there existed a large group of working people who did not qualify for employer-based health

Table 1 *Examples of healthcare clinics that exemplify Catholic social teaching*

Model	Name (Website)	City, State	Created	Funding sources ^a	Employees: volunteers	Services ^b	Estimated annual visits
Free	Matthew 25, Inc. (www.matthew25online.org) ^c	Fort Wayne, IN	1976	FD, FR, H, D, C, I, Ho, O	34:446	M, PAP, D, V, PT, ENT, U, WH, Pod, Derm, Pain M, Cardio, Pulm, L, X	20,712
	Gennesaret Free Clinics (www.gennesaret.org) ^d	Indianapolis, IN	1988	G, D, FR, I	15:220	M, C, D, V, S, Mobile, HC	6,632
	St. Clare Clinic (www.franciscanalliance.org/hospitals/crownpoint/about/st-clare-health-clinic/pages/default.aspx) ^e	Crown Point, IN	1996	Not available	7:19	M, PAP	5,001
	Trinity Free Clinic (www.trinityfreeclinic.org) ^f	Carmel, IN	2000	D, FD, FR, GovP, H	9:515	M, PAP, D, V, WH, Pod, SS, CS, Read	4,678
Charitable - Direct Primary Care (cDPC)	St. Luke's Family Practice (www.stlukesfp.org) ^g	Modesto, CA	2003	B, D, G	4	M, PAP, +	4,800
	Our Lady of Hope Clinic (www.ourladyofhopeclinic.org) ^h	Madison, WI	2009	B, D, FD, NaPro	4:35	M, PAP, NFP, +	1,068
	St. Joseph Primary Care (www.stjosephprimarycare.org) ⁱ	Raleigh, NC	2014	B, D, C	2:2	M, PAP, +	600
Hybrid	Church Health Center (www.churchhealthcenter.org) ^j	Memphis, TN	1987	G, Gi, Contr, PS, G, FR	17:1,000	M, BH, C, D, V, PT, Ed, W, O	105,000
	Neighborhood Health Center (www.franciscanalliance.org/hospitals/indianapolis/services/pcp/pages/neighborhood-health-center.aspx)	Indianapolis, IN	1990s	Not available	Not available	M, C, D, WH, Mobile, SS, BABE, Legal	Not available
	Simon Primary Care Clinic (www.stvincent.org/St-Vincent-Indianapolis/Events-And-Programs/Joshua-Max-Simon-Primary-Care-Center.aspx)	Indianapolis, IN	2007	Not available	Not available	M, C, WH, Surg, Derm, Cardio, SM, Pod, Rads, Pharm, L, X	Not available
Federally Qualified Health Center	Raphael Health Center (www.raphaelhc.org) ^k	Indianapolis, IN	1994	PS, R	9	M, BH, C, D, SS, Mobile, Garden	6,000
	Wabash Valley Health Center (www.wabashvalleyhealthcenter.org) ^l	Terre Haute, IN	1997	PS, R	4	M, BH, D, SS, PAP, O	9,295

Continued

Table 1 *Continued*

Model	Name (Website)	City, State	Created	Funding sources ^a	Employees: volunteers	Services ^b	Estimated annual visits
Rural Health Clinic	Tutwiler Clinic (tutwilerclinic.org)	Tutwiler, MS	1983	Not available	28	M, OMM, PAP, C, D, V, L, X, Trans	7,289

^aB = Benefactors, C = Churches, Contr = Contributions, FD = Foundations, FR = Fundraising, G = Grants, Gi = Gifts, GovP = Government programs, H = Hospitals, Ho = Honorariums, I = Investments, NaPro = NaPro Technologies, O = Organizations, PS = Patient/program services.

^bBABE = Beds and Britches, Etc. store, BH = Behavioral health, C = Counseling, Cardio = Cardiology, CS = Car seat program, D = Dental, Derm = Dermatology, Ed = Preschool, ENT = Ear, nose, throat, Garden = Garden on the Go (mobile farmer's market), HC = Homeless Care, L = Labs, Legal = Christian legal clinic, M = Medical, Mobile = Mobile unit, NFP = Natural family planning, O = Outreach, OMM = Osteopathic manual medicine, Pain M = Pain management, PAP = Patient Assistance Program (medications), Pharm = Pharmacy, Pod = Podiatry, PT = Physical therapy, Pulm = Pulmonary, Rads = Radiology, Read = Reach Out and Read Program, S = Screening for cancer, SM = Sports medicine, SS = Social services, Surg = Surgery, Trans = Transportation, U = Urology, V = Vision, W = Wellness, WH = Women's health, X = X-rays, + = additional DPC services.

^cMatthew 25 Health & Dental Clinic (2015); ^dGennesaret Free Clinic (2015); ^eMallers (2016); ^fTrinity Free Clinic (2014); ^gForester (2016); ^hJenson (2016); ⁱLe (2016a, 2016b), St. Joseph Primary Care, Inc. (2015), and St. Joseph's Primary Care (2016); ^jChurch Health Center (2014) and Mills (2015); ^kRaphael Health Center (2015); ^lWabash Valley Health Center (2015).

Note: The data included above are what each clinic was able to provide for this publication. It is based on clinic annual reports, website information, and specific questions directly answered by these organizations.

insurance due to reduced work hours, seasonal employment, and/or pre-existing health conditions. Yet, these individuals also did not qualify for government-based health insurance (i.e., Medicaid or Medicare) due to higher income status or age. As a result, there were large gaps in healthcare coverage in certain communities. After the PPACA was signed into law (March 23, 2010), approximately thirty-two states adopted a Medicaid expansion (including Indiana) that effectively filled in certain gaps in healthcare coverage. As such, several free clinics converted to federally qualified health centers (e.g., St. Ann Clinic —Wabash Valley Health Center in Terre Haute, IN) in order to accommodate the influx of new patients with Medicaid insurance, as well as to expand patient services to include primary care and behavioral health. However, other free clinics were unable to maintain their patient base and financial contributions, and were therefore subsequently discontinued. Simultaneously, there has been a national effort to reduce the shortage of primary care providers by training more physicians (i.e., creating more medical schools and residency programs) and allocating additional government funding to the National Health Service Corps program by providing medical scholarships or loan repayment for primary care providers in medically underserved areas. While these efforts have filled gaps of healthcare coverage in certain communities, there are still underinsured patients in places that rely substantially on charitable clinics.

Recently, many certified primary care clinics have adopted innovative healthcare models such as the Patient-Centered Medical Home (PCMH).

As of October 2, 2016, the Patient-Centered Primary Care Collaborative listed on its website that the PCMH was

developed in 2007 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association and that this model emphasizes patient-centric, cost-effective, high-quality, evidence-based primary care. (PCPCC n.d.)

Due to resource constraints, early adopters were primarily large clinical organizations (with at least 140 physicians) that possessed the capital and infrastructure to adopt new-model practices (e.g., advanced electronic medical records), payment reform (e.g., replacing fee-for-service with a blended payment model), and improved care-coordination (Rittenhouse and Shortell 2009). Following the enactment of the PPACA in 2010, however, additional grant programs and funding opportunities were developed to promote this new concept of healthcare delivery (e.g., Patient -Centered Medical Home—Facility Improvement Grant Program).

As of October 2, 2016, the Patient-Centered Primary Care Collaborative listed on its website that multiple federal agencies, 42 state Medicaid programs, dozens of health plans, hundreds of safety net clinics, and thousands of US clinical practices are considered “medical homes.” (PCPCC n.d.)

In addition to ameliorating primary care practices, these clinics have sought to improve upon behavioral health delivery for conditions such as depression and anxiety (Maurer 2009a). Despite this seismic shift to a more whole-patient approach to care, medical providers have been called to further strengthen their behavioral health efforts to better identify and treat serious mental illnesses such as schizophrenia (Maurer 2009a). Thus, integrated primary care practices are encouraged to offer more full-scope

behavioral health services to all people in the community. Such clinics may acquire an additional certification as a *Person-Centered Healthcare Home* if they meet the following components (Maurer 2009b):

- (1) Regular screening and registry tracking/outcome measurement at the time of psychiatric visits.
- (2) Medical nurse practitioners / primary care physicians located in behavioral health.
- (3) A primary care supervising physician.
- (4) An embedded nurse care manager.
- (5) Evidence-based practices to improve the health status of the population with serious mental illnesses.
- (6) Wellness programs

Under this whole-person model, participants are encouraged to adopt a bidirectional approach to physical and emotional health. Specifically, clinics should provide behavioral health services to their primary care patients in need, while providing their behavioral health patients access to critical primary care services (Maurer 2009b). To acquire the integrated services necessary for these patient- or person-centric approaches, clinics may seek funding through donors and grants (e.g., federally qualified health center reimbursement, Center for Medicare and Medicaid Innovation, etc.).

Moreover, there is also a standard framework for levels of health care beginning with coordinated care (Levels 1–2), co-located care (Levels 3–4), and integrated care (Levels 5–6) (Heath and Reynolds 2013):

- (1) Minimal Collaboration: Behavioral health and primary care providers work at separate facilities and have separate systems.
- (2) Basic Collaboration at a Distance: Behavioral health and primary care

providers maintain separate facilities and systems, but periodically communicate about shared patients.

- (3) Basic Collaboration Onsite: Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space.
- (4) Close Collaboration with Some System Integration: There is closer collaboration among primary care and behavioral healthcare providers due to collocation in the same practice space, and there is the beginning of integration in care through some shared systems.
- (5) Close Collaboration Approaching an Integrated Practice: There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a team, with frequent communication.
- (6) Full Collaboration in a Transformed / Merged Practice: The highest level of integration involves the greatest amount of practice change. The operation as a single health system treating the whole person is applied to all patients, not just targeted groups.

Free medical clinics

According to the National Association of Free and Charitable Clinics,

Free and Charitable Clinics are safety-net health care organizations that utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision, and/or behavioral health services to economically disadvantaged individuals. Such clinics are either 501(c)(3) tax-exempt organizations or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal/sliding fee to patients, may still be considered Free or Charitable Clinics

provided essential services are delivered regardless of the patient's ability to pay. Free or charitable clinics restrict eligibility for their services to individuals who are uninsured, underinsured and/or have limited or no access to primary, specialty or prescription health care.

Examples of services provided are primary medical care, physicals, wellness exams, testing, chronic disease care and management, dental care, behavioral/mental health care, vision, other specialty care, care coordination, women's health care, health education, smoking cessation, health navigation, immunizations, pharmacy services/medication access (Table 1). As indicated in Table 1, it is important to consider how these clinics offer comprehensive services for providing holistic health care in a cost-effective manner (i.e., number of employees and volunteers that serve the number of annual patient visits).

Charitable—direct primary care clinics

Charitable clinics provide essential services regardless of the patient's ability to pay. Charitable - Direct Primary Care (cDPC) clinics accomplish this by providing services to those who pay a direct membership fee for enhanced services (termed "benefactors/supporters"). These benefactors/supporters, in turn, financially support the free services provided to uninsured/recipients. These 501(c)(3) clinics are unique in that they do not bill third-party insurance organizations (e.g., Medicaid/Medicare/TRICARE, private, etc.), and, if necessary they may further subsidize their care through private donations (Table 2). In this model, no cDPC is the same, as they vary on annual benefactor prices, recipient criteria, and services provided. To the best of the authors' knowledge, the first Catholic cDPC (St. Luke's Primary Care, Modesto, CA) was created in 2003 by Drs. Robert Forester and R.J. Heck (Forester

2008). St. Luke's accepts all patients who meet criteria for charity care (Robert Forester, pers. comm.). Further, Dr. Forester noted that he believed the greatest asset of his clinic was the significant quantity of time for patient visits (>30 minutes) as well as the high quality of care since clinical decision making is not influenced by third-party insurance policies. Also, St. Joseph Primary Care (Raleigh, NC) takes recipients that are recommended by local clergy (Peter Le, pers. comm.).

Hybrid clinics

A hybrid clinic is a charitable clinic that uses a sliding-fee scale and also accepts public or private insurance. It is not a federally qualified health center (FQHC) or a look-a-like clinic. As previously mentioned, some free and charitable clinics converted to a hybrid or FQHC model following the implementation of PPACA when many of their patients acquired Medicaid or private insurance.

Federally qualified health centers

A federally qualified health center may include community health centers, migrant health centers, health care for the homeless programs, and public housing primary care programs. They may be private or public non-profit organizations that treat anyone regardless of ability to pay using a sliding-fee scale and receive federal funding under Section 330 of the Public Health Service Act. Look-alike health centers meet similar standards but do not receive federal funding.

Rural health clinics

A federally certified rural health clinic may be public or private, for-profit or non-

Table 2 Financial information for healthcare clinics that exemplify Catholic social teaching

Model	Name	Annual revenue FY 2015 (\$)	Funding sources (%)	Examples ^a	Annual expenses FY 2015 (\$)	Expenditures (%)
Free	Matthew 25, Inc. ^b	2,159,883	Foundations (54.1) Fundraisers (16.5)	– –	2,090,891	Personnel (68.3) Screening, Supplies, Medications (15.7) Rent (4.0)
			Hospitals and PHPs (15.8) Other revenue (.8)	– RoHC		Administrative costs (3.8)
			Churches, Investments, Honorariums, Organizations (12.84)	–		Fundraising, System maintenance, Dental lab equipment (8.36)
	Gennesaret Free Clinic ^c	1,475,235	Grants (47) In Kind Donations (19.9)	LH, LF, SGK TGH, CSP, LHD, LC, LI/F LI/F, RoHC	1,404,210	Patient services (82.3) Management (15.5)
			Private donations (16.7) Fundraisers (7.2)	– –		Fundraising (2.2)
			Investments, Other Income, Restricted Donations (9.1)	–		
	St. Clare Clinic ^d	375,005 ^e	–	–	526,217	–
	Trinity Free Clinic ^e	1,000,000 ^g	Private donations (34) Foundations (23)	RoHC, UW FF, RLF, EFF, CICF	Not available	Patient services (87) Fundraising (8)
			Fundraising (14) Government programs (13)	– LHB		Administrative costs (5)
			Hospitals (13) Private foundations (3)	LH –		
	St. Luke's Family Practice ^h	~1,000,000	Benefactors (80)	–	~1,000,000	Wages
			Private donations and grants (20)	RD		Rent IT Electronic health records
Charitable Direct Primary Care	Our Lady of Hope ⁱ	160,342	Benefactors (33.4) Private donations (30.5) Foundations (25.4)	– LCO, LH, LC KOC	153,163	– – – –
			Recipient donations, NaPro technologies (10.7) ^j	–		
	St. Joseph's ^k	62,026	Benefactors (52.1)	–	48,920	Rent, Utilities, Maintenance (69.4)
			Private donations (17.5) Catholic churches (13.1)	– LC		Employee benefits/wages (19.4)
			Lab fees, Flu shots, Recipient donations (17.4)			Other (11.2)

Continued

Table 2 Continued

Model	Name	Annual revenue FY 2015 (\$)	Funding sources (%)	Examples ^a	Annual expenses FY 2015 (\$)	Expenditures (%)
Federally Qualified Health Center	Raphael Health Center ^l	4,495,557	Patient services (53.4)	MR, MD, In, UIn	4,345,313	Wages (65)
			Federal grants (33.9)	–		Other (20.8)
			State grants (5.3)	–		Employee benefits (9)
	Wabash Valley Health Center ^m	1,845,000	Other revenue (7.4) HRSA federal grants (49) Patient services (26)	PD – MR, MD, In, UIn	Not available	Payroll taxes (5.2)
			Community grants (25)	–		–
Rural Health Clinic	Tutwiler Clinic	2,044,245.83	–	–	2,187,045.73	–
Hybrid	Church Health Center ⁿ	27,844,447 ^g	Contributions, Gifts, Grants (79.2)	–	20,030,037 ^g	Program services (89.3)
			Program services (15)	–		Fundraising (7.3)
			Government grants (2.9)	–		Management (3.5)
			Fundraising (.7)	–		
			Other revenue (2.2)	–		

Note: The data included above are what each clinic was able to provide for this publication. It is based on annual reports, 990 forms, and specific questions directly answered by these organizations. Any pertinent examples of funding sources are listed above to raise awareness of future funding for readers. Most examples for foundations, grants, donations, etc. are from local organizations, individuals/families, local churches, or small businesses, and were not included since these are only applicable to specific states, dioceses, counties, or towns.

^aCICF = Central Indiana Community Foundation, CSP = Cub Scout Pack, FF = Fairbank Foundation, In = Insurance, KOC = Knights of Columbus, LC = Local churches, LCO = Local Catholic organizations, LF = Local foundation, LH = Local hospital, LHB = Local health board, LHD = Local Health department, LL/F = Local individuals/families, MD = Medicaid, MR = Medicare, PD = Private donations, RD = Recipient donations, RLF = Ruth Lilly Foundation, RoHC = Recipients of healthcare service, SGK = Susan G. Komen for the Cure, TGH = Timmy Global Health, UIn = Uninsured, UW = United Way

^bMatthew 25 Health & Dental Clinic (2015); ^cGennesaret Free Clinic (2015); ^dMallers (2016); ^eIn kind donations; ^fTrinity Free Clinic (2014); ^g2014 data; ^hForester (2016); ⁱJenson (2016); ^j2013 data; ^kLe (2016a, 2016b), St. Joseph Primary Care, Inc. (2015), and St. Joseph's Primary Care (2016); ^lRaphael Health Center (2015); ^mWabash Valley Health Center (2015); ⁿChurch Health Center (2014) and Mills (2015).

Table 3 Key steps for creating a charitable direct primary care in a year

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<i>Key steps for starting a charitable direct primary care (Forester, 2008):</i>											
Step 1: Set annual revenue goal.											
Step 2: Calculate number of available annual visits and estimated revenue per visit.											
Step 3: Create mission statement.											
Step 4: Establish board of directors (healthcare, business, legal, spiritual advisors).											
Step 5: Complete articles of incorporation, bylaws, and IRS, 501(c)(3) tax status.											
Step 6: Verify details of status with PPOs, Medicare, and TRICARE.											
Step 7: Develop marketing campaign.											
Step 8: Begin patient recruiting.											
Step 9: Meet with local directors of Medicaid.											
Step 10: Prepare office (building, equipment, supplies, electronic health record).											
<i>Key steps proposed for starting a charitable direct primary care with preferential option for the poor:</i>											
Step 1: Create mission statement.											
Step 2: Establish board of directors (healthcare: medical, behavioral health; business; legal; spiritual advisors).											
Step 3: Complete articles of incorporation, bylaws, and IRS, 501(c)(3) tax status.											
Step 4: Develop marketing campaign.											
Step 5: Apply for grants, donations, fundraising, gifts.											
Step 6: Meet with local directors of Medicaid and county health department to verify highest uninsured patient population.											
Step 7: Purchase and supply mobile unit to utilize for free healthcare screenings at local places serving highest uninsured patient population.											
Step 8: Calculate number of available annual visits and estimated revenue per visit utilizing a sliding-fee scale.											
Step 9: Set annual revenue goal.											
Step 10: Verify details of status with PPOs, Medicare, and TRICARE.											
Step 11: Prepare office for fully integrated healthcare.											

profit organizations that are located in nonurban, medically underserved areas. The mission of these clinics is to improve “access to primary care services in under-served rural communities and utilizing a team approach to health care delivery” (Duke 2004).

The Tutwiler Clinic in Tutwiler, Mississippi, is an example of how a physician (Sr. Anne Brooks, D.O.) may transform a rural health clinic to meet the specific needs of a local community (Brooks 1991). Sr. Brooks has been a sister of the Order of the Holy Names of Jesus and Mary since 1955. Early in her career, she was a school teacher and volunteer at the Clearwater Free Clinic, where she and another sister eventually helped create the

St. Petersburg Free Clinic. During this time, John Upledger, D.O., the founder of those clinics, encouraged Sr. Brooks to attend medical school. Thus, in 1982, with the help of a scholarship from the National Health Service Corps, she graduated from the Michigan State University College of Osteopathic Medicine. Due to her strong commitment to provide health care to the poor and vulnerable in medically underserved areas, she opened the Tutwiler Clinic in 1983. She states:

To start Osteopathic College at age 40 was frightening and challenging to someone who hated chemistry! Supportive friends and successful completion of my degree set me firmly on the road to my

goal of providing holistic care of those who are marginalized and needy. These past 33 years in the Mississippi Delta town of Tutwiler have been so fulfilling and happy! With me are 2 other religious women from different religious communities, and [an] RN Franciscan brother drives 50 miles from the next city to work here. Our apostolic calling is rooted in our prayer and common life, so necessary when illness and sadness of others' burdens can so easily become overwhelming. Our task is to enable our staff of 24 to empower people so that healing can occur in every aspect of their lives. In return we are daily nourished and inspired by our patients' faith in God and their ability to "Keep on keepin' on" (as Fannie Lou Hamer said as she risked her life in our very town to register voters way back.) It is a gift that I cherish. What would my life have been like if I had not committed it to God? (Brooks, pers. comm.)

Among all of the medical, behavioral health, and social services that the Tutwiler Clinic provides, one of the most unique aspects is their diverse partnerships throughout their community. In addition to working with Habitat for Humanity, the clinic collaborates with the local education system to sponsor local high school students to train under the supervision of a mid-level provider (e.g., a master's level nurse).

CONCLUSION

A healthcare provider pipeline that supports CST should be created to encourage people interested in medicine to become primary care providers in underserved areas. The Catholic Medical Association (CMA) website has resources to connect people to CMA physicians by location and specialty. Additionally, the website has information to match medical students to CMA physician mentors. Further, the

annual CMA Medical Student and Resident Boot Camp is a five-day intensive experience of prayer, study, practical training, and mentoring with CMA physician members. An extension of these efforts could provide additional resources for providers to establish new clinics based on CST in a similar manner as the Empowering Community Healthcare Outreach (ECHO) replication workshops offered by Church Health Center in Memphis, Tennessee. Also, the American Academy of Family Physicians sponsors various conferences that may be appropriate for offering a special entrepreneurship workshop to assist physicians (and future physicians) for creating novel clinics. This would enable resident physicians and/or physicians seeking to optimize their practice to better fulfill the healthcare needs of the poorest and most vulnerable in their local communities. Key steps followed by Dr. Forester and others as well as a proposed outline for creating a charitable, direct primary care with a preferential option for the poor is shown in Table 3.

Ideally, clinics should continue integrating primary care and behavioral health services to obtain full integration (Level 6/6) of a Person-Centered Healthcare Home (Heath and Reynolds 2013) in order to deliver high-quality, holistic care. However, this is very challenging, especially for new and smaller clinics. There are a couple of approaches that have been successful for similar clinics:

- Employees are cross-trained through continuing education to provide multiple services and to help reduce the risk of burn-out. For example, nurses may receive additional counseling education to provide primary care and/or behavioral health services.
- Volunteers, especially retired healthcare professionals, are included as providers of the healthcare team.

For example, the Church Health Center has about 1,000 volunteers that enable the healthcare organization to serve the needs of over 105,000 annual visits. One approach to do this would be to connect healthcare volunteers to integrated clinics at a local/regional level through Catholic Charities or at national and international levels through the Catholic Volunteer Network.

Additional clinics should consider whether becoming an NHSC-approved site could help encourage more students to become primary care providers to address our national shortage. For example, the NHSC builds healthy communities by supporting qualified healthcare providers dedicated to working in areas of the USA with limited access to care. Currently, 9,200 NHSC members provide care to more than 9.7 million Americans, regardless of their ability to pay. The NHSC scholarship program pays tuition, fees, other educational costs, and provides a living stipend for students studying to become primary care physicians, dentists, nurse practitioners, certified nurse-midwives, or physician assistants in return for two-year work commitment at a NHSC-approved site in a high-need, underserved area. Similarly, primary care medical, dental, and mental/behavioral health clinicians may receive up to \$50,000 towards repaying their health profession student loans in exchange for a similar two-year commitment. NHSC-approved sites are outpatient facilities providing primary care medical, dental, and/or mental and behavioral health services. These facilities may be FQHCs (auto-approved), FQHC look-alikes (auto-approved), American Indian Health Facilities (auto-approved), correctional or detention facilities, certified Rural Health Clinics, private practices (solo or group), critical access hospitals, community mental health centers, state or local health departments, community outpatient facilities (hospital- and non-hospital

affiliated), school-based clinics, mobile units, or free clinics.

As these examples, and many others not discussed here, show, there are feasible models for providing inexpensive or free health care to the poor and vulnerable that are in-line with the CST principles of promoting the dignity of each individual as an essential participant in the common good. The principles of subsidiarity and solidarity are mutually operative in these examples as local efforts—which often rely on volunteers—utilize state and federal resources in models of responsible financial stewardship to fulfill their mission to actualize the provision of healthcare services as a fundamental social good, if not a natural human right.

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