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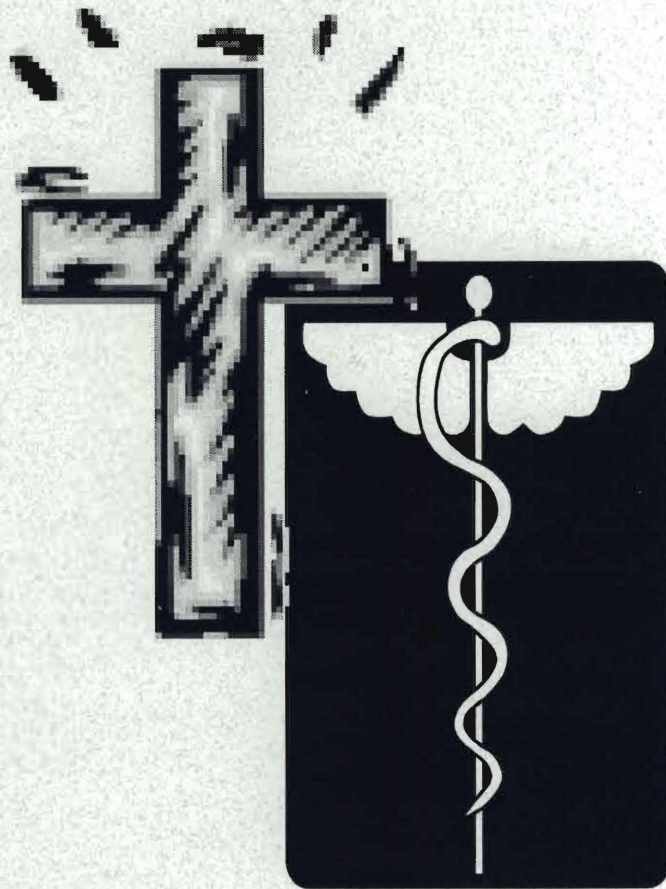
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ERIKA
MICHELSEN

Healing Ministry



2007

Preface

The information written in Chapters Two and Three of this paper was supplied to me by the generosity of InterFaith Health Clinic from whom the archives were loaned. I have much gratitude for the Medical staff, specifically Dr. McDonald who permitted the interviews of his patients and supported my interest in the clinic, and the Administrative staff who answered my questions and informed me on many aspects of the clinic and others like it. The staff and the volunteers who selflessly support the clinic are unique assets to the Knoxville community. The indigent members of this area see the giving nature humans are capable of and regain their sense of self-worth in addition to their physical health. InterFaith Health Clinic is one stride in a society of burgeoning crises that seeks to heed the word of God and care for those in need. I thank the clinic for opening their doors to me, for providing an example of the duty I have in the community, and for always being supportive in the use of their work for the focus of my Senior Project, "Healing Ministry."

Introduction

“America’s health care system is in a profound state of transition.” The health care reform debates of the early- and mid-1990s have focused their attention on both the strengths and the weaknesses of the health care system and on possible ways to address these weaknesses. The U.S. health care system, at its best, provides effective, high technology care that is unsurpassed in the world. At the same time, our health care system is recognized as being expensive, inefficient, and fragmented, and millions of Americans lack the resources to obtain basic services (Lonnquist and Weiss 289).

Health insurance policies are expensive regardless of whether the source is private or from the government. In 1992, employers paid more than \$1,500 per employee and \$3,650 per employee family for health insurance coverage. Rapid increases in insurance premiums in the late 1980s and early 1990s prodded many companies to require greater employee contributions on insurance premiums, higher premiums for dependents, and other mechanisms to increase the employee contribution. By the early 1990s, about three-fourths of companies required employees to chip in for their own insurance and more than 90 percent required employee contributions for family coverage. Equally important in the manner to which we pay for health care has been the shift from a reliance on private sources to increased dependence on government funding. “From 1960 to 1996, the percentage of health care financing that came from the government increased from 24.9 percent to 46.7 percent. This increase was largely attributable to the implementation of the Medicare and Medicaid programs in 1966 and to periodic expansions in them in the intervening years” (293).

Medicare (the federal government's health insurance program for the elderly) and Medicaid (a federal-state-local health insurance program for the poor) represent the primary vehicles through which the government is involved in the health care sector (294-295). Medicare was created by Title XVIII of the Social Security Act of 1965. It was originally designed to protect people 65 years of age and older from the rising costs of health coverage. However, permanently disabled workers, their dependents, and people with end-stage renal disease were added to the program in 1972. In 1996, Medicare covered 38.1 million people at a cost of \$203 billion, which was financed by a combination of general tax revenues, payroll taxes levied on employers and employees, and enrollee payments. On the other hand, Medicaid is a jointly funded federal-state-local program designed to make health care more available to the poor. Funds paid through Medicaid for personal health care amounted to more than \$147 billion for 36.1 million recipients in 1996. Eligibility is determined by Medicare enrollment and falling below a designated income/assets line. Thus, the government has little control over the number of participants, and it can restrain the costs of the program only by tightening eligibility requirements, withdrawing benefits, or reducing already meager reimbursements to health care providers (295). The result of the expensive nature of these programs is that many of the country's poor citizens are not covered. "About half of all persons under age 65 who fall below the poverty level in the United States are not covered by Medicaid." Furthermore, the inadequate physician reimbursement from Medicaid has caused many health care providers to refuse to see patients covered by Medicaid (296).

Government-sponsored programs are not an effective safety net for people who do not have private health insurance. "By 1996, on any given day, an estimated 41

million Americans (one-quarter of them under age 18) did not have any private or public health insurance coverage.” In addition, millions more Americans are underinsured--they have an insurance policy that contains major loopholes, requires large out-of-pocket payments for services, or both. More than half of the uninsured are in families with a full-time worker, and an additional 30 percent are in families with a part-time worker (296). One study based on a national survey found that the working poor are only one-third as likely as the nonpoor to receive health insurance from their employer, and they are more than five times as likely not to have any health insurance whatsoever (296-297).

Research indicates that the uninsured are less likely to have a regular source of care; have fewer physician visits per year; are less likely to have a hospital stay; if hospitalized, average a shorter stay; and receive fewer procedures in the hospital. The uninsured were found to have a higher risk of in-hospital mortality and a greater chance of dying in the hospital. Sick newborns without health insurance were even found to receive fewer in-patient services than comparable newborns with insurance.

Many physicians do treat some patients who lack the financial means to pay for care. Two-thirds of physicians provided some amount of care to patients without charge or at a reduced fee in 1994. However, one-third of physicians provided no “charity care.” Public health departments offer care on a sliding scale and free health clinics provide care at no or minimal charge to those unable to pay for private care. Even so, these resources have fallen short of meeting the increasing need (297).

The free health clinic movement emerged in the United States in the late 1960s to establish free health centers for people unable to afford private care and/or for those estranged from the conventional medical system (316-317). The early forms of these

clinics were targeted to people experiencing drug-related illnesses, problem pregnancies, and venereal disease. By the early 1970s there were approximately 300 to 400 free clinics in the country. The clinics continued to evolve through the 1970s and 1980s and new clinics were created; yet a far greater number went out of existence. The focus of the clinics shifted more and more to serving either the very poor or the medically indigent--those just above the poverty level who do not qualify for Medicaid.

There are many variations in the more than 200 free clinics that were operating in the late 1990s. However, most (1) offer primary health care services; (2) by a staff comprised largely of volunteer physicians, other health care providers, and laypersons; (3) to people unable to afford private medical care; (4) in an atmosphere that emphasizes treating each patient with dignity and a supportive, nonjudgmental attitude. Local governments, United Way, church groups, private donations, contributions (often in-kind) from the medical community, and patient donations provide the financial support for free clinics (317).

Even if we believe that all men and women are created equal, one cannot deny that we are not created equal with regard to health. Some of us are blessed with good health and live to old age without the meddling of physicians and nurses. Others are born with or develop catastrophic diseases requiring massive amounts of medical attention in order to survive from day to day.

One cannot also deny that we are not equal with regard to access of health care. Some are born into wealthy or middle-class families that can either purchase all the health care they want or buy enough insurance to cover their needs. The rest come from poor families that cannot afford adequate housing, clothing, and nutrition, let alone

insurance for health care. These losers in the “social lottery” often have desperate needs for care that go unmet.

In many cases, access to health care is an entitlement in name only for those poor enough to meet the definition of poverty stipulated by their state-run Medicaid programs. Very few physicians are willing to treat Medicaid patients since most states reimburse only a small fraction of the usual rates. With the exception of some extraordinarily devoted physicians, those who do accept these patients are often poorly qualified and offer substandard care in large, impersonal practices. Hospitals dealing with a predominantly Medicaid population are notoriously understaffed and undersupplied (Arras and Steinbock 617). Yet at the university-affiliated hospital, the insured paying customers benefit from state-of-the-art technology and care.

Individuals not poor enough to qualify for Medicaid yet too poor to afford private health care, pose the greatest challenge both to our nation’s emerging health policy and to our collective moral conscience (618). Numbering roughly 54 million people, these uninsured individuals must either go without treatment or obtain care from chaotic emergency rooms.

The questions now arise of how to deal with these inequalities in both the natural and social lotteries. Are they merely instances of misfortune that should elicit pity and charity, or should we view them as injustices that call for rectification? Supposing that health care is a right rather than a privilege, to what kind of health care are we all entitled (618)? Has our society produced citizens that deafen to the call of charity or violate the rights of the underprivileged?

Health care is different from other consumer goods. It is crucially related to our level of well-being, helping us to ward off pain, suffering, and premature death. “Like education, health care is necessary to achieve equal opportunity in society.” Health care is weighted with interpersonal significance. The failure to obtain needed health care in our society signals a lack of full citizenship. According to the President’s Commission, the free market alone cannot be counted on to meet health care needs and society therefore has an obligation to help meet them. Moreover, the Commission believes that not all inequalities to health care constitute inequities (618), so long as everyone is guaranteed access to an “acceptable level” of health care. Society will then have lived up to its moral obligation. From a civil perspective, other important interests besides health care—such as needs for good schooling, housing, nutrition, and jobs—must also figure into the conception of equal opportunity. So the task of public policy is to weigh and balance these higher-level interests in fashioning a just system that protects equal opportunity. “In this view, access to health care is seen as vitally important, but not so uniquely important that making it available to all threatens to break the societal bank” (619).

People from different cultural, religious, or philosophical traditions define justice and equality in radically different ways. Allocating health care in a pluralistic society is a key problem because any scheme for allocating such care espouses one or another vision of justice. Libertarians insist individuals must remain free from societal or governmental interference to make their own choices; no one should be forced to give away his or her resources for the benefit of others (620).

David Hilfiker, a physician with the inner-city poor in Washington D.C., believes in the understanding that God calls us to care for and move into solidarity with those who have been excluded from society. Yet he sees how societal values have shifted. We have trouble understanding service, sharing, justice, and equality, not because we are worse people, but because we have unwittingly transformed capitalism into a religion. Capitalism has shaped our basic assumptions about life—economic, social, political, and spiritual—to spawn a religion of self-interest. Pursuit of self-interest may or may not make good economics, but it shares no common ground with biblical ethics, which emphasize love, community, and justice for the poor. The focus on profit, on earning money, has exploded beyond the sphere of economics to become central to our understanding of life itself. The purpose of work is to make money. The biblical view is that money is only a minor part of the purpose of work. We work to provide for the basic needs of our families and ourselves, out of love for others, to express our creativity, to be fulfilled, to create a better environment for our community, and to make a more just world (Hilfiker).

Dr. Hilfiker is often considered a saint among his contemporaries and students for taking a salary 50 percent higher than the national average. “I choose to do wonderfully meaningful, desperately needed, community-oriented work with profound intrinsic rewards—yet I become saintly because I decline work that would pay me more money than anyone really needs,” Hilfiker stresses. The accumulation of vast wealth is exalted by society. Once an innocuous economic principle, the capitalist system has seeped into our consciousness to reshape our underlying assumptions about the purpose of work.

Price is the mechanism used to allocate resources in the free-enterprise system. In medicine, cost-benefit economic analysis has become a primary way to choose among treatment options even though it requires giving a dollar value to human life. And the only way to mobilize social forces against poverty is to show how much money society would save by investing in poor neighborhoods and preventive medical care—a cost-benefit analysis of poverty. Why does planning for the future not mean creating strong community, or working for social change, or fostering a deep love within one's family? Why has the hoarding of financial resources become the only thing that builds future security?

According to Hilfiker, an essential principle of the free-market system is a formulation of injustice. The necessities, such as food, shelter, basic education, and health care, are meted out mostly on the basis of private wealth. Neither modern capitalism nor economic imperative requires these necessities be distributed according to how much money people have. Economic systems can be modified to provide for all. Yet in the last few years, steps have been taken to dismantle the few social mechanisms that provide for those who do not possess private wealth.

Capitalists feel free from sharing what is "private property." For example, physicians no longer feel much responsibility to society, even though society invests heavily in the education of physicians. "The assumption of private property, nestled into our very being, has eroded our consciousness of ties to family, community, nation, and world. My things, my education, my abilities, my ideas—they all belong to me (Hilfiker)." In Washington's inner-city, Dr. Hilfiker encounters people who are desperately poor and remain poor because they are always helping their less able relatives

out of financial crises. Most of us would question such behavior. Will our relatives use this money responsibly? Are we enabling the relatives to remain irresponsible? Yet for these inner-city inhabitants, family has a claim on what they earn.

There is a different set of values consistent with the gospel of Christ. All men and women are our neighbors, and self-interest is not a primary concern. When our decisions are based on a love for God and God's creation, profit is not a determinant. The value of a person or a part of nature is determined by its intrinsic value, not how much people can and will pay for it. Furthermore consistent with the Christian faith is the belief that necessities for everyone come before luxuries for some. Until all have obtained the necessities, decisions about what is produced should not be based on who has the most money.

Even those who do not call themselves spiritual sense that something is desperately askew. They realize that it is not right for homeless families to walk the streets of the richest nation. They acknowledge the responsibility that people have to one another. These are challenging times in which to eradicate the assumptions of capitalism that have been enculturated within us. Nevertheless, biblical values—spreading the love and forgiveness of the gospel, moving into solidarity with the poor, and caring for the earth—are gifts from God that can anchor us (Hilfiker). For this reason, faith-based organizations have entered into the health care business to cover the needs of poverty-stricken Americans where other citizens, the government, and managed care programs have failed.

Chapter One: Faith and Community Action

The awareness of health care issues is on the rise, yet the need to provide health care to all individuals and the fact that millions of people lack basic care is often overlooked. Whether this be the result of neglect, apathy, or merely the ideology that health care is a privilege and not a right, few and often unpublicized strides are being made to change the state of access to health care in the United States. InterFaith Health Clinic of Knoxville, Tennessee is not the first nor will it be the last of these strides, but this clinic is a model in its own right as a solution to reaching individuals who fall between the cracks.

What is becoming one of the most pressing social problems of the times--the lack of access to health care—was confronted by two Knoxville residents, Mary Leslie Simpson and David Dotson. Their vision prevailed over past oversights that sought to battle other social tragedies such as hunger and homelessness but failed to recognize the need to make the prevention and treatment of illness and injury accessible to all. Furthermore, they searched for an effort that would impact the problem and do more than provide a temporary fix. InterFaith Health Clinic became the solution they looked for.

InterFaith Health Clinic is a not-for-profit primary healthcare facility. The clinic's mission is to provide accessible, affordable, and quality health care to the low income, working uninsured in the Knoxville area, through the support of religious, healthcare, and business communities. The services of the clinic are provided regardless of race, creed, age, religion, or national origin of the patient. Most of the patients are the working poor, those who live near the poverty level but do not have any medical benefits because they

are not eligible for TennCare, do not have medical benefits through work, and cannot otherwise afford a family doctor. In 1990, over 18 percent of the population in Tennessee were medically uninsured, almost one million people. Of that group, over 35 percent were children under the age of 17. And 75 percent of those uninsured individuals had full-time jobs (InterFaith Health Clinic Archives). Many of the clinic's patients work in service industries, such as hotel/motel work, restaurants, and cosmetology. Another aspect of the patient population is the elderly covered by Medicare who do not have supplemental policies covering office visits or medications. Aside from basic health care, services available at the clinic include eye care, podiatry, minor surgery, dental care, pharmacy services, and counseling. Leaders from the medical community emphasize the emotional well being of the patient as an integral part of healing. Pastoral counseling as well as clinical counseling is made available. In addition, specialized medical services and tests are available by referral to local hospitals and by volunteer physicians, dentists, social workers, psychologists, and psychiatrists who see clinic patients at their private practice and charge according to the same sliding scale fee used at the clinic. Patients are charged according to this sliding scale fee based on the number of people in the household and the total household income. The scale ranges from 10 percent to 50 percent. Most patients fall at the 10 percent level of the sliding fee scale. The difference between an average visit and the fee a patient pays is made up by donations. Funding for the InterFaith Health Clinic comes from various sources, including donations from local hospitals, individuals, businesses, charitable foundations, and religious congregations and institutions. The clinic faces great challenges as public funding for health care is debated and reformed. The demand for the clinic's services is likely to increase as funding

availability decreases. Therefore, InterFaith Health Clinic serves a great number of people on a small budget and staff (www.interfaithhealthclinic.org).

Simpson and Dotson's search for a remedy to the lack of health care availability ended during a visit to Memphis, Tennessee. The Church Health Center inspired their vision for the Knoxville community—the result became InterFaith Health Clinic. The Church Health Center in Memphis opened its doors on September 1, 1987. Heeding God's call to care for the sick and the poor, Scott Morris created a faith community health ministry to provide affordable, high quality health care to uninsured workers, their families, the elderly, and the homeless. Patient care is provided at the center, at volunteer physician's offices, and through the MEMPHIS Plan—a health care program offered by the center. Furthermore, it encourages its community to promote health—in body and spirit—at Hope and Healing, the Church Health Center's state-of-the-art wellness facility. The Church Health Center is funded primarily by private donations from businesses, foundations, individuals, and more than 200 congregations of every faith. It does not rely on government funding as donations account for almost all their annual budget. The center serves more than 32,000 with the help of hundreds of volunteers and the work of the full-time staff. On-site volunteerism alone totals more than \$225,000 a year. Finally, fees for its services are based on a sliding scale, according to income.

Although the center officially opened in 1987, its origins date back to the 1960s when the center's founder, Scott Morris, M.D., M. Div., was in high school. This young Atlantan decided he wanted to be a minister who helped care for the sick. His dream was to start a faith-based health center for the working poor. In 1986, after college, seminary, medical school, and his ordination as a Methodist minister, Dr. Morris headed to

Memphis. Memphis has historically been one of the poorest major cities in America, with a vast and growing population of uninsured. Therefore, if his dream could prosper in Memphis, it could prosper anywhere.

St. John's Methodist Church hired Dr. Morris as an associate pastor in 1986 while he raised the initial funding for the center. The church purchased the center's first building, a dilapidated boarding house across the street, and agreed to lease it to the Church Health Center for \$1 per year--a fee that has remained the same since. Central Church agreed to finance the renovation of the building and its conversion into a clinic. The Memphis-based Plough Foundation and Methodist Hospital each donated \$100,000 to launch the center. The center's ministries have only matured and expanded with the continuing financial support of the community.

Dr. Morris and one nurse saw twelve patients on the first day of September 1, 1987, the fewest ever seen on a single day. Today the clinic has more than 30,000 patients on record and an on-site staff of five physicians, a full-time dentist, six nurses, and two pastoral counselors. Furthermore, a network of over 600 volunteer physicians, nurses, dentists, optometrists, and other health care professionals keep the clinic open at nights and on weekends or see patients in their offices.

The Church Health Center can serve only a portion of the large and growing number of uninsured in Memphis (more than 150,000 by one estimate) as a result of space and staffing limitations at its midtown clinic. Because of this discrepancy, the center created MEMPHIS Plan in 1991. MEMPHIS Plan is an affordable health care program for lower-wage, uninsured, working people. It answers the needs of those who earn too much to qualify for state/federal-sponsored programs, yet cannot afford

traditional health insurance. This plan secures primary and specialty care, hospitalization, and other medical services for its participants. It is not health insurance. The program is made possible by the generosity of several hundred local physicians, hospitals, labs, and diagnostic centers that willingly donate their professional services. Patients are treated in physicians' private offices, the same as other private patients.

Employers can now enhance job productivity and retain valued employees with MEMPHIS Plan. As an employer-sponsored program, the responsibilities of the employer are to pay at least \$10 of the monthly fee, remit 100% of the monthly fee to MEMPHIS Plan, and make certain employees meet the plan's eligibility requirements. Participants are assigned to a primary care physician and to a local hospital. Participants see their primary care physician for check-ups and sick care, and then can be referred to a specialist if needed. These physicians coordinate lab and diagnostic testing as well as hospitalization. Emergency room visits for emergencies and approved surgical care are covered. Discounts up to 40 percent at Super D, Super D Express, and Ike's Pharmacies are offered. Additionally, participants have access to the Church Health Center's dentistry, optometry, pastoral counseling, and Hope & Healing programs. Monthly fees are \$35 per month per employer (at least \$10 paid by employer, \$25 paid by employee); \$20 per dependent age 12 or older; \$15 per dependent under age 12 (no hospitalization available); \$95 monthly maximum per family; and a \$5 payment at each office visit with a physician. Certain eligibility requirements do exist for employers, employees, and the self-employed to become participants in the MEMPHIS Plan.

Tennessee legislature passed a special act in 1991 that gave the Church Health Center permission to offer MEMPHIS Plan to members of its community. This act

recognizes that MEMPHIS Plan is a health care program—not to be mistaken for health insurance—made possible by providers donating the service.

The Church Health Center recognized that two-thirds of the patients seen were seeking medical treatment for illnesses that could have been prevented. The conclusion was to keep people healthy, and the solution was to create a place where all people—regardless of income or level of health—could go to strengthen their physical and spiritual well-being. Hope and Healing, a ministry of the Church Health Center, was developed. Since January 2000, this state-of-the-art wellness facility has combined the wisdom of disease prevention and the experience of health professionals with the love and encouragement of the faith community. Other Church Health Center ministries are also working to keep people healthy in body and spirit. The Congregational Health Ministries, established in 1989, offer training and consultation to help congregations become healthier. The Caldwell Neighborhood Initiative (1997) is a pilot program intended to improve the health and well-being of the Caldwell Elementary School students and their families. Caldwell Elementary School is located in the heart of one of Memphis' underserved areas. In 1998, Smart from the Start, a program of early intervention, was developed to help inner city infants and preschoolers with social and learning skills. Perea Preschool (1999) is a faith-based preschool aimed at preparing disadvantaged youngsters for future academic success while addressing their physical and spiritual health (www.churchhealthcenter.org).

With many calling it “the perfect health care solution,” the ministry of the Church Health Center is a growing phenomenon in the world of health care and in communities

reaching out to those in need. InterFaith Health Clinic is based upon this very successful effort in Memphis.

The plans for InterFaith Health Clinic originated within the Catholic Social Services of Knoxville, a department of Associated Catholic Charities of East Tennessee, Inc. (ACCET). The effective implementation of the plan was extremely important. A few of the most critical components were the operational funding, medical personnel, a facility, and the medical director. A twelve-member Steering Committee was formed, a model for the clinic postulated, and an operational budget estimated. The Steering Committee was a remarkable coalition of representatives of Catholic, Jewish, and Protestant denominations, physicians, dentists, and social service professionals who had interest in the clinic. Rabbi Howard Simon, Rabbi Arthur Weiner, Father Demetrius Carellaus, Reverend Larry Carroll, Dr. Leslie Hargrove, Dr. Joe Moon, Mrs. Marilyn Jacobsen, Mrs. Josephine Zarger, Mrs. Jean Gangaware, Mr. John Hurley, Mrs. Shelley Vadergriff Holt, and Mrs. Kathy Wright made up the initial committee. Also represented were several organizations, such as the Knoxville InnerCity Churches United for People (KICCUP), the Knoxville Academy of Medicine, the Knoxville Area Hospital Council, and the Knox County Health Department. On January 5, 1990, the committee members in addition to David Dotson and Mary Leslie Simpson had their first meeting and divided into sub-committees for site, fund raising, and community relations.

The basic elements of the concept were recorded. A full-time, paid, core medical staff of at least one physician, a nurse, and the appropriate number of additional staff to support the clinic would be necessary. Because of the lack of money to be redirected to salaried staff, a pool of volunteer medical professionals would be called for. Physicians

and nurses would be recruited to fill evening hours and Saturday mornings. Specialists would be asked to see one to three people a month in their offices. The evening and Saturday morning hours would make the services more accessible for the working poor who would be unable to leave work for medical attention. And services by appointment would manage the heavy demand. The sliding scale fee and acceptance of patients under Medicaid and Medicare would make the service affordable to the target population. Free and low-cost contributions from the medical industry could provide drug samples, generic drugs, lab work, and equipment. It would also be important for the facility to be near the target community, which would be near downtown Knoxville and on or near a bus line. In addition to providing primary health care, prevention strategies, social work services, and dental care would be offered.

The financial potential was estimated at the initial Steering Committee meeting. The revenue pattern was determined by the experience in Memphis at the Church Health Center. It demonstrated that 50 percent of the revenue would come from fees and the other 50 percent through subsidy. These subsidies included grants from hospitals and foundations, state funds, churches, and an individual giving program. Local funding possibilities included individual donors, the Community Health Act, hospitals, HCA Foundation, Robert Woods Johnson, East Tennessee Foundation, and the federal government. The initial funding strategy included the Community Health Act, Knoxville area hospitals, two foundations, donors of cash, and contributions of a site, equipment, and supplies. A proposed timeline was plotted. By January, the Steering Committee would meet, sub-committees would be formed, and the proposal would be prepared for the Community Health Agency. By July of that same year, a site would be secured, 50

percent of the funds would be secured and committed, physician recruitment would be underway, and a structure ratified. By November, both the physician and the equipment for the clinic were to be secured and 100 percent of the operational budget was to be committed. And finally, the doors of the clinic would be opened as of December of 1990.

Chapter 2: The Birth of a Health Clinic

The inaugural Steering Committee meeting of January 5, 1990 was behind them and a year of deadlines, meetings, negotiations, and the creation of a health clinic ahead. The progression of the idea for a health clinic to serve the working poor began with 14 Steering Committee members with a single passion in mind. It quickly expanded and by the second meeting on February 2, three new members, Dr. George Changas, Diane Lewis, and Reverend Velma Smith, agreed to serve. The clinic was going to be the subject of a Knoxville InnerCity Churches United for People (KICCUP) Seminar on March 25 in which three of the committee members were going to participate. Meetings had been held with Mayor Ashe and Dr. Duffy of the Knox County Health Department; they both pledged their full support. Four new Steering Committee members were approved: Dr. Don Ellenburg, Michael Willard, Michael Williams, and Lois Russell. Suzanne Siebert, County Welfare Director, was recommended to serve. And the Chairman of the Steering Committee was selected to be John Hurley, all on this day of February 2, 1990. A list of agencies and individuals was compiled to seek letters of support. And the possibility of joining forces with the University of Tennessee Social Work Department for the clinic's social services component was reported. The offer to talk to the media again was postponed until after the hospital administrators had been officially contacted. The two original staff members, David Dotson and Mary Leslie Simpson, had previously made a trip to Memphis to meet with Robert Howerton, Senior Vice President of Methodist Hospital. He agreed to come to Knoxville to speak to the area hospitals about the impact of a health center such as this on their emergency rooms.

And in final business of the meeting, a name for the clinic was chosen. It was to be called InterFaith Health Clinic.

March 2, 1990. An Associate Professor of Nursing at the University of Tennessee, Dr. Dava Shoffner, was added to the Steering Committee. A sub-committee on the formation of a dental component of the clinic was formed. A proposal summary was submitted and the arrangements were made to mail the full proposal and budget to all Board members the week of March 12th. The Board voted to consider the proposal for their submission to the State Community Health Agency Office on April 1, 1990.

April 6, 1990. The KICCUP Seminar was a success. Volunteers totaling 36 signed up and ten of those were physicians. A report came in from the Community Health Board meeting. A request of \$250,000 was needed for the clinic. The programmatic funds would provide \$150,000 and \$100,000 was to come out of the special projects fund for the start-up costs. There was \$1.3 million in special projects that would be distributed across the state of Tennessee. The funding would begin July 1, 1990. David Dotson and Mary Leslie Simpson planned a trip to Nashville with the Health Department staff to meet with the State Community Health Agency staff. A letter of intent was to be sent by the Community Health Board to the State in order to secure the special projects funding. Dr. Changas and Dr. Creasman had discussions with Dr. Bill Rose and the Dental Society Vice President, Dr. Rupert Knierim. It was agreed that a specific program needed to be developed and presented to the Dental Society. There would be emergency service two nights a week and a donation of two dental chairs had already been made. Three additions to the growing Steering Committee were proposed: Charles Susano, an attorney; Beth Levelly, Assistant Vice President of Planning at St. Mary's Hospital; and Tommy

Strickland, Chairman of SICK. A suggestion to add a member from the financial community was made and led to the recruitment of Dale Keasling, President of Valley Fidelity Bank. Steering Committee membership now totaled 24.

At this point in time, an overview of the progress towards InterFaith Health Clinic's completion showed that securing the site of the clinic was most important. The site sub-committee met with Karl Fillauer to discuss a property on Gill Avenue. It was agreed that the building should be under their ownership since extensive renovation would be necessary. The next concern was for an architect to be properly experienced in medical facilities, but luckily a committee member recommended an architect. An interview with *The Knoxville News Sentinel* to inform the city that a site was being sought now felt appropriate.

The committee's next leap of faith was to ask for a contribution by each member of \$50 for a conference fund. The first of the two conferences to take place with employment exchanges for physicians was the Christian Community Fellowship Conference held in Chicago on April 27th. It was estimated to cost approximately \$900. The second one, the Rural Health Conference in New Orleans on May 15th was to cost around \$600. These conferences were used for the clinic's physician recruitment. Finally, arrangements were made for Chaplain Robert Howerton, Senior Vice President of Methodist Health Systems in Memphis, to fly to Knoxville for the Area Hospital Association meeting on May 9, 1990. He was speaking on the impact of the Memphis Church Health Center on his hospital's emergency room.

April 24, 1990. The Site Sub-Committee met and began with a recommendation by David Dotson that a site be chosen in the next month, as at least four months were

needed to renovate or build. He reported on a meeting with Ron Watkins, President of Partners and Associates. Mr. Watkins suggested developing a new building and offered to have the plans drawn. He felt it would be a mistake for many reasons to renovate the site on Gill Avenue. Mr. Dotson reported another meeting with Karl Fillauer. Mr. Fillauer offered to pay for renovations, lease the building with an option to buy every five years, and finance the amount for the clinic. Dale Keasling, Chairman of the Executive Board of Salvation Army, made an offer of property the Salvation Army had recently purchased on Broadway. They were planning to build a family shelter in a year. However, the committee agreed that the InterFaith Health Clinic should be in a separate location rather than seeming connected with the Salvation Army.

May 25, 1990. Cost figures began coming in. A "turn key" medical facility of 5,704 square feet would cost \$524,626 by Partners and Associates. A deal from Karl Fillauer to remodel a Gill Avenue site would cost \$150,000 for the 6,000 square feet and another \$200,000 for the land and building. Meanwhile, the President of Valley Fidelity Bank, Dale Keasling, advised that \$150,000 was a fair price for the Fillauer property. The option to work with the Salvation Army remained open, but the committee had to decide if they could afford to wait the several months until the Salvation Army would be ready to begin building. A letter was written to the county requesting the donation of property at the corner of Pearl Place and North Central. A decision would have to be made soon in order for the clinic to meet its target opening date. Mr. Keasling reported that his bank would provide a loan of money at a lower rate with backing from individuals or even the area hospitals. The first week in June, a negotiation with Karl Fillauer would take place.

Physician recruitment began. David Dotson and Mary Leslie Simpson attended the Christian Community Health Fellowship Conference in Chicago. Contact was made with three physicians, all of whom were interested and would make a decision in the near future. A resume from a doctor in Nashville was also received.

June 8, 1990. Negotiations proved to be positive. The new offer from Karl Fillauer stood at \$154,000, the amount he owed to the bank, and an additional \$18,000 that could be paid in one year with no interest. And a new roof would be put on the building. Wood Brothers Construction Company and Broome, Lothrop, and Associates made appraisals of the property in the \$130,000 to \$150,000 range. The higher appraisal offered by Mr. Fillauer in the negotiations was termed the "value in use" appraisal. This did not represent market value for the appraisal was done on the building when it was a meat processing plant. The Committee agreed to offer him a minimum of \$136,000 and negotiate up to \$154,000 maximum. Mary Leslie Simpson and David Dotson met with bank presidents, Bill Brown and Larry Martin, to discuss financing the renovation. Through the Clearing House Committee, the banks would lend the money at a preferred rate with backing from the three area hospitals. A meeting at the Health Department concerning the Community Health Agency funding determined that it would be possible to hire the Medical Director earlier than the projected date of December 1, 1990. This resulted from an increase in operational funding. The question of hiring an Administrator by July 1, 1990 was raised, and Mary Leslie Simpson was recommended to fill the position.

On June 1st Jean Gangaware, President of the KICCUP Board and IHC Steering Committee member, sent a letter to area churches requesting the donation of \$5000 by

their congregations. This was done following the March 25th Second KICCUP Urban Ministry Seminar and the public endorsement of the projected InterFaith Health Clinic by KICCUP and member churches.

June 22, 1990. The Hospital Funding Committee agreed to approach four area hospitals, St. Mary's, Baptist, Ft. Sanders, and Children's Hospital, when all of the figures for renovation costs were settled. The probability of backing on the loan and purchase of the building becoming separate was also discussed. Karl Fillauer agreed to let InterFaith Health Clinic take over his existing loan at First American Bank. The amount remaining totaled \$154,000 and Mr. Fillauer offered to guarantee the loan for the clinic. Rob Leuking, Vice President in charge of community lending at First American Bank, met with David Dotson and Mary Leslie Simpson, to offer assistance. The bank committed to loan the renovation money to the clinic and offered office furniture from the bank's warehouse. Bryan Pickens, an architect for Baptist Hospital, was taken to the Gill Avenue building. He offered to draw the schematics at no charge and speak with the firm of Lindsay and Maples about doing the remaining work at no charge. He had already provided the committee with preliminary drawings. There was the possibility of a contractor doing the work at cost. Four companies were contacted for estimates on a new roof and thus far, Brogdon Roofing seemed to be the best report. The first Press Conference was scheduled for June 24, 1990 at the Gill Avenue site.

July of 1990 a document was printed with a threefold purpose: to provide an update on the implementation of the plan to get InterFaith Health Clinic established; to discuss the current interrelationships among the clinic, Associated Catholic Charities of

East Tennessee (ACCET), and the Diocese of Knoxville; and to outline the plan for raising sufficient funds to repay the loan.

The most critical components of an effective plan in this case were adequate operational funding, volunteer medical personnel, a facility, and the medical director. The clinic secured \$250,000 of seed money from the state government. These funds were targeted to salaries and non-personnel expenses. An additional \$33,000 would be needed to cover the expenses from January through June of 1991. Another \$102,000 was budgeted for equipment. However, the actual expenditures on equipment would be far less due to the enormous response to the call for donations. An X-ray machine would be purchased for \$9000 rather than \$35,000, two dentist chairs were donated, all of the exam tables were donated, and donated waiting room and office furniture was already in storage. The figure for purchasing equipment would probably be half of the budgeted amount.

A key component of the plan was the success in attracting medical volunteers on a daily basis. A structured volunteer solicitation plan had not been implemented, yet over 50 physicians had indicated a desire to participate in the program. By December, 100 physicians and 60 nurses would be enrolled in the program. Additionally, a diverse network of sub-specialists would be in place for referrals from the clinic. Discussions were underway for a host of in-kind contributions from medical institutions. These included admitting privileges for the medical director, hospital coverage, lab work, X-ray review, and pharmaceuticals. Thus far, the response from the medical profession had exceeded expectation and the resources were nowhere near fully tapped.

The site was located at 315 Gill Avenue. The building was being purchased from Karl Fillauer by assuming the balance of his note at \$154,000. The monthly payment of \$2500 was in the total operational budget. In order to offer low cost health care, front-end expenses had to be kept as low as possible. Broome and Lothrop appraised the value of the building between \$140,000 and \$160,000, which made the clinic's price competitive. Architectural services were purchased for \$10,800. This figure represented 4 percent of the estimated renovation expense. This price was made possible by the donated labor of Bryan Pickens, staff architect for the Baptist Health System, and by the good graces of Bruce McCarty. Johnson and Gaylon agreed to provide construction services for cost, fees, and no profit margin. These generous offers were indicative of the breadth of support this project attracted.

Finally, the two key personnel of InterFaith Health Clinic were the administrator and the medical director. Mary Leslie Simpson was appointed administrator and efforts were underway to recruit a medical director. Recruitment took place through advertising, conferences, and by word of mouth. The appointment of medical director would desirably be made by October so that he or she could be involved in the final phase of the clinic's development.

At this point in time, InterFaith Health Clinic was operating as a department of the Associated Catholic Charities of East Tennessee (ACCET). The daily guidance of its activities was charged to the administrator, the steering committee, and the executive director. InterFaith, like all ACCET departments, was accountable to the ACCET Board and the Bishop. A decision had yet to be made for the future of the clinic. The Steering Committee decided to focus its efforts on the development of the program and return to

the question of structure at a later date. By the fall a decision was expected as to whether the clinic would remain part of ACCET or spin off as an independent organization. A number of factors including administrative overhead, utilization of ACCET's executive director, fringe benefits for the employees, and the public perception had to be intensively researched before a final decision was made. If IHC remained within ACCET, the Steering Committee would become the Board and it would elect two representatives to the ACCET Board. It would function much like the Board of Columbus Home or Catholic Social Services. On the other hand if IHC spun off, all official relationships with ACCET and the Diocese would cease. This would also relieve the Diocese of its role as guarantor of the renovation loan, the employees would no longer be employed by ACCET and would not participate in diocesan retirement and health plans, and there would not be administrative support from the executive director and the fiscal staff of ACCET. As a department of ACCET, IHC would follow the same rules and procedures as every other department. Minimally, this relationship would exist through June 30, 1991.

Two loans were under consideration and the repayment of those loans was considered. The first of the loans was the assumption of Mr. Fillauer's loan for the purchase of the Gill Avenue building. The facility would be leased to ACCET/IHC in the amount of the monthly payment of the loan. The second loan was for the renovation of the building. First American Bank agreed to a two-year loan with interest-only payments on a monthly basis. The interest rate was the prime rate. Payments on the principal could be made at the convenience of IHC, but the total amount was due after two years. If the

principal was not repaid by the end of the two-year period, the terms of the loan would be renegotiated. The approximate amount of the loan was \$250,000.

Several levels of checks and balances for the construction process existed. First, the Finance Committee requested that Dorman Blaine review the construction documents. First American asked that a member of their staff review the documents. Finally, Bryan Pickens would serve as the clinic's project manager to review the documents and oversee the renovation process. The cumulative efforts of these individuals assured the proper oversight of InterFaith Health Clinic's progress.

The terms of the loans were compatible with the needs of the clinic. The interest-only payments kept the monthly expenses to a minimum and allowed the clinic the time needed to implement a fundraising strategy. The details of the fundraising plan were not yet devised. However, a plan was installed at the next Steering Committee meeting of August 3rd. The fundraising drive began late fall of 1990 and ended by early summer of 1991. The goal was to raise an amount equal to the renovation cost and anything more would go to a building fund to care for future needs of the facility. Despite the lack of a solidified plan, several components were included as in any fundraising plan. Meetings with area hospital executives regarding their involvement with IHC took place. All displayed a willingness to help, especially with in-kind services. The four hospitals were asked to contribute financially to the project at a suggestion of \$75,000 per year. The first year request (1991) would apply to the loan repayment and subsequent amounts would apply to operations. If agreed upon, the loan would be immediately repaid. Additionally, the involvement of the faith community was the backbone of InterFaith Health Clinic. In Memphis, an annual drive within the religious community produced \$250,000 a year for

operational funds of the Church Health Center. Most of the operational expenses for the initial January to June period were covered. Therefore, the faith community contributions could be targeted for the renovation loan. Finally, the community at large, which included local foundations, corporations, and individuals, was targeted. Professionals such as physicians and attorneys were approached for contributions. The approach used for the Columbus Home would be utilized for this project. Individuals were approached for a donation of \$1000, which could be pledged over a two or three year period. This strategy yielded around \$400,000 in \$1000 donations.

To have confidence in the plan, the committee raised certain questions. Was there a realistic goal? Was \$250,000 to \$300,000 a realistic amount? Could the work of the organization be sold? Could the plan be properly administered? Were there experienced fundraisers involved? To answer these questions, the following were recognized: an examination of the Steering Committee, including members of the religious community, which revealed a list of individuals who could raise funds; the staff of ACCET who successfully managed the Columbus Home campaign that raised over \$500,000; and the experience to date which revealed unbridled enthusiasm for the project. Undoubtedly, raising the funds would require work, yet there was little doubt that the funds could be raised in two years given the breadth of community support.

August 3, 1990. The Steering Committee meeting agendas were no longer printed on Catholic Social Services stationary but were printed on stationary with the heading, InterFaith Health Clinic: A Division of Associated Catholic Charities of East Tennessee. At the same time, concern arose that InterFaith Health Clinic was being perceived as a Catholic Charities project. Father Bill Cantwell, who was on the Board of the Church

Health Center in Memphis, urged the clinic to spin off and become a separate entity as they had done in Memphis due to the strong affiliation with the Methodist Church. Because the ecumenism was of utmost importance to the success of the clinic, this move could be in the best interest. It was unanimously agreed and a committee was formed to write the By-Laws. The Steering Committee would become the Board of Directors. New stationary would have to be reprinted, this time leaving off the Catholic Charities relationship.

A report on the loan information for the Catholic Diocese Finance Committee was given. Bishop O'Connell agreed to guarantee the loan to the clinic by First American Bank and a recommendation by the Diocesan Committee was being awaited. First American Bank was ready to process the loan as construction prices were complete. Thus, the actual renovation work could start by the end of August and the target opening date would remain on schedule.

The architects, McCarty, Holsaple, and McCarty, completed the final drawings and presented them to the construction firm of Johnson and Gaylon. Both firms generously consented to do the work at cost with no profit margin. Bryan Pickens, the architect for Baptist Hospital, was responsible for recruiting these companies and agreed to be the construction manager. He oversaw the renovation project and worked with Mary Leslie Simpson.

A Religious Fundraising Committee and Hospital Fundraising Committee were compiled and a Business Fundraising Committee was in the works. Finally, drawings for the logo of the clinic were presented, the first by Jim Wood, Art Director of *The Knoxville News Sentinel*.

August 31, 1990. A summary addressing the issues of InterFaith Health Clinic as a separate entity was written by David Dotson. As an employer, IHC would be responsible for mandated benefits such as worker's compensation, social security, and unemployment. Health and dental insurance could be more expensive. IHC would not have a problem obtaining insurance, but the cost for the clinic as an independent organization could be a factor. In the current budget, the insurance expense was at the rate established with the policy for Catholic Charities. The Dioceses of Nashville and Knoxville had insured all of their lay employees; therefore it represented a fairly large pool. It was a possibility that IHC employees join a larger pool such as enrolling with one of the hospitals or another group policy to alleviate this problem. A second insurance issue was the need for general liability and insurance on the property and building. Any entity within Catholic Charities was automatically covered by the diocesan blanket policy for board liability. This coverage had a million dollar cap. IHC would need to purchase this form of insurance. The clinic's cost of building insurance was inexpensive in relation to the general market. IHC could purchase this coverage as a department of Catholic Charities, but as a separate entity must purchase the policy elsewhere. Additionally, IHC could participate in the diocesan retirement program. With the spin-off, a new program had to be identified. Accepting bids from other insurance companies and comparing the rates was the only way to obtain the exact price differential for the different insurance plans.

As a freestanding organization, IHC would inherit the responsibility of all financial activity for what would be a complex operation. Accounting for government funds and third party reimbursements (Medicaid and Medicare) would add a significant

burden to the normal collection of fees and payment of bills. Given the clinic's present administrative placement within Catholic Charities, a total of \$13,800 was charged to IHC for financial operations. This included payroll, check writing, accounting, generating monthly reports to the state, and audit. Assuming the clinic remained under Catholic Charities, a full-time position would be added to handle on-site fiscal responsibility. Auditors would probably want more money the following year because the scope of IHC would add to their work. Additional expenses would include computers and a software package to handle medical operations and Medicaid reporting. Due to the fact that the clinic was building upon an existing staff and system, the expenses were low and there was an advantage of an economy of scale. According to Mr. Dotson's estimation, the load generated by IHC was as follows:

Insurance clerk:	\$15,000
Fringe (25%):	\$3,700
Fiscal allocation:	\$13,800
Computers:	\$8,000
Audit:	\$2,000
Total:	\$42,800

As a self-contained operation, it was possible that a fiscal officer, full-time insurance clerk, and another part- or full-time position would be needed. In addition, the clinic would purchase a more powerful computer and at least two more computers for financial activity. In rough figures, this totaled:

Fiscal officer:	\$25,000
Insurance clerk:	\$15,000
Fringe (25%):	\$8,700
Computers:	\$20,000
Audit:	\$5,000
Total:	\$68,700

There remained the possibility of contracting for some services rather than creating a financial staff. The amount of time required would be the wild card to this option.

IHC paid for its administrator, the services of David Dotson, and clerical support. For the fiscal year of 1990-1991, the services from Mr. Dotson and the clerical support totaled \$14,700. The administrative and fiscal expenses were allocated according to a scale formula and were not negotiated in any way. From January to June of 1990, all expenses of the clinic were born by Catholic Charities. The staff cost was estimated at \$20,000. Furthermore, IHC had not been charged for its operation out of the building on Dameron Avenue. The Steering Committee needed to delineate more carefully the job description of the administrator. When the ties with Catholic Charities were severed, the load carried by Mary Leslie Simpson changed. Fundraising, volunteer recruitment, and increased time spent with personnel were a few of the duties of administrators. The staffing pattern needed revision to add either a part-time fundraiser and/or a volunteer coordinator. When the responsibilities of the two staff separated, it was understood why additional staff was necessitated. Mrs. Simpson recruited volunteers, donations, and funds; handled public relations; organized events; coordinated the work of the architect and contractor; organized the Steering Committee and other committees; and recorded the minutes from meetings. Mr. Dotson wrote the grants, did the public speaking, conceptualized the planning, and handled the budget and financial negotiations. Together, they acted as each other's sounding board for advice and strategy. Thus, one person could not take on the responsibilities of both of these individuals. The decision to hire an office manager, a fundraiser, a volunteer coordinator, or a fiscal officer had to be made.

Separation from Catholic Charities would be more expensive and required a revised budget and fundraising goals. Yet, the issue surrounding InterFaith Health Clinic's identity and the fear that the public would not perceive the effort as ecumenical seemed to outweigh the additional expense. Specifically, the process of separation would require the IHC Board to assume corporate responsibility for the repayment of all loans and mortgages. Someone would be assigned to explore the development of a fringe benefit package, particularly the cost of group health insurance and a retirement program. The building and property would be insured with a company other than Catholic Mutual. IHC would explore insuring for general liability. Either a separate financial staff needed to be installed or a new contractual relationship with Charities would be negotiated. The clinic would develop a relationship of its own with its auditors of choice. Delineation of the administrator's responsibilities in relation to the additions of office manager, fiscal officer, volunteer recruiter, fundraiser, etc. was of primary importance. The total operational budget would be revised. New personnel policies would be written and approved by opening day. Finally, by-laws, charter, and a 501C3 application would be written and approved.

September 7, 1990. A progress report on the renovation of the clinic was made. Johnson and Gaylon estimated the total cost of renovation to be \$319,272. However, the budget was between \$250,000 and \$300,000. Johnson and Gaylon suggested alternatives to reduce the cost and most of those were accepted by the committee. The alternatives constituted a savings of \$21,278. Therefore, the cost of renovation totaled \$297,994, and this estimate was accepted. Four companies presented estimates on the roofing, with Johnson and Gaylon advising the committee.

The Fundraising Committee met with Scott Morris on September 9th at Central United Methodist Church. The committee decided to add two new board members, Reverend George Doeblner and Reverend Peter Keyes. The “spin-off” report was presented to the committee and a more detailed estimation of the costs for a spin-off versus remaining a part of the Associated Catholic Charities of East Tennessee was made. This date became a landmark by the first donation to InterFaith Health Clinic of \$5,000 from the ecumenical community. Immaculate Conception Catholic Church gave this donation.

As of this date, Sue Mitchell-Nagge, a MSSW/MPA student, joined Mary Leslie Simpson and David Dotson as Steering Committee staff.

October 2, 1990. The first fundraiser to benefit InterFaith Health Clinic was announced. The Charity Auction would be sponsored by St. John’s Lutheran Church on October 26th, at Emory Place at 7:00pm. The goal was \$10,000.

October 19, 1990. A progress report on the clinic reported that the building loan closed. Delay on renovation would be about one month due to the building permit. The building was covered under the Catholic Charities insurance as long as it remained a part of Catholic Social Services. Bryan Pickens agreed to be construction monitor in addition to his other roles.

The Fundraising Committee had a promising update: Immaculate Conception donated \$5,000, KICCUP \$9000, Morgan Guaranty Trust \$25,000, Bank of East Tennessee \$350, First Tennessee Bank \$300, St. Mary’s Medical Center \$500, Church Street United Methodist \$1,000, and the Episcopal Diocese of East Tennessee \$5,000. The donations totaled \$46,150. Several other groups were presented with information

about the clinic and the feedback on receiving financial assistance was positive. The \$5 ticket sales for OktoberFest at St. John's Lutheran Church on October 26th would benefit the clinic. The seven members of this sub-committee agreed to meet again to establish additional plans of action to raise money.

The internal systems of the clinic had various individuals working on many different aspects. Therefore, the pursuit of the next few months would be to unite these aspects into the formation of InterFaith Health Clinic. The Provider Committee came to decisions on what services to render to clients and what not to. A decision was made against offering detox and OB/GYN services. Dr. Hargrove reported on new equipment that would be needed, new lab regulations, and how x-rays must be read. He felt that the clinic should open with at least one full-time physician on staff and that a registered nurse be hired at that time as well. He also stated that all hospitals wanted to have an equitable share in giving assistance to the clinic. The Social Services/Pastoral Counseling Committee reported that they encouraged the hiring of an L.C.S.W. The committee developed an intake form for clients and considered the development of the professional counselors volunteer base.

For the months of November and December, the Steering Committee focused on the following: fundraising within the religious community, fundraising within the hospitals and business community, hiring of the clinic physician, nurse, and L.C.S.W., creating a draft of policies and procedures, and organizing the volunteer component with a newsletter to be sent out to the community. Under old business, the "spin-off" report was delayed until the end of December because the committee felt that other issues were

more critical. As a result, all donations made to InterFaith Health Clinic were tax deductible for it remained under the Catholic Charities umbrella.

November 30, 1990. A progress report was given which included information regarding the interviewing of doctors and nurses for the clinic. A physician was scheduled to arrive on December 8th for an interview. Steering Committee members were invited to a dinner at Regas on Gay Street to meet Dr. Gary Abel. The second interview with Dr. Susan Wyatt went well. In addition, three nurses were interviewed and two of them were scheduled for a second interview. Another advertisement for an L.C.S.W. was placed in the newspaper with some modifications due to no resumes being received from the first advertisement.

Diane Friar, a graduate student of Public Health, was working with the clinic. Her focus was the utilization of professional volunteers other than physicians or nurses and the establishment of pharmacy policies. A planning meeting with all the graduate students, David Dotson, and Mary Leslie Simpson on November 29th initiated the idea of a Grand Opening Gala highlighting the medical community.

The majority of the 35 people attending the fundraising luncheon on November 20th expressed an interest in the clinic. Next, the committee reviewed a planning chart for the clinic. The physician and nurse would be hired by the end of December. The budget would be revised to add a Volunteer Coordinator, and it would be presented at the following meeting. The first copy of "The Starlight," the InterFaith Health Clinic newsletter, remittance envelopes, and other stationary items were presented to the committee.

Bob Kopel from Children's Hospital and Mary Leslie Simpson met with the County Executive, Dwight Kessel. Mr. Kessel stated in this meeting that InterFaith Health Clinic would in no way affect the indigent care budget. Dr. Hargrove reported that he had spoken to all the hospitals except Children's and had an appointment with them in the next week. Thus far, the hospitals' main concerns were equitable and tandem contributions to InterFaith Health Clinic.

The Social Services Committee finalized the intake form and would not meet again until the next year. The Fundraising Committee had a final meeting set for December 10th, 1990.

January 11, 1991. The Provider Committee presented the name of Mary Headrick for the position of Medical Director. She was an internist and currently employed by the UT Student Health Clinic. Discussion ensued over the concern about the importance of religious activities to the individual appointed medical director of IHC. The vote was unanimous to appoint Dr. Headrick. A standing recommendation from the Provider Committee to hire Dr. Linda Hoersten as a part-time pediatric physician led to the inclusion of this position in the budget. It would cost approximately \$16,000 for five months and \$40,000 for one year. The vote was again unanimous in favor of hiring Dr. Hoersten. Informing the Board of a February meeting with hospital administrators concluded the report.

The Fundraising Committee requested assistance of other Board members to visit area churches. A contribution of \$5,000 for start-up operation funding and a budget line in the future was asked of these congregations. The visiting Board members had bulletin inserts, letters, and volunteer options for the clergy to present to their congregations.

Nancy Knisley, RN was introduced to Board members. She worked with the Red Cross and Health Department in Kingsport, Tennessee.

The progress report on the building projected the completion date to be February 1, 1991. The Rogers Foundation covered half of the X-ray machine. The State renewed its grant of \$250,000 for the next year and possibly the year after next. The spin-off report summarized the steps necessary to complete the independence of IHC. The clinic needed to incorporate a charter and by-laws. The by-laws would define the structure. A 501C3 needed filing in order to be considered a non-profit organization. A committee to nominate Board members was created. On February 7th, a press conference was held to introduce the medical director, pediatrician, nurse, and office staff of the clinic.

February 8, 1991. The building was complete and the clinic staff had been introduced to the community. Invitations to the Grand Openings were sent. The Health Care Professionals Opening would be March 1st. The Community Grand Opening was set for March 3rd.

The clinic staff was in the process of purchasing equipment for the exam rooms. Forms arrived daily from volunteer physicians and nurses. The Provider Committee reported that volunteer physicians were concerned about malpractice coverage when working at the clinic. Interviews were conducted for the insurance and Medicaid clerk.

The meeting with hospital administrators focused concerns on radiology, cardiology, and pharmacy. Each hospital agreed to donate \$5,000 each quarter with an even distribution of admissions based on sub-specialist rotation. St. Mary's lab agreed to cover the first quarter and help establish lab protocol. The hospitals wanted quarterly

reports on their donations to IHC. The first was due in 90 days. The bottom-line totaled \$120,000 from area hospitals.

The Social Services/Pastoral Counseling Committee continued its search. Chaplain Harry Bruen called for a meeting on February 22nd to discuss CPE student placements in the clinic. Fundraising was an ongoing pursuit and the churches were contacted. Some meetings with area churches were set. The By Law and Charter Committee was meeting in two weeks to discuss the mix among the religious, medical, and business community to be on the new Board.

The presentation by George Changas to the Dental Association went well and the Steering Committee thanked David Creasman for his donation of dental equipment.

The question was raised about a statement on “The Sharing of Faith.” Father Brimley and Rabbi Simon agreed to formulate a formal mission statement.

There would be an eye clinic one night a week and Paul Witke arranged for the donation of equipment.

February 22, 1991. The Nominating Committee presented the officers. President was Howard Simon, Vice President was Les Hargrove, Treasurer was Beth Llewellyn, and Secretary was Tommy Strickland. These officers were a mix of the medical, business, and religious communities and were active members of the Steering Committee. Charles Susano presented the charter and it was unanimously accepted. The next item to be approved was the By-Laws.

“The Sharing of Faith” statement was presented and read as follows:

“The InterFaith Health Clinic respects the religious views and beliefs of all individuals and therefore seeks to establish a network of interfaith clergy to meet the spiritual needs

of the patient's religious persuasion, will be contacted whenever said patient expresses the desire for such counseling or attention." The policy was accepted.

Finally, the Kres Agency prepared two brochures for fundraising and patient purposes.

March 22, 1991. President Simon opened the meeting that began with an Administrator's report. Over 500 people attended the openings. On March 6th, opening day for patient services, the clinic saw 12 patients. After one year of planning, InterFaith Health Clinic was officially open to the public and operating.

Chapter 3: The Primordial Years—An Indigent Population Finds Relief

Following the one year and two month development period that led to the grand introduction of InterFaith Health Clinic to the Knoxville community, the Board of Directors took over and daily operation began.

March 1991.

- Sue Mitchell-Nagge hired as clinic social worker
- Provider and Finance Committee formed
- Clinic became Junior League project
- Harry Moskos, editor of *The Knoxville News Sentinel* nominated to Board

April 1991.

- 735 encounters with 463 patients

May 1991.

- 1304 patient visits to the clinic
- Fundraising Committee proposed a golf tournament, “Celebrate the Dream” Anniversary celebration, and the establishment of a “speaker’s bureau” to make presentations

June 1991.

- Over 2,000 patient visits and over 1,000 patients on record
- All staff positions filled
- IHC received its first award, the Agency of the Year Award from the American Society of Public Administrators

- The Dental Clinic opened and operating
- Health care coverage plan approved with Preferred Health Care through the brokers of Rainwater and Hart
- IRS received the 501C3 and needed 100 days for processing
- July 1st 1991, InterFaith Health Clinic separated from Catholic Charities of East Tennessee
- 111 referrals made, \$10,000 of pharmaceuticals given out, and \$3,500 of lab services provided to patients

September 1991.

- Thompson Cancer Survival Center offered to start giving free mammograms at the clinic in November
- Dr. Harry Ogden became the new Medical Director of IHC
- Dr. Scott Morris from the Church Health Center in Memphis visited the clinic and spoke on the operations of the clinic in Memphis
- 92 percent of the clinic patients were from Knox county; 98 percent were accounted for by adding Anderson, Blount, and Sevier counties; 2 percent were from out-lying areas
- Search for pharmacists in regard to the clinic's medical dispensary

October 1991.

- Annual Giving Drive recommended by the Fundraising Committee

November 1991.

- Rogers Foundation donation of \$25,000 received
- "Clown Wall" donated

- 31 dentists volunteered at the clinic
- Oral surgeons agreed to take referrals
- Autoclave donated
- Thompson Cancer Survival Center began mammograms on a monthly basis

December 1991.

- Decision made not to treat alcoholics with Antabuse
- Volunteer physicians' physician assistants may work if covered by insurance
- 632 patient visits in November; patient visits down for December
- 1934 patients at the clinic with an average 30 per day encounter
- \$15,484 received from the Christmas newsletter; grant request to St. Joseph Health System for \$82,500 over three years
- Annual Dinner coordinated by the Academy of Medicine Women's Auxiliary
- Insurance package changed from TIME to Principal
- Finance Committee priorities were the review of Quality Assurance, budget for the next fiscal year, the Computer/software need, and Medicaid Cost Report

February 1992.

- Dr. Dan Beale became clinic pathologist, Dr. Kim Morris worked part-time
- 720 patient encounters in January

- Hilary Clinton planned visit to InterFaith Health Clinic March 6th

March 1992.

- Discussion to expand mental health services
- \$10,000 software package needed to update the clinic
- \$30,000 a month needed from mid-April until the end of June

April 1992.

- Discussion to limit number of Medicaid patients to 20 percent
- City Council grant approved; grant application sent to the Monday Foundation Broadway Center/Holiday Inn Properties through the United Way of Greater Knoxville
- 67 religious institutions agreed to participate in the Count-Me-In campaign
- New billing policy required minimum payment of \$5 to be paid on account before next visit
- Hospitals agreed to increase their quarterly support from \$5,000 to \$7,500

May 1992.

- Park-West and Fort Sanders-West Hospitals made quarterly payments of cash for pharmaceutical purchases
- Count-Me-In campaign raised \$13,136
- 12 grants were in process; the following were likely to be received:

Virginia Rogers Foundation	\$25,000
The Episcopal Foundation	\$5,000
St. John's Episcopal Church	\$12,000
Gene Monday Foundation	\$10,000
Sister of Mercy	\$10,000
Wise Foundation	\$10,000

Public Welfare in Washington D.C.	\$50,000
Total	\$122,000

- Need for licensed social services worker on staff

June 1992.

- Volunteer physician Rob McDonald, volunteer R.N. Sally Cohen, and Margaret Peery to appear on “InterFaith Dialogue” on Channel 10, July 19th
- Donation from the Monday Foundation of \$10,000 for the purchase of equipment
- Catholic Charities requested release from the debt commitment
- 943 patient encounters in May with charges of \$31,439 and adjustments of \$26,645
- Setback occurred when two volunteer physicians hired two staff members from the clinic’s three member business office
- Count-Me-In contributions totaled \$40,288 with a daily average of \$600
- Proposed grants: R.W. Johnson Foundation and J.C. Penney Foundation of \$500,000, American Health Systems Association Care Award of \$50,000, Monica Cole Foundation, and the William B. Stokley, Jr. Foundation

July 1992.

- 1,008 patient encounters in June with \$36,410 in charges and \$28,670 in adjustments
- Count-Me-In contributions totaled \$44,444.25
- Rejections by Amoco Foundation and William B. Stokley, Jr. Foundation
- UPS visited IHC site

- Councilman Gary Underwood agreed to donate from his discretionary funds
- Fundraising accounted for 70 percent of clinic budget
- Suggestion of creating a foundation for fundraising which would work entirely outside of the Board of Directors
- \$7,500 pharmacy payment and a \$10,000 capital gift were used to meet year-end obligations during the last month of the fiscal year; draw received from CHA monies; the clinic was expected to operate in this fashion until an endowment was built
- Patients outside of Knox County comprised 10 percent of total patient population; clinic continued accepting these patients

August 1992.

- Need for staff contributions to Community Shares
- Urgent need for Family Practice Nurse Practitioner because of patient backlog
- 1,038 patient encounters in July; over 3,000 patient charts filed
- \$10,000 grant received from the Weiss Foundation
- Grant applications to: Alcoa Foundation, Robert and Monica Cole Foundation, UPS Foundation, Frank and Virginia Rogers Foundation, Episcopal Diocese Opportunity, Sisters of Mercy, and Lucile S. Thompson Foundation
- Grant requests declined by National Medical Enterprises, Eli Lilly Foundation, and Public Welfare Foundation

- President's Commission on Families (comprised of mayors from across the country) toured the clinic
- Proposal approved to develop Capital Fund Drive to raise \$1,000,000 in a three-year period

September 1992.

- Business Plan Development Committee formed
- Mission statement and Guiding Principles adopted

October 1992.

- Staffing goals determined; question addressed of whether to hire a new Medical Director, Nurse Practitioner, or Physician Assistant
- 65 percent of patients were uninsured, 5 percent on Medicare, 18 percent on Medicaid, and 12 percent on private insurance
- Need for Fundraising support person

November 1992.

- Park West-Fort Sanders Alliance Foundation Board considered contribution of \$100,000 a year for three years to IHC for medical salaries
- Dr. Ogden willing to continue until new Medical Director came aboard in July; interviews proceeded
- Need for volunteer gynecologists; possibility for acute care clinic
- 1,169 patient encounters in October
- Knoxville Junior League donated \$1,000 for secretarial chairs

December 1992.

- Provider Committee recommended hiring Dr. Rob McDonald, who was willing to give up his private practice to come on staff as Medical Director and begin August 1, 1993
- Applicant for Nurse Practitioner considered
- Verbal assurance of \$100,000 from Fort Sanders Hospital; requests to UT and Children's Hospital for assistance; and request of \$100,000 from St. Mary's Hospital to provide for the additional staffing
- Thompson Foundation grant of \$100,000 received for capital expenditures, but hope to divert to operational expenses
- Nominating Committee formed
- Hilary Clinton and Vice-President Elect Gore toured InterFaith Health Clinic

January 1993.

- Dr. Rob McDonald was introduced as the new Medical Director
- Michael Richmond was hired as Nurse Practitioner
- Appeal to Thompson Charitable Foundation to divert echo cardiogram funds to the purchase of medications
- Plan to establish the clinic as an in-service site for UT senior students
- Computer and printer donated by Board member, Daniel Beals
- *The Knoxville News Sentinel* wrote a feature article on InterFaith Health Clinic
- Fiscal year 1992-1993 grant adjusted to \$217,571 from \$224,000 by CHA

March 1993.

- \$85,000 needed to be raised in five months to meet projected expenses
- Possibility of medication fees on a sliding scale as opposed to the current charge of \$2 across the board
- Board meetings scheduled bimonthly; Executive Committee meetings monthly, and others scheduled as needed
- CHA grant cut to \$102,000 from \$217,500 for the next fiscal year
- \$5,000 grant to purchase pharmaceuticals received from the Knox Children's Foundation
- Baptist Hospital guaranteed the mortgage over a five year period

May 1993.

- Mary Leslie Simpson, one of the founding members, resigned
- Increased staffing needs, budget, and clinic volume remained uncertain

June 1993.

- Approximately \$330,000 in contributions must be raised to fund the new budget
- Job descriptions submitted for new positions of clinical administrator, medical assistant, secretary, social worker, and director of fundraising/public relations

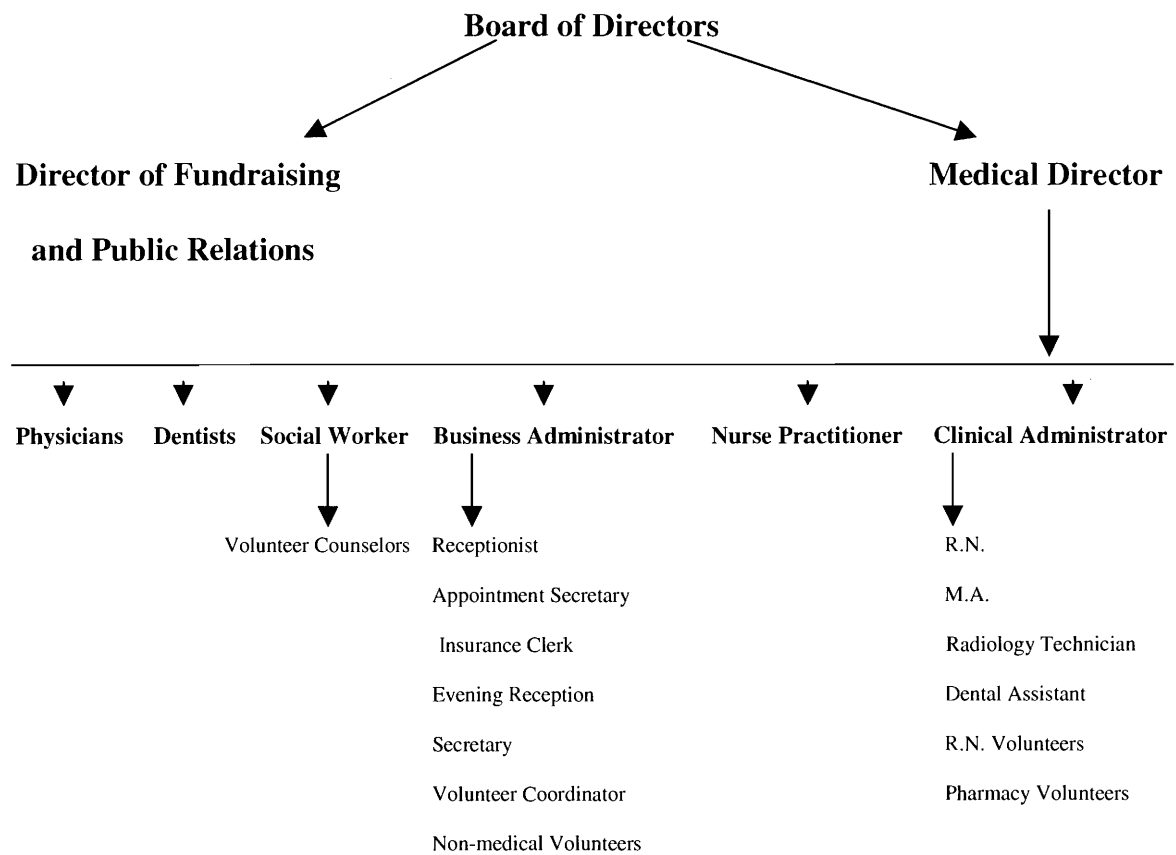
September 1993.

- Dr. Harry Ogden retired as Medical Director
- Michael Redmond, Family Practice Nurse Practitioner, and Diane Montgomery, Director of Fundraising and Public Relations, came on staff

- Catholic Diocese, current guarantor of the loan, wished to be removed from that role
- New patient appointment wait reduced to two weeks since the addition of Nurse Practitioner to staff
- Patient satisfaction and survey on TennCare results: 37 percent had not heard of TennCare, 42 percent indicated that they would continue to seek medical care at IHC, 50 percent had no response, and 8 percent would return to their previous physician

November 1993.

- Expenses ran \$45,000 to \$50,000 a month
- Fundraising activity focused on Congregational, Individual, and Corporate giving
- Board voted not to participate with TennCare

InterFaith Health Clinic Table of Organization

Chapter 4: Is It Worthwhile?

A Mature InterFaith Health Clinic

In 1990, the State of Tennessee estimated that more than 120,000 individuals in the Knox County area were without access to primary health care. InterFaith Health Clinic emerged as a mechanism to combat this rising number and as a way for people of faith to fulfill their moral obligation in caring for the poor and sick. Today the non-profit clinic continues to serve low income working people and their families who do not have health insurance. Located in Knoxville's inner-city at 315 Gill Avenue (one-half block from the city bus line), the clinic remains open five days a week, occasional Saturdays, and maintains extended hours to accommodate work schedules. A small core of paid personnel and a large number of volunteers staff the clinic. It offers basic medical care, specialty clinics for pediatrics, eye care, podiatry, cardiology, gynecology, minor surgery, dental care, diabetic education and counseling, and mental health services. Specialized medical services and tests are available by referral to local hospitals, volunteer physicians, dentists, social workers, psychologists, and psychiatrists who either donate their services or charge on the sliding fee scale adopted by IHC. In addition, prescription medications are dispensed for \$3 per prescription.

Funding for the clinic still comes from numerous sources, including donations from area hospitals, religious congregations, charitable organizations and foundations, local businesses, private individuals, and donations of public funds from local representatives. Neither the federal government nor the United Way provide money for the clinic. Patients are charged on a sliding fee scale based on income and family size.

Their eligibility for service is established using federal poverty guidelines. A typical patient pays around \$15 per visit, which actually costs the clinic about \$55. This leaves \$40 per visit or \$1,750 each day to be made up through donations, grants, or other fundraising methods. Clerical volunteers, as well as donated services and equipment, have kept administrative expenses to a minimum. Direct and in-kind donations of the Baptist Health System, the Covenant Health System, St. Mary's Medical Center, and the University of Tennessee Medical Center support the clinic's operation and facility. Other charitable foundations, about 60 religious congregations, and a number of local businesses offer significant financial support. The Greater Knoxville Sertoma Club, the Junior League of Knoxville, and other organizations host fundraising events each year for InterFaith. Additionally, local physicians and pharmaceutical company representatives donate samples of prescription medications. The on-staff pharmacy technician organizes teams of volunteers who repackage the samples and some purchased medications that stock the shelves of the clinic pharmacy. IHC dispenses more than \$50,000 of medications each month. Medical and dental equipment continues to be donated by the local medical and dental communities, equipment manufacturers, and the Junior League of Knoxville.

A policy-making Board of Directors drawn from the religious, medical, and social service sectors, as well as other interested community volunteers governs the clinic.

What Does 'InterFaith' Mean?

Often the question arises, "Is InterFaith Health Clinic a Christian organization?" The clinic is a product of a group of individuals representing diverse religious groups and

diverse ways of life who united in 1990 to found a medical facility open to all in need. Approximately seven percent of its budget comes from the support of the more than 60 Christian and Jewish congregations in the Knoxville area that support InterFaith. They are an ecumenical group that respects the teachings of all religions and remains unattached in a formal way to a specific religious group or faith. Their work is a ministry and an expression of God's love for humankind—all of humankind.

They do not “preach” to their patients, but when it seems appropriate, the medical staff may offer words of comfort and prayer based on Christian or Jewish beliefs or based on the patient's faith in the power of God.

InterFaith Health Clinic offers an opportunity for the community to express love for its neighbors by supporting the healing ministry. Its ministry is based on religious teachings shared by people of faith. All are children of God, sharing His blessings, accepting the moral obligation to help those less fortunate regardless of belief or expression of faith. IHC is a health facility serving God and humanity in the finest way possible.

Who are InterFaith Health Clinic's Patients?

In March 1997, the governor announced that approximately 95 percent of Tennesseans were covered by health insurance, including the state's version of Medicaid known as TennCare. Approximately five percent—or about 20,000 in Knox County alone—remain uninsured. The clinic serves about 4,500 low-income workers and their family members, elderly people on limited incomes, and those who do not qualify for medical care under public or private programs. Average monthly patient visits are around

1,400. Of all patients at the clinic, 74 percent pay at the 10 percent level of the sliding fee scale.

Patients eligible for care at the Health Department or for coverage under TennCare are not eligible for care at IHC. Two general criteria must be met to obtain services: a lack of basic medical insurance and a low household income. Household income must fall between indigent level and 250 percent of federal poverty guidelines. For example, one-person financial eligibility falls between \$4,320 and \$20,125; three-persons between \$5,040 and \$34,125; and five-persons between \$5,940 and \$48,125.

Clinic Facts

In the 1998 fiscal year, the clinic dispensed \$795,549 worth of medicine. They purchased 13 percent, and doctors and pharmaceutical companies donated the remaining 87 percent.

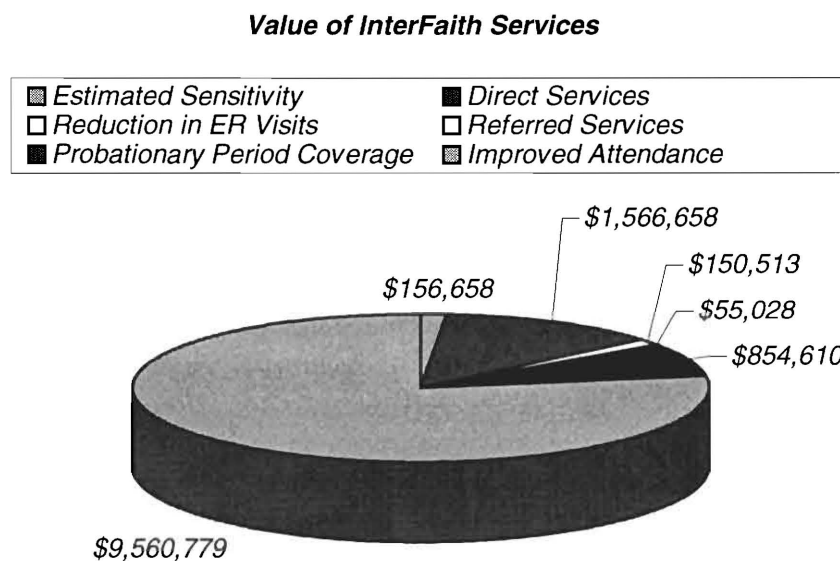
All area hospitals admit and provide diagnostic services for InterFaith patients. Thompson Cancer Survival Center provides mammograms for a minimal fee. Bearden's Lion Club and a local optical company provide eyeglasses at no charge to patients.

On-site volunteer professionals total 91 physicians/providers, 44 dentists, and 37 nurses. Another 300 physicians are available for referral services. Total on-site volunteer count exceeds 200 (doctors, nurses, radiologists, dentists, dental assistants, dental hygienists, mental health, clerical, pharmacy, etc.). Volunteers logged 6,882 hours in the 1998 fiscal year.

In October of 1998, the building mortgage was paid off eliminating the clinic's debt and freeing over \$3,000 per month for patient care.

Medical patient encounters in 1999 totaled 7,865; dental encounters totaled 1,523; mental health encounters totaled 936; and other encounters totaled 4,824. Total patient encounters for 1999 came to 15,148, a number which grows from year to year (www.interfaithhealthclinic.org).

The clinic's estimated economic impact on the Knoxville community falls between \$34,620,780 and \$54,804,801. The lower value is based on patients earning a minimum wage and the higher value is based on patients earning the average Knox County wage. Included in the estimate are factors such as reduction in direct services, referred services, improved attendance at school and work, coverage of those waiting for insurance (probationary coverage), and reduction in emergency room visits. The following graph reveals the estimated value for each of these areas (Holthaus):



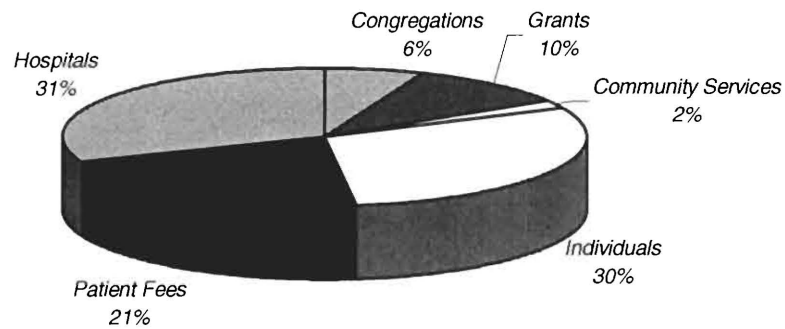
InterFaith consists of one full-time doctor, one part-time nurse practitioner, two full-time medical assistants and one part-time medical assistant, one full-time L.P.N., and

one part-time R.N. During the fiscal year 2000, the dental clinic expanded from part-time to full-time dentist hours in an effort to reduce the seven month waiting list. An additional part-time dental hygienist and full-time dental assistant were hired. University of Tennessee M.S.W. students play a crucial role in the clinic's mental health care services. A paid Director for Mental Health and Social Services handles counseling. In 2000, the Board of Directors created a new position to support the Director for Mental Health and Social Services, the purpose of which was to introduce new patients to the clinic services, inform patients on clinic policies, and find affordable services for individuals who do not qualify for IHC services. Finally, one pharmacy tech staffs the on-site pharmacy.

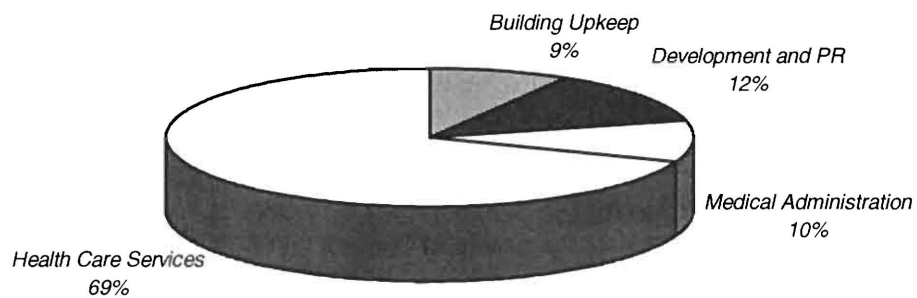
Expenses and Income Increase

Hospitals contributed the highest percentage of income during the 1998-1999 fiscal year. The previous year, patient fees comprised the majority of the clinic's income. Each category's percentage of giving varies from year to year, but the following charts offer a general overview of the annual income increases and expenses that InterFaith Health Clinic incurs. The major factors contributing to the changes in percentage of giving and expenses are paralleled with the needs of the clinic during that fiscal year.

FY 1998-1999 Income



FY 1998-1999 Expenses



Volunteer Hours For 1998-1999

Physicians	1,492
Dentists	435
Dental Assistants	39
Dental Hygienists	150
Registered Nurses	759

Pharmacy Workers	1,967
Mental Health Counseling	1,269
Clerical	290
Medical Transcriptions	123
Miscellaneous	95
Total Volunteer Hours	6,619 (www.interfaithhealthclinic.org)

The Patient's Voice

Statistics can answer questions about the progress of a business such as InterFaith Health Clinic. However, the consumer's opinion can speak volumes in the determination of worth and effectiveness of a cause.

During the months of September through November of 2000, I interviewed patients of InterFaith Health Clinic. These interviews—conducted with the knowledge and permission of the staff—took place in the waiting lounge of the clinic. The attempt was to produce a non-intrusive and non-intimidating atmosphere. The purpose of the interviews was to obtain the patient's perspective of the operations at IHC and not personal or confidential information. I approached patients after check-in and asked if they would mind talking about their experience at InterFaith Health Clinic and with health care in general. These encounters were guided by a set of pre-determined questions. Some people refused, some had little to say, and others were very open about their experiences and with their opinions. The interviews were guided by the following:

Information to be requested of patients:

Age
Sex
Race
Ethnic origin

Questions to be used during interviews:

Why do you seek care at InterFaith? Do you carry health insurance? If yes, what kind?

Where did you receive care before coming to InterFaith? Describe your experience in that setting: average time spent with physician, quality of care, level of attentiveness felt for your concerns and well-being, etc.
 How were you referred to or hear about InterFaith Health Clinic?
 What differences do you recognize between this clinic and other settings in which you have been treated? Describe your experience at InterFaith: average time spent with physician, quality of care, level of attentiveness felt for your concerns and well-being, etc.
 What have been the financial costs/burdens at previous medical settings visited and those incurred at InterFaith?
 What hassles with health care have you experienced, if any? Have those been alleviated or enhanced since coming to InterFaith?
 When being referred to other settings such as hospitals for more specialized treatment, do you feel the care received is any different? Does the fact that you are being referred from InterFaith seem to affect this?

The following figures accounted for the 30 patients who consented to interviews:

Number of Males	6
Females	24
Number of Caucasians	25
African-Americans	3
Hispanics	2
Age 18-29	5
30-39	8
40-49	8
50-64	6
65 and older	3

Not one of the individuals that I spoke with completely disliked the clinic and its services. Although five of the 30 did express one or more negative concerns about the operations at IHC or with a particular experience they had:

A 24-year-old, female, Caucasian.

- She has been coming to IHC for one year because her husband's employer offers no health insurance.
- Previously covered by John Deere and under the care of a private physician, she felt that the care and attentiveness of the staff was good. She had no problems

getting appointments. However, waiting periods were at least one hour and she felt rushed and like just another number.

- A friend who is also a patient at InterFaith referred her to the clinic.
- Her experience at IHC has been good and the overall quality is fine. Yet, she cannot see the same physician and feels that this created mixed communication; not all of her problems get taken care of. The waiting periods are not as long, but she still feels rushed during her appointments.
- The costs are reasonable at IHC.
- She has experienced no hassles with health care. When carrying an insurance plan, everything was covered.
- With referrals from IHC, she is limited to who she can see for second opinions. Her complaints are more with the hospitals than with the particular physicians.
- Her final words were that equal health care should be available to all. Doctors have moved away from being personable, not showing empathy. They treat patients as the “problem” and as “numbers.”

A 30 year old, female, Caucasian.

- She has no health insurance because the cost is too high through her employer.
- Previously, she paid a private physician out-of-pocket for services.
- A social worker referred her to IHC.
- The service at the clinic is the same; quality has not changed. However, she believes that the services rendered are more prompt when paying full price. The dental clinic is also too slow and she claims a one year waiting list. She cites a hurried feeling she experienced at the clinic as well as with her private physician.

- Paying 100 percent of the cost for services with her private physician, the costs at IHC have been alleviated.
- No hassles have been encountered at IHC. Yet other settings will not accept patients seeking care unless they carry health insurance.
- She feels that IHC does a good job and it makes good with what it has.

A 36-year-old, female, Caucasian.

- Carries no health insurance. She went to the Health Department but now makes over the poverty level. Blue Cross Blue Shield covered her but her current employer does not offer it.
- The care she received before was good, they were attentive, and spent enough time with her.
- A friend and fellow patient of IHC referred her.
- She sees no difference in the quality of care between IHC and the Health Department. Although, she has experienced longer waits at the Health Department and it was more difficult to get an appointment there.
- Her concern was over cost. Prescriptions at the Health Department were free and the sliding fee scale was lower.
- The care she received from referrals was fine, but she did not care for the students at UT Hospital.

A 47-year-old, female, Caucasian.

- Carries no insurance.

- Summit Medical Care at Cedar Bluff covered her before. Under this coverage, she received good care and attentiveness, responsiveness even in the evenings, long physician visits, but also long waiting periods.
- She became aware of InterFaith through her own involvement in charities.
- Everything is easier at IHC; even prescriptions can be filled within the clinic. Having to return every four days to refill those prescriptions is a problem. No lowering in standard of care, no increase either. She was satisfied with both her present and previous modes of care. Yet she has been surprised with the service at IHC. Attentiveness to her needs has been excellent. Learning the system at the clinic was difficult. And mental health care at the clinic is a “nightmare.” She has been waiting several months to obtain counseling services.
- Her costs were about \$500 per month before the clinic, and about \$27 per month with the clinic. A huge cost relief.

A 55-year-old, female, African-American.

- Her current employer offers no health coverage. She has been at InterFaith for one year.
- Blue Cross Blue Shield Preferred Care offered through an employer had been her coverage plan until she was laid off. The care under her private physician was good and she never felt rushed. Occasionally there were long waits.
- The Health Department recommended IHC.
- The system is different at the clinic and she is not yet accustomed to it. She is unsure if the quality is any less or if it is just her own experience. She expresses apologies for complaining, but the clinic does not feel “right” to her and she

thinks the wrong treatments have been chosen. She has encountered some long waits but understands there is a reason for them. And, she has never felt rushed by the physician at the clinic.

- Costs are very reasonable at IHC.
- Thus far, she has not dealt with any hassles over health care. Everything has always been paid for, and at one time she was able to pay the deductibles. She has been disappointed that some services would not get coverage.
- In her referral for a mammogram, she paid the sliding fee scale and did not feel treated any differently.
- Her final words were that she only wanted to feel better and have answers for her medical ailments.

The remaining 25 individuals discussed only their gratitude and positive sentiments for InterFaith Health Clinic:

A 22-year-old, male, Caucasian.

- Previously had health insurance through St. Mary's. Under a private physician, he only had five to ten minutes for visits.

A 22-year-old, female, Caucasian.

- After a divorce, she was left without health insurance.
- Husband's coverage provided a private physician. This physician was good to her, she never had to wait, and he spoke to her on an understandable level. He was persistent, acted as if he cared, and never rushed her.
- This same physician referred her to InterFaith.

- She noticed no differences in the quality of care. The staff at IHC was very caring, always recognized her, and was always concerned and willing to work with her problems, even over appointment conflicts and confusions. She never feels rushed and never has long waits.
- She pays 10 percent and believes that it is much cheaper than insurance.

A 25-year-old, female, Hispanic.

- This patient had insurance under her parents. She no longer has private insurance and comes to IHC because it is less expensive.

A 28-year-old, female, Caucasian.

- Previously covered by TennCare, she no longer carries health insurance.
- Before coming to IHC, the care she received was attentive and physicians were good at answering her questions.
- A friend recommended the clinic.
- She has not noticed any significant differences, but the staff is friendlier at IHC. Costs are not bad, but TennCare covered all costs.
- The medical waiting periods are not long. Dental and eye care waiting periods can be long.

A 33-year-old, male, Caucasian.

- He has never had health insurance, except for the time he was in the service. A Desert Storm veteran, he feels that the care from the VA has been a waste of time. He spent hours waiting, he was sent multiple places for care, and not one physician would sit and talk to him. He had many tests run, but no one to explain

what they were. The VA does not want to pay or admit their wrong; it is all about politics and money.

- A friend referred him to InterFaith Health Clinic.
- The quality and attentiveness at the clinic has been much better. The staff wants to help and visits are not rushed. Still he has no answers to his ailments but he recognizes that the clinic is doing all they can. The costs are very reasonable.
- He was referred to St. Mary's for tests and experienced the same problems he had at the VA.

A 36-year-old, female, Caucasian.

- She has no health insurance and has been coming to IHC for two and a half years. Lost her coverage when changing jobs.
- Under her private physician, whom she saw for 10 years, the care was good. She never felt rushed, all her concerns were considered, and she received preventive health care. Long waits did ensue. Although she was content with her physician, the insurance was a pain. Her HMO never agreed on the medication and tests that her physician prescribed.
- A Department of Social Services referred her to InterFaith.
- At IHC, the quality of care is very good. She has always gotten an appointment when needed; the services are more accessible. She has only felt rushed once when getting a quick diagnosis. Never experiences long waits unless getting worked in. Additionally, there are resources at IHC which she did not have before, such as a nutritionist.

- Financial costs are reasonable, a “God send.” She stated that she could not see any health provider until she found the affordable services of IHC. At one time, she became very sick and went without medication because it was unaffordable.
- Hassles with health care have been encountered. Her HMO would not pay for medication and her physician had to call for special exceptions. She waited for long periods to see a physician. Certain procedures requiring multiple visits would only get covered for one visit. When seeing a specialist, only three months of care were covered and she was required to go through the entire process to obtain coverage again. It was a financial burden and a hassle on her and her doctor’s office to get services paid for.
- InterFaith referred her to a nutritionist which she had a very good experience.
- In her final thoughts, she felt that it was important for clinics like InterFaith Health Clinic to be available in the community. Coming to the clinic was a “last straw” for her, and she is appreciative for it.

A 36-year-old, male, Caucasian.

- Previously covered by Blue Cross Blue Shield. Visits lasted about an hour, he never felt hurried, and the quality was fine.
- A friend recommended IHC.
- The care at the clinic is better and the staff cares more about what he says. The visits are about equal in duration to those with the private physician. The costs at IHC are great. He appreciated the time that the clinic donates.
- He has at times before encountered hassles getting tests covered. The statements would get resolved but the time it took to resolve them was too extended.

- He believes that other health care settings could learn how to treat patients from IHC. At the clinic, one does not feel like a number. Other settings could care less. In his opinion, health care in the United States is pathetic. We are the wealthiest nation, yet people cannot afford health care. He cites Canada's health care system as a good model. He feels that the medical profession does not care about people anymore; it is all about money. Things have changed since his childhood. Employers paid for health care and it was never an issue. His current employer does not offer benefits because it claims coverage to be too expensive.

A 36-year-old, female, Hispanic.

- Sought care with her family at InterFaith because she did not have enough money to go anywhere else. This was only her second visit.

A 37-year-old, female, Caucasian.

- Received care in Pennsylvania and under Medicaid, but now has no insurance.
- A friend recommended the clinic.
- She sees no differences between the care here and before; they are equally attentive. However, the costs have definitely been alleviated. Under Medicaid she was limited to doctors. She feels better off at InterFaith and likes the number of services that are available.

38-year-old, female, Caucasian.

- She has not had health coverage for 16 years except for the last two in which she has come to IHC. Coming from Massachusetts, she felt that you got what you paid for. On occasion, the quality was good, but physicians were not attentive and visits were only five minutes long.

- A Board of Health referred her to IHC.
- The physicians care more at the clinic and do not prolong or put off needed procedures. She spends 10 to 20 minutes with the physician, but no longer is needed. Doctors are much more attentive, the quality is better, and the waits never exceed one hour. The costs cannot compare, especially over prescriptions. She cites paying \$3000 for services elsewhere, which now cost her only \$300.
- No hassles encountered at IHC, but definitely with her care before.

40-year-old, female, Caucasian.

- She has come to IHC for two months. Blue Cross Blue Shield covered her at one time. Physicians would not spend time with her. They only wanted her money and to get her out. The quality was not good and it just ran up her bills.
- An ER doctor referred her to InterFaith.
- At the clinic, services are very prompt and the staff is concerned. No problems except that she has never been seen by the physician, only the nurse practitioner. She never feels rushed, the quality is excellent, and the staff never treats patients as rejections of government assisted programs. She believes that communities need more clinics like IHC. The staff is very informative to patients, describing things thoroughly. They return calls immediately. The staff is made up of “good folks who care about you.” The costs are reasonable as she pays 10 percent on the sliding fee scale. She had to cancel Blue Cross Blue Shield because it became too expensive (\$311 per month for her and \$254 per month for her husband).

- Referrals to other settings have been easy because the clinic handles everything. They operate as a business should. She is treated at other settings just as if she had insurance, even better at times.
- In her final words, all healthcare venues should operate on the sliding fee scale because health care has become too expensive. People should be treated equally, with rights to health care. Her wish is that more people could learn about InterFaith Health Clinic, as there are many people who are in need but are not aware of the clinic. Enough cannot be said about the clinic, they are great people. They do not rush; they go over everything thoroughly. The staff works as a team and she never sees conflict. The waits are minimal or never encountered. This kind of treatment cannot be found at any hospital or other physician's office.

A 46-year-old, female, Caucasian.

- Never had health insurance and has come to InterFaith for two years. She previously went to UT Hospital and paid out-of-pocket emergency care. She always felt rushed and thought the quality was low.
- When her husband was in an accident, an attending physician referred them to the services of IHC.
- The quality at IHC is much better. The staff is thorough, they take their time, and they are friendly. The staff follows up on her referrals to other settings to make sure that the services she needed were properly rendered. She believes in the policy to see the physician before obtaining prescription refills. Additionally, she agrees with the other policies of the clinic that provide consumer discipline such

as the maximum three chances a patient is given to call the clinic if he or she misses an appointment.

A 46-year-old, female, Caucasian.

- Once covered by Columbus Regional Medical Healthcare in Georgia. She has been a patient of IHC for one year and four months.
- Her care in Georgia was adequate, 20 to 30 minutes per visit, which was enough.
- She was a volunteer at the clinic and knew the nurses gave good care. And so she became a patient herself. The quality of care at IHC is good, better than medic units because it is more prompt. IHC is always accommodating. An average visit is 20 to 30 minutes. She likes the variety of doctors she sees because of the large volunteer staff. The costs are reasonable. She has paid \$60 per visit at times, and now pays only \$3. A specialist at the clinic has seen her, and she has been seen by the breast clinic (mandatory for individuals over 40 years of age) for only \$5.
- In her final words, she expresses how glad she is that InterFaith Health Clinic exists. When her job downsized, she went three years without health coverage.

A 46-year-old, male, Caucasian.

- Currently covered by TennCare and coming to InterFaith for one month—his second visit. No health coverage before.
- A clinic in Crossville, Tennessee recommended IHC.
- The quality of care is high. The staff explains things well and they are friendly and courteous. The cost of care is more than reasonable as he paid the full out-of-pocket price for all services prior to IHC.

- He has not yet experienced any problems with TennCare but he has only been covered for one month. Even so, he heard that others using Access Med Plus have hassles obtaining payments for services.
- In referral to a lung specialist, he felt no difference in his treatment.

A 47-year-old, female, Caucasian.

- She has been without health insurance for 10 years.
- Never have any problems at IHC. They do many tests and make sure that all bases have been covered.

A 49-year-old, female, African-American.

- Previously, she was covered by a PPO at UT and sought care at the UT Student Health Clinic. The Student Health Clinic's quality of care was fine. Care she received from Baptist Hospital was good, there were not long waits, visits were about 20 minutes, and they asked if she had questions. The PPO was well explained and she encountered no problems, but the cost was high, \$50 to \$100 per month. Although, she is aware of others who have many problems, especially with the Standard Coverage Plan.
- Her thoughts on health care in general are that everything is too expensive and drugs are too dangerous. Medical care is higher than the cost of living—higher than her mortgage and car payment together. She feels that individuals are discriminated against when trying to obtain health insurance. Our nation is too greedy; they have forgotten the quality of life. There is more wealth in our country and people are being taxed to death. She prefers socialized care because many places will not treat a patient unless they are covered. "Don't dare get sick,"

she exclaimed. She partly faults her employer who falsely classifies her as a temp to avoid offering expensive benefits. Meanwhile, she is working on a master's degree to teach, working full-time, and at one time she also had to worry about where to find medical care.

- The UT Student Health Clinic referred her to InterFaith.

A 49-year-old, male, Caucasian.

- Previously had TennCare, but the quality was low. He was forced to change care frequently. He encountered only one physician that was attentive to his needs; others brushed him off. He experienced long waits. TennCare would not pay for many of his medications.
- He came to InterFaith upon being dropped by TennCare. Despite this, he stated that he was glad to be rid of TennCare.
- The quality of care at IHC is much higher. The time with the physician is about the same but he feels more open to express his concerns.
- Upon referrals, there has been no change in the manner to which he is treated.

A 55-year-old, female, Caucasian.

- She has been a patient at IHC since May of 2000. No previous health coverage.
- For all services, she paid a private physician out-of-pocket. He was an older physician who took his time and was attentive to her needs and concerns.
- A friend referred her to IHC.
- The staff at the clinic is more thorough. They are nice people who are truly concerned with your problems.

A 55-year-old, female, Caucasian.

- She does not have health insurance.
- She expresses her love for InterFaith Health Clinic and the services they provide.

The staff, especially the nurses, is very nice.

A 56-year-old, female, Caucasian.

- At one time covered by Blue Cross Blue Shield, she has been coming to IHC since May 2000.
- She was not content with her private physician and felt that he wanted to get her in and out. He was not as attentive as he should be.
- A friend of the family recommended InterFaith Health Clinic because she needed a hysterectomy and could not afford it.
- No words can express how good InterFaith makes her feel. She is more at ease at IHC, she can talk to the staff, and they have been nice since day one. The quality is wonderful and she has never heard complaints from anyone. The costs are reasonable and have helped her out a great deal. At other practices, it was \$60 just to walk in and that was difficult for her to cover.
- She and her husband have experienced problems trying to get covered by TennCare. And Blue Cross Blue Shield was too expensive, \$500 per month.
- She was referred to Baptist Hospital, and they were excellent.

A 57-year-old, female, Caucasian.

- Once covered by Metropolitan, she lost her health insurance and had to file bankruptcy. She has been coming to IHC since 1994.
- Metropolitan was good insurance and the quality of care under it was excellent. She had a good relationship with her physician.

- A coworker recommended IHC.
- She notices no differences in the care except that preventive medicine is taught at the clinic. She has been referred to a surgeon that works with the clinic and has no complaints. Her treatments have ranged from estrogen therapy and pap smears to mammograms. And follow-ups were done when she broke an ankle. The costs are unbelievably reasonable. Only \$3 for a 30-day supply of medications and \$9 for all her medication.
- The clinic is an excellent model for other areas. It is a positive establishment for the community.

A 64-year-old, female, African-American.

- Never has had health insurance. She sought care at the Health Department, which only covered certain services. For this reason, she became a patient of InterFaith Health Clinic. The quality of care at the Health Department was fine and she felt the staff was attentive.
- A friend recommended IHC for the availability of more medical and dental services.
- The costs at IHC are reasonable.
- In general, she believes that health care is too expensive. She performed hard, laborious work all her life, in cotton and cornfields, and never received any benefits. Hard workers deserve their health and treatment. "There is no love anymore," according to this patient.

A 74-year-old, female, Caucasian.

- Sought care at UT clinic years ago and is now under Medicare.

- She has been receiving care from InterFaith for two to three years and says everything is great. She has been fortunate enough not to need a lot of care but thinks that the physicians at the clinic are great.

A 77-year-old, female, Caucasian.

- Carries Medicare and some supplemental insurance. A patient of IHC for six to seven years.
- The quality of her care before qualifying for Medicare was fine.
- A friend referred her and her husband to IHC.
- InterFaith cares about getting her healthier, the staff is very sweet, and the quality is good. Medications are cheaper and the convenience of filling them at the clinic is an advantage.
- Has received referrals to area hospitals and experienced no problems.
- She states that because InterFaith has the title of “clinic,” there is an impression that the treatments are rushed. Conversely, the clinic operates nothing like that; Dr. McDonald takes his time and cares about his patients.

A 77-year-old, male, Caucasian.

- The husband of the former patient is also covered by Medicare and has experienced no problems. He has had problems with the supplemental insurance not wanting to pay its fair share. It took four months to obtain a payment.
- InterFaith Health Clinic has been absolutely great, and the physician has tried every way in the world to help his wife and him.

The InterFaith Health Clinic understands that an individual's health is measured by more than just the newest medical technologies, breakthrough treatments and procedures, cures, and scientific discoveries; health is a quality of life and longevity that all are entitled to. It is ensuring that each of us, wealthy or poor, have a life worthy of being in its best condition. For those of us blessed with health or the money to secure a certain health status, we should recognize that it is not something to be flippant about. At any moment it could be stripped of us. In a privileged class, it is often difficult to accept the moral obligation to provide for those in need and agree that all have the right to receive equal health care. If found among the 54 million uninsured Americans, would we wish to be denied access to any, let alone quality, health care?

Our nation is in a state of health care crisis. The United States has the most expensive health care system in the world. National health care expenditures reached \$1.035 trillion in 1996—more than twice as much was spent in 1985. This figure accounts for 13.6 percent of the gross domestic product (Lonnquist and Weiss 289). On average, Americans spent \$3,708 per person on health care in 1996 (290). When you are a full-time employee living at the poverty level and supporting a family of four, this cost is astronomical. For the 11 percent of employed Tennesseans that lacked health insurance in 1997 (Tennessee Health Status Report of 1999 www.server.to/hit), InterFaith Health Clinic and others like it offer financial relief and a new perception of health for the working poor and their families. I believe that one patient I interviewed said it best: InterFaith Health Clinic is a "God send."

A Final Note

Often, limited incomes fueled by unlimited gratitude and generosity become some of the most dedicated donors. These individuals know how each and every dollar received by a non-profit organization is stretched. The following letter, written by the Founder and Executive Director of the Church Health Center in Memphis, Tennessee, is a fine example of this humility:

Dear Friends,

The first year the Church Health Center was open, Katherine (my wife and, at that time, my nurse) suggested we go Christmas caroling with some friends to a select list of our elderly patients. We set off one mid-December day as soon as it was dark. Our first two visits went well. Everyone was having fun.

The third stop on our list was at the home of Virgye Shinn. Virgye was a woman in her seventies whom I had seen several times for a variety of problems. She was one of the first patients Katherine and I thought to include on our caroling tour. Her apartment was in a rough part of town. We had trouble finding her address. The halls were poorly lit, and we had to climb to the second floor. I knocked and knocked at her door, almost giving up, until Virgye finally appeared. Rather than expressing delight in seeing us, she told us in a gruff voice to "go away." I was startled and embarrassed.

A few days later Virgye apologetically told me that she had been in the middle of giving James a bath. I had not realized until that moment that Virgye did not live alone. James was terminally ill. He needed constant attention. She shared her apartment with him in order to save money, and she took care of him. The experience, which previously embarrassed both of us, now bound us together. Although Virgye lived on a fixed income, she started sending the Church Health Center \$20 every month. I told her, "You don't have to do this, Virgye." She replied, "Oh, but I do. It's the one way I can give back and help others like me." For 12 years Virgye kept her monthly check coming.

Two years ago she told me she had a favor to ask me. "Doctor Morris, I want you to promise me that when I die, you'll be there to do my funeral. Will you do that?" I said I would.

Last spring the time came around for me to keep my promise. At Virgye's funeral, I read the passage from Luke about the widow's mite: As Jesus looked up and saw rich people dropping their gifts into the chest of the temple treasury, he noticed a poor widow putting in two tiny coins. "I tell you this," he said: "this poor widow has given more than any of them; for those others who have given had more than enough, but she, with less than enough, has given all she had to live on."

I have also made a promise to the tens of thousands of other patients we care for. The Church Health Center will be here to offer the best health care that Memphis has to offer for years to come. I have made this promise on faith—the faith that there are others like Virgye who will support our work month in and month out. With confidence born of this faith, we have created the Virgye Shinn Society for those of you who have made more than 100 gifts to the Church Health Center. Virgye’s \$20 may not seem like much, but it can immunize a child or buy a pair of glasses. Over time, her gifts have made a difference in dozens of lives—and so can you. Please join her so that we can keep the promise we have made to care for those who work among us but are uninsured. With hope for healing,

Scott Morris (www.churchhealthcenter.org)

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