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Missoula County's "Partnership Health Center" : a community program to care for the medically indigent.

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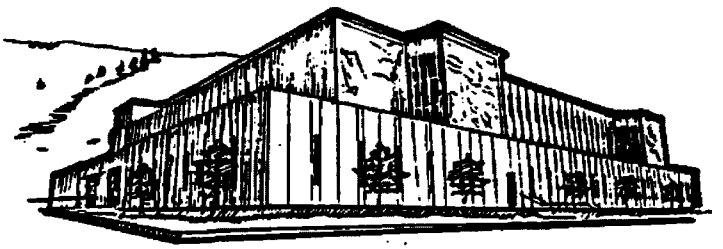

MISSOULA COUNTY'S "PARTNERSHIP HEALTH CENTER": A COMMUNITY PROGRAM TO CARE FOR THE MEDICALLY INDIGENT

By

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CHAPTER I

STATEMENT OF THE PROBLEM

Low-income people and those on Medicaid have not had adequate access to health care and their numbers are increasing. Growth of this segment in the population has had a negative impact on the entire community health care system, particularly the physicians, hospitals and local government.

The community of Missoula, Montana has taken charge of solving its own problems rather than waiting for the national government to solve them for it. The joint participation of Missoula's two hospitals, 80% of its physician group, the Missoula City/County Health Department (MCCHD) and the city-county government produced the PARTNERSHIP HEALTH CLINIC. This partnership was formed to provide medical access to a group of people who were uninsured or underinsured for medical care.

A Nationwide Dilemma

In order to respond to the challenges of such complexity, an understanding of the past is important. Access to heath care is not a new problem. National Health Care was proposed in President Truman's Administration and rejected by Congress in 1949. Since Truman's time, we have

continued to grapple with the issue by reacting incrementally to only parts of the whole structure.

Medicare and Medicaid were implemented in the 1960s, providing medical care to the elderly and low income persons, respectively. Medicare primarily established federal guidelines for universal enrollment of all Americans over the age of 65; whereas, Medicaid was designed as a welfare program to make health care available to the nation's poor.[1]

Medicare and Medicaid were maintained for years on a high percentage of reimbursement, essentially unchecked. The recipients were not monitored by any mechanism; no controls or calculations were maintained regarding such matters as how many or which specialties of physicians they visited, whether the visits were legitimate or if the emergency room visits were bona fide emergencies.

The physicians were not given guidelines to conduct treatment. It was left to their discretion to run tests, provide treatment and prescribe medications. They always received the same percentage of reimbursement for "reasonable" care. The lack of financial restraints created a lack of incentive to conserve; expenditures for entitlements skyrocketed.

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[1]Office of the Legislative Fiscal Analyst "Fiscal Training Manual," p. 126, Helena, Montana, February 1989.

The federal government became increasingly concerned in its efforts to control costs because of the unanticipated bigness of the programs, compared to what was envisioned when they were instituted. Unforeseen developments, such as high costs for new medical technologies and the substantial and sustained increase in the elderly population led to major impacts on the insurance industry, business outlays for employee benefits and the federal budget. The Congressional Budget Office projected alarming cost increases by the 1990s that could bankrupt the trust fund that finances Medicare. Action had to be taken.

By the early 1980s, Congress enacted legislation which provided for cost shifting. DRGs (diagnosis-related groups), were established by the legislation, creating a prospective reimbursement system that shifted economic risk onto providers. Deductibles and increased premiums were also required, shifting more costs onto the individuals.

Grass Roots Repercussions

Medicaid policy, which is funded jointly by federal and state governments, was shaken when the federal government cut its match rate, shifting increasing burdens to the states. The first thing the states did was to cut provider-reimbursement rates, basically (physicians average 45-50 cents on the dollar for taking care of someone on welfare) pushing costs and responsibilities onto the providers. When

that did not balance the budget, the states increased the requirement for Medicaid eligibility, forcing many people out of the program altogether.[2]

As a group, the low-income typically are "walk in" patients, do not show up for appointments and further abuse the system with excessive visits and physician shopping. The low-income also exhibit high rates of unhealthy behaviors such as poor diet, smoking, alcohol and drug abuse, teen pregnancy and violence, which worsened the preceding antagonism created by reduction in reimbursement. This cycle was further exacerbated by physicians reducing the numbers of medicaid patients they would see or rejecting them entirely. Running out of choices, the medically indigent increasingly used the emergency rooms for inappropriate reasons. These non-profit facilities could not turn anyone away.

The emergency room's true mission is care of the crises patients. Yet, statistics showed that 75 percent of indigent visits to the emergency rooms had been for nonemergencies and this percentage appeared to be increasing. This was one of the first warning signals that something was wrong with Missoula's health care system.

If a person does not have insurance coverage and does not have the funds to pay cash for an appointment, that

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[2]John Kitzhaber, "Uncompensated Care--The Threat and the Challenge," The Western Journal of Medicine 48 (June 1988): 711-16.

person has increasingly lost access to the health care system--either because providers would not accept any additional indigent patients or the patient delays treatment because of an inability to pay for it. The MCCHD picked up more and more of the overflow by shifting funds for that type of nonmandated service. Ultimately, insufficient funds caused the MCCHD to stop providing primary care. This was the event that precipitated community heads toward reinvention of health care for the medically indigent.

The commitment to universal access, at all levels, was showing signs of erosion. A consequence of real and measurable deterioration of health for an increasing number of people followed. Growth in infant mortality and low-weight births was one of the first obvious indicators of the malady.

One Local Model for Success

On the local level, the MCCHD, in cooperation with a few physicians, responded to the problem of infant mortality with a program called "Access Links." It started with a few physicians who agreed to work with it.

The Access Links program played a crucial role in assuring better pregnancy outcome for both mothers and infants in Missoula County. The program has reflected the experience nationwide that early comprehensive prenatal care has been effective in reducing the incidence of low birth

weight, even in high risk populations. Highlights of the program's effects for prenatal care were reductions in prematurity and infant mortality. Its cost-benefit ratio has been attractive; for every $1 invested, $3.38 has been saved in the cost of care for prenatal care.

It came as no surprise that legislation increased Medicaid reimbursement for obstetrical delivery and care because of the significant savings. Eventually, most physicians became participants.[3]

Access Links has served as a model for further community efforts, e.g., the Partnership for Access (PFA) and follow-on Partnership Health Clinic (PHC) programs, to provide health care to the larger medically indigent population. However, it is only one success story in the rising tide of demand and reduced level of support for the system.

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[3]St. Patrick Hospital Archives. 1985-1992, File "PFA," Missoula, Montana.

CHAPTER II

PRELIMINARY COMMUNITY EFFORTS

A decade ago, the Missoula Health Care Community was scratching its head while fumbling with more signs of the broken system. Constant searches for definition of the problem and abortive attempts for a solution were precursors for today's working model for health care.

Walk-in Clinic Initiated

The MCCHD initiated a walk-in clinic in 1985. It was for the expressed purpose of treating minor illnesses and injuries of people not covered by medical assistance programs and otherwise unable to afford existing medical services. These persons were targeted because of the belief that they were not efficiently using health care services (e.g., for prevention or early treatment), but were using it sporadically and only after suffering because of significant illness or injury. These circumstances strained further the already over-extended use of scarce resources.

To worsen further the condition of health care for Missoula's poor, the city/county resources were subjected to budget cutbacks in 1985. Then, in 1986, Montana voters adopted Initiative-105, freezing property tax rates at the level of local government. Now, it was no longer possible to raise funds to solve these growing problems. The cost of

providing care for the medically indigent exceeded the fiscal capacity of MCCHD to fund the service.

The Health Department and One Hospital Join Hands

In 1986, the MCCHD contracted with St. Patrick Hospital for managerial, medical and financial support to continue treatment of minor illnesses and injuries for people not covered by medical assistance programs or unable to afford existing medical services. Specifically, the agreement stated the following:

> FIRST: The concept of the 'Public Health Clinic,' if it is to have long-term value, requires that both parties have a strong commitment to the program that is not based on the annual availability of funding.
>
> SECOND: The county will supply space for the clinic.
>
> THIRD: The county will provide a monthly expense and revenue accounting for the clinic. The expenses included in this accounting must be direct expenses only and not allocated overhead expenses.
>
> FOURTH: The difference between total direct expenses and revenue from the clinic will be divided between the county and the hospital on a 67%-33% basis, respectively.
>
> FIFTH: Physicians may volunteer to work in the clinic and may bill medical assistance programs for patients qualified for such programs.
>
> SIXTH: Patients whose care is beyond the scope of the clinic will be immediately referred to an outside physician and/or hospital of patient's choice.
>
> SEVENTH: Files will be kept by the county on each patient and documentation will be provided for each visit in a log book and in the patient's chart.

EIGHTH: The county will review applications for free care, or care at reduced cost and assign the appropriate payment schedule for each patient.

NINTH: An Oversight Committee will be established with one representative from the county, one from the hospital and a member at large representing the medical community. The purpose of the committee will be to review monthly operations, establish financial operating policies and to advise on staffing, hiring and other operating policies.

TENTH: The clinic is established primarily to treat acute minor illness or injury and to refer patients requiring more extensive treatment or care.

St. Patrick Hospital continued to encourage physicians to volunteer as staff members at the clinic, help identify physicians to which patients might be referred if further medical attention was needed, provide hospital diagnostic work for acute care as hospital resources were available, provide clinic supplies at cost and participate in the oversight of the clinic.

Full-time Physician Assigned

In 1987, St. Patrick Hospital sponsored a primary care physician for the clinic at the MCCHD. He functioned as an advisor and consultant on the medical services provided to insure quality care. He also focussed on reducing concerns of some community physicians that too many people would be seen for acute care treatment at the Health Department by nonphysicians. Finally, this "sponsored physician" acted as

a liaison between the MCCHD and the hospital, in their efforts to clearly define the problem.

In the spring of 1988, additional goals were established jointly by the MCCHD, St. Patrick Hospital and the sponsored physician. First they examined the feasibility of developing a pool of volunteer primary care physicians to assist the nurse practitioner at the Health Department. Second, they established a surveillance system at St. Patrick Hospital's admitting office and emergency room to determine what additional modifications of the care system would lessen the need for in-hospital services.

Indigent Health Care Task Force Formed

Spearheaded by the sponsored physician at the MCCHD, a citizens' task force on health care for the medically indigent was formed. Health care groups were contacted. Concurrently, a clinic study of 105 randomly-selected charts of patients seen by a family nurse practitioner was summarized. MCCHD was providing care to outpatients and the survey revealed that the caseload was rising. This elicited more questions: Would the load soon exceed MCCHD's physical and financial capabilities? Was the quality of care satisfactory? Was the MCCHD diverting patient flow from physicians' offices? What sort of clients were being seen at the MCCHD? Was the care considered similar in quality to

that which is delivered in the average primary care provider's office?

A community problem-solving process began in the spring of 1989. It was facilitated by a consultant whose charge was to assist in addressing the question of how to provide quality affordable health care to those citizens who could not afford it. The task force identified broad concepts of need, reviewed MCCHD's primary missions (mandated, traditional and expected) and brainstormed current issues. Its charge was to work with the community to define, examine and bring to resolution the question of how to provide quality, affordable health care to citizens who are under-insured or uninsured. It also identified and communicated with others who needed to be involved in the process, developed and assessed alternative solutions and assisted the MCCHD in the development and presentation of a final recommendation to the County Health Board. The issues to be explored were identified as follows:

- What is the mandated responsibility of the Health Department?
- What social services exist to provide health services and to what citizens?
- What is the community need?
- How far should the community go with health care?
- What is the likely outcome of solving the problem?
- What are the causes of the problem?

o How does the problem manifest itself on the other health care providers?

o What are the implications if nothing is done to change the current situation?

o What is the definition of "medically indigent?"

o In what ways might donated care be provided and what liability problems exist?

o Is dental care a part of this problem, and if so, how?

o What is currently being done about this problem?

o What current local health care delivery systems exist for citizens who cannot pay?

o What are people's expectations of health care in this community?

o How might we define health consumer(s)?

o Should the MCCHD provide service for clients who are able to pay through programs such as Medicaid?

o How do we get health care providers to participate in the solution?

o How might we fund solutions?[4]

Indigent health care task force meetings continued in a quest for answers. It held panel presentations representing various interests, for instance, the insurance industry, local businesses and the Institute for Medicine and Humanities. Reports were provided by: a Missoula County

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[4]Ibid.

Health Officer on legal mandates, commissioners on federal programs, the sponsored physician on information regarding the indigent and the nature of their problems, representatives for the physicians on a summary of their comments, the Western Montana Clinic on liability of donated care and the Human Services Director on government and social assistance.

Local Physicians Volunteer

A positive response was received from St. Patrick physicians when they were asked to see an occasional no-charge patient on referral from the MCCHD. Subsequently, the Missoulian presented a story including news that the MCCHD was being paid for seeing Medicaid clients. Additional challenges followed.[5]

Inquiries from physicians resulted regarding the anomaly of asking them to see clients at no charge while the MCCHD was being paid for seeing clients with Medicaid benefits. Other physicians were concerned that the Board of Health policy permitted the clinic to see, at no charge, fully insured persons, such as those with military or county insurance coverage. A request for the Board to establish provisions for primary care services for clients with medical coverage was submitted.

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[5]Ibid.

Client Base Characterized

Meanwhile, formalized questions were developed to characterize the clients seen at the MCCHD. By fall of 1989, the Director of MCCHD received results of the questionnaire/surveys. Together with additional research, MCCHD defined the segment of the population that was in need of health care.

Antithetical to former reality, many of the falsehoods regarding the medically indigent were dispelled by these surveys. The resulting attitude change proved essential in gaining acceptance for increased community commitment and eventual approval for the Partnership for Access (PFA). It allowed the planning stage to get underway.

The following myths were believed to be true about the children who came to the PFA clinic without insurance: their parents were single heads of household, they were of minority race, they had poorly educated parents, they never used the private health care system, they were from large families, they had transient families, they did not have a physician, their families received government subsidies, their parents were unemployed and were misusing their resources. Survey findings reported the following facts about these children:

- 82% had married parents
- 92% were Caucasian
- 66% had parents who had completed high school

- 62% belonged to households with unpaid health care bills and 61% had bills over $500
- 35% attempted to get health care in the past year but were unable to because of inability to pay
- These children belonged to households averaging 2.1 children
- 92% lived in Missoula (average length of residency was approximately 15 years)
- 58% had a physician and 74% had visited a physician within the year
- 64% received some public subsidy
- 32% of those bringing the child were partially employed and 16% were fully employed; when another adult was in the household, 88% were employed
- 76% were estimated to be in households at or below poverty level

Myths concerning the adults who came to the clinic without insurance were that they: were very young male persons, were of a minority race, were poorly educated, did not receive health care, were childless, received welfare checks, were transient, overused the clinic resources, were not political, misused all of their resources and were never employed. Survey reports revealed the following facts about the adults:

- 74% were 21-40 years old
- 66% were female

- 78% were white
- 63% completed high school
- 69% had unpaid health care bills and 56% had bills over $500
- 46% lived in households where health care was denied to someone because of inability to pay
- 43% had a Missoula physician and 62% had visited the physician in the last year
- Their households averaged 1.19 children
- 16% of the households received welfare checks, 31% received food stamps and 20% received WIC (Women, Infants, and Children program) funds
- 96% were from Missoula and had been in Montana an average of 17 years
- Their households averaged 3.35 visits for the year
- 59% were registered to vote in Montana
- 83% were estimated to be near or below poverty level
- 48% were not employed, 41% were partially employed and 11% were fully employed[6]

Increased Community Involvement Needed

Early in 1990, the indigent health care task force was able to narrow its scope with the new substantial data on "who" the clients were; it requested additional feedback

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[6]Britt Finley, "Client Survey: Characteristics of Clients Using Acute and Chronic Care Service," submitted to Missoula City-County Health Department, Montana, March 1990.

from the members. They discussed a formal expansion of the present group (President of St. Patrick Hospital, the sponsored physician and MCCHD) involved with indigent care needs. St. Patrick Hospital owners and the medical staff were obvious potential partners but other community entities had to be considered. They also discussed a walk-in clinic to substitute for the emergency room visits.

The number of indigent and Medicaid patients was still increasing. MCCHD was seeing about 2500 clients per year by 1990, and acute and chronic care was not part of its required responsibilities. This service, in fact, diverted money from MCCHD mandates which were designed to prevent disease and to promote the health and well-being of individuals and families in Missoula County. It was advised that acute and chronic care probably would not be feasible at MCCHD after Fiscal Year 1990-1991. For this reason, the sponsored physician advocated a "Joint Staff Physician Committee" to become operative in this area.

On February 9, 1990, the President of the Medical Staff presented the following information to St. Patrick Hospital's Executive Committee:

o Persons in two groups sometimes have trouble obtaining ambulatory health care.

- Medicaid patients. These persons saw a regular provider who now declines to accept Medicaid patients.

- The medically indigent. These are persons who cannot pay cash, do not have insurance and are not eligible for Medicaid or other assistance programs.

o A person from these two groups had the following alternatives:

- Search for a physician who does accept Medicaid clients or provides care at no charge
- Go to the emergency room
- Go to the Indigent Care Clinic of the MCCHD
- Omit or postpone care

On March 16, 1990, the Missoulian announced the end of the MCCHD program that treated minor illnesses of low income people, explaining that the decision was made by the Missoula County Commissioners based upon a recommendation by the MCCHD staff.[7] The clinic was closed by the end of June, because of a lack of funding.

Joint Staff Formed

It was this precipitating event that propelled the staffs of both hospitals to form the "Joint Staff Liaison Committee on Indigent Care" to perform functions that would relate to ambulatory care of the indigent and Medicaid patients. The committee would provide a mechanism for communication and problem-solving between members of the hospital medical staffs and MCCHD personnel.

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[7]Ibid.

The President of St. Patrick Hospital arranged for an informal forum. He invited the staff members from the other hospital to a luncheon to get them talking about the dilemma. This meeting was also informational; the survey results about the indigents and figures supporting how many of those individuals inappropriately used the St. Patrick emergency room helped to broaden their awareness. It was crucial that the physicians viewed themselves as one force heading for the same goal--they would be the creators of a solution for problems that had everything to do with their expertise.

The first official meeting of the "Joint Staff Liaison Committee on Indigent Care" was April 18, 1990. The purposes of this meeting were to insure that everyone clearly understood the situation, review relevant facts such as trends in emergency room visits by uncovered nonurgent patients, review numbers of physicians not accepting Medicaid patients and examine proposed changes in the ambulatory care services provided at the MCCHD.

In July, 1990, a survey instrument was distributed to all physicians by the Joint Staff Liaison Committee on Indigent Care. It sought information of current provider policies regarding indigent patients, and future policies if there was to be a system to evenly distribute indigent patients.

CHAPTER III

IMPLEMENTATION

Initial Actions and Planning

The hospital medical staffs made the decision to lead the operation and charged the Joint Staff Liaison Committee on Indigent Care to respond to these concerns: access, inefficiencies, equitable sharing and the need for a structured partnership among physicians, hospitals and local government units. The first committee action was to add the chief executives of the hospitals and MCCHD to its membership.

Goal and Objectives Defined

The Joint Staff Liaison Committee on Indigent Care met frequently for six months before developing a proposed goal and related objectives pertaining to care for the medically indigent. The official wording of the goal and objectives is as follows:

> GOAL: To provide medically indigent and Medicaid patients with reasonable access to ambulatory health care in a manner that makes efficient use of resources.
>
> OBJECTIVES: The mechanisms developed to achieve this goal will:
>
> 1. Coordinate and facilitate patient access to and use of the system.
>
> 2. Enable appropriate use of hospital emergency rooms, physicians' offices and the MCCHD,

thereby preserving the ability of these entities to meet their primary missions.

3. Promote efficient and equitable use of provider time, volunteers and other resources.

4. Decrease costs that result from futile billing.

5. Promote access to resources necessary for diagnosis and treatment such as tests, prescription drugs and appliances.

6. Facilitate referrals for financial and social assistance.

7. Obtain financial, physical and professional resources sufficient to maintain the system in a predetermined manner.

8. Provide for coordination, oversight, evaluation and modification of the system.

9. Foster a community response to the problem of medical indigence through the educating and involvement of community members.[8]

Partnership for Access (PFA) Program Approved

The next step was to convince the city and county that the plan was worthy. The program needed their endorsement in addition to financial support for the PFA clinic (located within the MCCHD and also referred to as the PFA's "Central Facility").

The sponsored physician designed a strategy for creating a climate of acceptance. Knowing that it was crucially important, he insured that the administrators of

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[8]Indigent Care Committee of the Joint Medical Staffs of Community Medical Center and St. Patrick Hospital, "Partnership for Access." Missoula (Montana) Indigent Health Care Plan, 22 April 1991, p. 4.

both hospitals, a representation of volunteer physicians, a representative from the Board of Health, MCCHD supporters and other parties with political clout were present. These persons needed only to verbalize their identity, position and statement of support following the slide show and formal presentation--and to personally respond to questions from Council members.

The City Council and the County Commissioners unanimously endorsed PFA and provided a one-time financial investment for the sole purpose of starting the program. PFA would be required to look elsewhere for future financial support.

Implementation Strategies Developed

Strategies were then developed which would not only allow for goal and objective accomplishment, but would also be feasible for the various partners:

o The committee was charged to work vigorously with the County Commissioners, City Council, hospitals, Board of Health and other sources to fund the Central Facility at a realistic level.

o Participating physicians would continue to provide the bulk of patient care.

o Hospitals would provide cash, services and certain emergency room care.

o City and county governments would provide in-kind support and a portion of the funds needed to activate the Central Facility.

o The Central Facility would continue to provide about the same amount of medical care as it had been delivering. It would provide eligibility certifications as well as referrals to appropriate public agencies. It was planned that proper screening methods, case management strategies and patient education would permit appropriate medical referrals and reductions in both doctor shopping and inappropriate use of the emergency facilities.

PFA and The Health Care Gap

The PFA program was implemented in November, 1991. Because of its limited resource base (e.g., funding, personnel and facility), it was determined that the program could only afford to target a portion of the most needy of the medically indigent population.

The income levels of the medically indigent fall into a health care "coverage gap" which is below the threshold for private or employer-provided health insurance and above the eligibility for public coverage, such as Medicaid and Medicare. (Eligibility for public coverage in Montana, i.e., Medicaid, is available for some populations below 133% of federal poverty level. Currently, the federal poverty level is $11,600 gross annual income for a family of three; 133%

for such a family would be approximately $15,400. General Assistance provides coverage for those below 45% of poverty level.)

The upper limit is less precise. It is estimated by the Montana Seniors' Association that Montana families earning up to $24,200 (200% of federal poverty level for a family of four) have little or no disposable income.[9] It is believed that only when families earn more than 250% of the poverty level that their disposable income can contribute to premium costs typical of most employer health plans. For comparison, the United States Department of Agriculture's nutrition program (WIC) has identified 185% of poverty level as the income below which families may have nutritional and health risks due to financial constraints.[10]

Missoula's medically indigent population that was targeted by PFA fell primarily in the 133-to-150% poverty level and was estimated to include more than 9,300 people. In order to qualify for PFA assistance, these people had to be Missoula County residents, uninsured for office visits and ineligible for Medicaid or State Medical Assistance.

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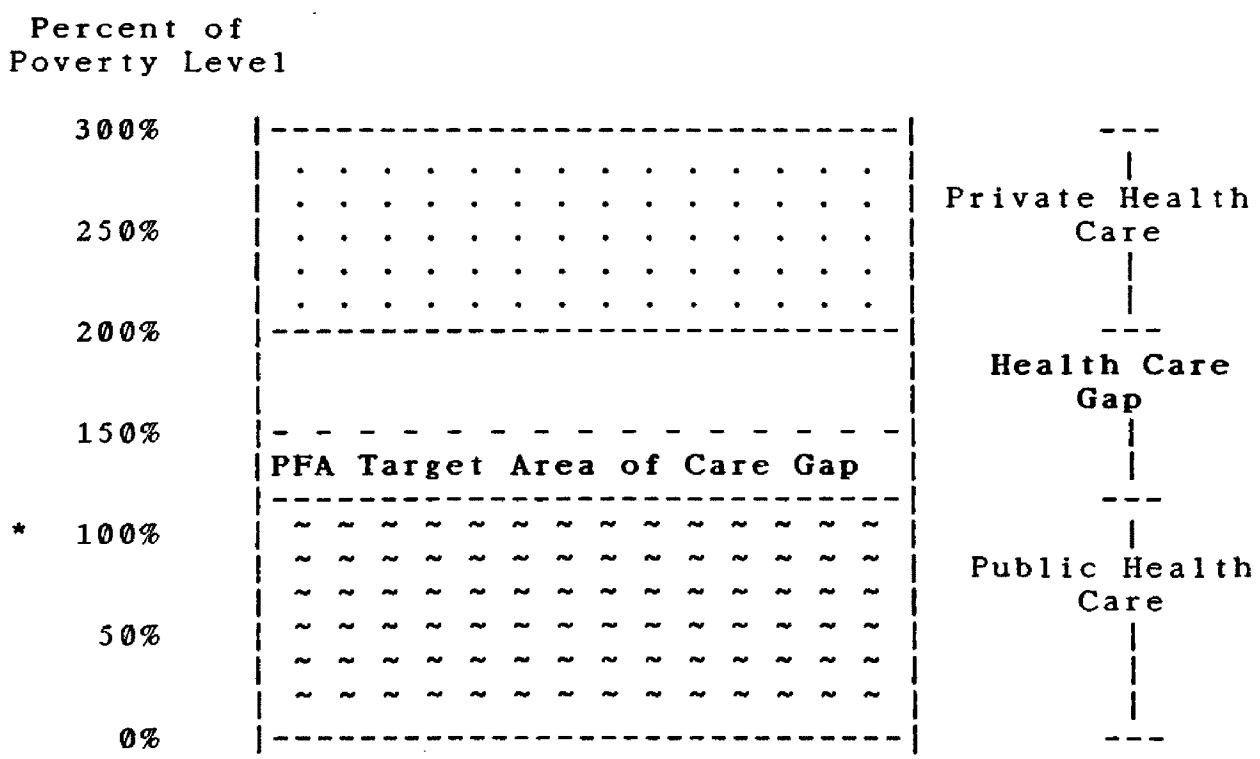
[9]Montana Seniors' Association, "The Affordability of Health Care for Montana's Working Families. The National Health Care Campaign, 1986," cited by Britt Finley, "Client Survey: Characteristics of Clients Using Acute and Chronic Care Service," March 1990.

[10]Indigent Care Committee of the Joint Medical Staffs of Community Medical Center and St. Patrick Hospital, "Partnership for Access," Missoula (Montana) Indigent Health Care Plan, 22 April 1991, p. 4.

The following figure depicts health care coverage as related to the federal poverty level. Note that, because of resource limitations, the PFA targeted its efforts at only a portion of the "Health Care Gap." Persons in all areas of this "gap" were considered to be working people who simply earned too much to qualify for public care benefits, but not enough to afford to purchase private coverage.

Poverty Level and Health Care Coverage



* The federally established poverty Level (or 100% poverty level) for a family of three is approximately $11,600.

Eligibility screening required proof of income documented by two most recent pay stubs. Family incomes could not exceed:

Family Size	Annual Income
1	$ 9,420
2	12,630
3	15,840
4	19,050

Persons who claimed no income, or income low enough to suggest eligibility for Medicaid, were not eligible for PFA's indigent care program unless they provided proof of denial for Medicaid or State Medical Assistance. However, they could be served by the program for a temporary period while waiting for a determination.[11]

Residence could be documented by providing a Missoula address or by claiming homelessness. The Poverello Center, Inc., has been a referral base for PFA and has sometimes been used as a documented place of residence. As an ecumenical ministry of churches in and around Missoula, it provides temporary emergency assistance to persons in transit and strives to coordinate with other social agencies, such as PFA, to insure long-term assistance.[12] Poverello reported that the general health of its residents

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[11]Ibid., p. 23.

[12]Poverello Center Inc., "Poverello Center" (organizational brochure, Missoula, Montana).

significantly improved when the PFA became an available referral.[13]

PFA clients had to be recertified every six months and sign an agreement certifying eligibility information. They had to agree to notify the central facility of changes in income or insurance status.[14]

Current Program Status

There have been significant changes to this program during the last 6 months. PFA's new name is the Partnership Health Center (PHC). The program has received additional funding from the Robert Wood Johnson Foundation and from the federal government to expand and solidify the health center. Subsequently, it has opened its doors to the entire community and it must offer a greater variety of services. The program's success has been insured because of the durable, planned, cooperative relationships among its several components, described below:

Advisory Council

The Advisory Council represents the clients, partners and community; it meets monthly and reports to the Board at

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[13]Interview with Beth Metzgar, Poverello volunteer nurse, Missoula, Montana, 16 September 1992.

[14]Indigent Care Committee of the Joint Medical Staffs of Community Medical Center and St. Patrick Hospital, "Partnership for Access," Missoula (Montana) Indigent Health Care Plan, 22 April 1991, p. 23.

least annually. The members and the chair are appointed by the Board of Health to one-year, renewable terms.

The functions of the Council are to provide oversight of the Central Facility and referral system, monitor the indigent health care situation in Missoula, provide a forum for indigent health care issues and monitor and communicate information about state and federal actions pertaining to indigent health care, insurance and Medicaid.

The Advisory Council membership is as follows:

- o Client representation (number to be determined)
- o Missoula City-County Health Department (2)
  - Administrator
  - Primary Care Provider or Public Health Nurse
- o Community Medical Center Chief Executive
- o St. Patrick Hospital Chief Executive
- o Office of Human Services
- o Poverello Center (provides meals, shelter and referrals for the homeless)
- o Native American Services Agency
- o Physicians (5) nominated by the medical staffs and representing the following:
  - Emergency Department, Community Medical Center
  - Emergency Department, St. Patrick Hospital
  - Primary care providers (family practitioners)
  - Pediatricians
  - Surgeons

Hospitals

Both hospitals continue to provide support and financial contributions to the indigent care program, as pledged. Their donations include cash and in-kind lab costs, supervisor salary, facility use and phone costs.

Participating Physicians

Agreement by the physicians to participate in providing low cost care for eligible patients is voluntary, revokable, and very simple. Not every physician has chosen to participate. Some have been willing to see eligible patients in their offices; others prefer to make this contribution by scheduled volunteer time at the Central Facility.[15]

Central Facility

The PHC's Central Facility is an evolving entity that remains housed within the MCCHD. Its limited space is being remodeled to enable it to streamline operations and procedures and handle an increased client load. (Remarkably, during this remodeling effort, PHC has not turned away any clients.) Once the remodeling is completed, PHC plans to market its capabilities to help insure that care is accessible to all people in the community who have been

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[15]Indigent Care Committee of the Joint Medical Staffs of Community Medical Center and St. Patrick Hospital, "Partnership for Access," Missoula (Montana) Indigent Health Care Plan, 22 April 1991.

"locked out." This will be accomplished by targeting two specific groups:

- o Those in the social service system.
- o Those not in the system, many of whom do not see themselves using it (e.g., university students, the working poor, and the "hidden" population within employee organizations with low pay and/or no health insurance).

The PHC is currently searching for a full-time physician. Between this person and a joint effort with an "on call" physician group practice or other willing group, PHC plans to provide access 24 hours a day, instead of the current 8 hours a day. This will also provide the clients with consistency and a physician with whom they can feel more comfortable and confident.

Grant Funding and Related Requirements

The PFA program had been seeing patients for about a year when it applied for grant funding. It was endowed by a federal grant and a private grant from the Robert Wood Johnson Foundation (RWJ); they each contributed about $400,000, and specified varying conditions for expenditures.

The RWJ Foundation views its funding as an incubator for a working program. Its conditions for expenditure have been rather loose, with the money having been provided as a direct result of the Partnership's innovative, active, and successful approach to solving a community problem. RWJ

appreciated PFA's method of looking at what the community had, what it needed to serve more people and how it could better network with other social service agencies. The Partnership operates by the wheel perspective, with the MCCHD being the hub and all other participants being the spokes to strengthen the program.

The government grant for a "Community Health Center" has been much more rigid, in terms of what the government requires. For PFA to be eligible, it has to implement several significant changes:

o The Community Heath Center must be governed by a Board of Directors, with the majority of its membership being made up of its health care recipients--the philosophy being that those who receive services should have the strongest voice.

o The Center would be required to charge a fee for services which would be structured by the government, but remain in sync with medical economics. The fee schedule would mirror a schedule for family practice, the difference being that the patients would pay according to ability. A sliding scale acceptable to the government would appear basically as follows:

- From zero to 100% poverty level = pay $1.00
- Between 100-200% poverty level = pay 20% to 60%
- Over 200% poverty level = pay 100% of billing

The Center also is permitted to bill Medicare, Medicaid and insurance companies.

o Eligibility requirements must be dropped so that everyone is eligible.

o A range of "non-negotiable services is required (e.g., primary medical service, lab and x-ray, dental, pharmacy, prevention, transportation, referral, case management, and translation), with a range of suggested services being recommended (e.g., restorative dental care, health education, mental health and nutrition).

o The Center is to be more than a provider of care; its purpose also is to upgrade community health status through prevention, education and tracking outcomes.

The federal grant was received only a couple of weeks following the endowment from RWJ. The RWJ grant, designed to be disbursed over a period of three or four years, was not jeopardized; in fact, their contract has been modified to coordinate with the federal grant.

Program Effectiveness

According to the results of a survey, the PHC has been meeting the needs of its clients. A survey was taken in May 1992 of clients of Missoula's PFA clinic to evaluate their perception of the service they had received. Of the 35 participants, 26 were female and 9 were male. The ages of the clients were distributed as follows: 6 were 0-5 years; 4

were 6-12 years; 8 were 13-21 years; 15 were 22-45 years; and 2 were 46 years and older.

The clients were asked how they had heard about the clinic. Thirteen replied that they had learned of it from the Health Department (public health nurses, WIC and receptionists); 11, from parents, friends, or co-workers; 5, from community agencies; 3, from the newspapers; 2, from physicians' offices; and 1, from "Ask-A-Nurse" (a St. Patrick Hospital sponsored on-call telephone service).

Three questions asked for a satisfaction rating on how clients thought they were treated during various aspects of the clinic process. When asked about treatment when going through the eligibility process, 27 clients were very satisfied, 6 were satisfied, 2 were neutral and none were dissatisfied. With regard to treatment when scheduling an appointment, 21 clients were very satisfied, 9 were satisfied, 3 were neutral, 1 was dissatisfied and no one was very dissatisfied. Twenty-seven clients were very satisfied with their treatment during the clinic visit, 6 were satisfied, 2 were neutral and no one was dissatisfied. Comments reflected that most clients were very positive about the kindness and respect with which they were treated. Adverse comments were related to occasional delays in getting appointments because the clinic was fully booked.

Clients were asked if their health problems were taken care of by the visit; 32 responded positively and 3

negatively. Two of the latter said their coughs persisted; one said his condition was chronic and he did not expect it to be cured.

Five questions related to the quality of the interaction between the client and the health care provider. Thirty-four of the clients said the health care provider had spent adequate time with them, while one felt that the nurse practitioner seemed rushed. Clients were asked if they felt that they had enough time to ask questions and if the answers were clear. All of those who thought that questions were applicable (33), felt there was enough time for questions. Twenty-nine of these agreed that the answers were clear; four did not respond. The clients were questioned about health education, specifically if they had learned anything new about their health during the visit being evaluated. Seventeen said they had learned something new, 13 said they had not and 5 clients could not remember. They were asked whether they had clearly understood any follow-up instructions (concerning medication, diet or procedures). The 33 who needed instructions said they had clearly understood. The last question in this series asked if clients were satisfied with the adequacy of any follow-up care they had received, such as a return appointment, a phone call or referral. All of the clients (17) who had follow-up treatment stated that they were satisfied. Several clients added that they appreciated knowing someone cared

enough to call or otherwise follow up on their health problem.

Clients were asked what they would have done about their present problem if the PFA clinic had not been available to them. Fifteen stated they would have done nothing, 11 would have sought care from a private physician, 3 would have gone to the emergency room, 3 would have cried or suffered, 2 would have gone to Now Care and one said she would have "hocked something else." Most of the cases where other care would have been sought involved children, whereas most adults would not have sought alternative care for their own problems. When asked where they had gone for health care before learning about PFA, 11 utilized private physicians, 8 had gone to clinics, 7 had used the emergency room, 5 went to Now Care and 4 did not get care.

Clients were asked three qualitative questions about their care at the clinic. They were asked how the care at PFA compared to the last health care they had received, 14 said it was the same, 13 thought it was better, 5 felt more comfortable at the clinic, 4 said it was good and 1 person said she could tell the difference between medical doctor and nurse practitioner/physicians' assistant care. They were asked what they liked <u>most</u> about PFA. Nineteen said it was the friendliness and/or concern for people, 9 liked the cost, 5 liked the quick and good service, 5 liked the way things were explained, 3 liked the nonjudgmental atmosphere,

2 liked the clinic's availability to low-income people, 1 liked the follow-up treatment and 1 liked the nurse practitioner. When asked what they liked least about PFA, 15 stated that they liked everything, 15 disliked the wait to get an appointment or to be seen, 3 disliked their own sense of hurt pride, 1 did not like the children running around and 1 thought she was treated differently because she had no income.

The last question solicited further comments or suggestions. Sixteen had none; 14 responded with positive and appreciative comments; 1 client was impressed by the emphasis on prevention.[16]

It is noteworthy that the PFA/PHC program does not appear to have been abused. Clients have legitimate health care concerns and tend to follow up only when necessary. This type of service certainly does not appear to be the degrading experience that some public assistance programs are considered. The care has been very good quality and should continue to be so.

The Partnership also has been effective in terms of the number of patients it sees, both in return visits and new patients. Offering access to everyone has been a substantial change and it is too early to cite clinical data

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[16]Senior Montana State University community health nursing students, "Partnership For Access Clinic Client Satisfaction Survey". Results submitted to PFA program, Montana, March 1990.

in support of success. However, the Welfare Office has not been receiving calls in quest of medical attention. On the flip side, the number of non-emergent visits to the emergency rooms has not declined. This will, no doubt, change when 24-hour access is provided.

Mechanisms for measurement and tracking are in the process of being developed. PHC's ultimate success rate will be measured in a triumvirate of criteria. First, patient utilization will be analyzed to determine if the program has reached those it intended to and that patient needs fit the program's capabilities. Second, financial indicators will reveal if PHC can survive using the current fee schedule, while continuing to search for other sources of support. Third, continuation of meeting the goal of providing high quality care will rest on a team of professionals and its ability to effectively link up with other health care related resources within the community.

CHAPTER IV

CONCLUSION

Evaluation

Despite rather formidable odds and much skepticism, the PFA/PHC program has succeeded, to date. It went through an extensive metamorphosis, developing from a relatively small, free, walk-in clinic run by a single agency that was running it on a shoestring budget. It grew into the larger Partnership for Access (PFA) Clinic, still independent and still providing free medical care. Although it initially functioned primarily as a referral clinic for ambulatory care, it quickly turned towards having the primary function of providing in-house care. PFA was supported by multiple community health care providers and was targeted at a rather refined group of needy indigents. Today, as the Partnership Health Clinic (PHC), it has received increased grant funding. Some of the grant money came from the government--and along with that, governmental "strings" that have required PHC to greatly expand its target population and to charge clients on a "sliding scale" based upon their individual ability to pay. Future changes are inevitable.

Regardless of the changes, who would have imagined a community being able to:

o Put together any type of survivable "free" medical care facility?

o Obtain a substantial base of physicians that would provide services on a strictly volunteer basis?

o Use the teamwork of multiple community health care resources--many of whom are in competition with each other and have extremely varying attitudes regarding how the health care business should be conducted?

o Develop a facility that would be so highly regarded by its clients, and that those clients would not inundate or misuse the provided services?

To a large extent, this has all been accomplished because of the exceptional qualities of the various heads of provider organizations and individual members of the "committees" who worked through the years to accomplish a very lofty goal. They had the right attitudes, motivations and perseverance, but most incredibly they had those additional intangible administrative qualities that are indispensable in our increasingly resource-constrained and competitive environment--i.e., ingenuity, vision and savoir-faire. They tried new avenues described as being required in Osborne and Gaebler's book, Reinventing Government, and they realized that they needed to remain particularly flexible; changes are inevitable; decisions usually will lead to more complex decisions.[17] As Aaron Wildavsky stated, Policies don't succeed so much as they are succeeded. It is not

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[17]Ted Gaebler and David Osborne, Reinventing Government (Massachusetts: Addison-Wesley Publishing Company, Inc., 1992), pp. 219-49.

resolution of policies, but evolution that should interest us.

Challenges

The skills of the administrators and leaders of today's PHC have tremendous challenges still facing them--a situation that likely will be with them forever.

o They need to ensure that they, the leadership, continue to maintain the motivations and lofty ideals that started them down the road towards insuring that health care is available to everyone. They will continue to need to be energized by the emotions of determination and the momentum they created together. They will need to cooperate ever more closely, particularly when we all can expect shrinking resources of various types (regardless of the type of health care reforms the current Clinton government is able to implement).

o Second, they need to continue encouraging local physicians to volunteer their services--whether that be accomplished by emphasizing good conscience, ideological reasons or long-range monetary benefits. Motivation of this type always is difficult to maintain over the long haul--past the initial "infatuation" stages. Motivating PHC physician volunteerism will likely be exceptionally challenging in light of PHC's realization that it needs to hire a full-time, salaried physician to work in the clinic.

This cannot help but result in questions such as, "Why is he/she getting paid for what I'm doing on a volunteer basis?" Also, the volunteer physicians are noting that PHC in-house care is on the increase and that referrals have been significantly reduced. They must be asking themselves, "How many referrals are we really going to receive from this project, now that so much care is being provided within the facility itself?"

o Third, funding will always be hounding the administrators. Some grant monies currently obtained will continue to flow in for two to three more years, but then what? What other options will be available and how can they be obtained? Will additional salaried employees be required? How expensive will required resources (e.g., increasingly costly dental care, expendable supplies and new technologies) be? How large will the client load become?

o Fourth, what can be accomplished to control activities and expenses--to keep the project from running away--to the point that it will be halted for lack of cost effectiveness? The key here will be the implementation of a tracking system that will "watch" all aspects of the program--from resources being "donated" by major providers, to "sliding fees" provided to individual physicians, and frequency and type of usage by individual clients. In essence, an innovative, responsive, timely tracking system

will be necessary for PHC's survival--just as it will for whatever national health care system is to be implemented.

Recommendations

Based upon an examination of what has happened with the PHC program in Missoula County, the following steps are recommended to quicken the pace of implementation of such a program in other communities--realizing that each situation is unique and strict guidelines will not work for all.

Steps for Duplication in Other Communities

o Lay the ground work, to include defining the problem (e.g., exactly what segment of the local population is not receiving adequate health care and what health care services is the project going to provide to them) and establishing an initial committee.

o Select a "champion" (the name endowed upon the "sponsored physician" by the interviewees).

o Charge the "champion" with bringing together the physicians and other key health care personnel.

o Let the physicians design their own plan.

o Invite other interested and/or affected agencies to participate (e.g., the local health department, hospitals, city/county governmental officials, and welfare officials).

o Articulate solutions with clear, concise goals and objectives, particularly those that are measurable within a specific time frame.

o Monitor progress and analyze results.

o Be ready for change, understanding that decision-making is problem succession rather than problem solution; every solution is followed by another problem, which is often unanticipated.

Requirements for Success

Finally, regardless of the community involved, the following qualities are considered requirements for effective program development and maintenance:

o Strong leadership, teamwork and cooperation among key community health care administrators. In the PFA/PHC development, a number of leaders have stood out--each of whom led with an active, positive style. They guided their departments while never taking their eye off of the overall mission. Of special note, they all were great listeners and communicators.

- The President of St. Patrick Hospital is a "no nonsense man" and a "quick study." He has a remarkable ability to study an issue/problem, recognize its implications, make appropriate decisions and take action. He respected time, giving of it whenever needed, but he never wasted a moment in insuring required financial and

administrative support was provided. Concurrently, he never failed to exercise exceptional finesse--the importance of which, for this project, cannot be overstated.

- It was most fortuitous that a retiring cardiologist (sponsored by St. Patrick Hospital) consented to provide his expertise to the overall PFA/PHC program. Referred to earlier as "the sponsored physician," he truly developed into the "project champion." Other younger, inexperienced physicians who needed the position for their career advancement were seriously considered, but only a seasoned physician could have envisioned the nature of the issues. To gain the attention of his peers he had to have credibility, respect and trust. It appears he was primarily responsible for convincing 180 physicians to participate--a remarkable accomplishment.

- The Director of the Health Department was totally committed to providing health care (which she personally refers to as "the magic") for the indigent persons within the "health care gap." Her unique ability to obtain vertical and horizontal support proved invaluable, and she was able to wield influence through her non-abrasive, communicative demeanor. Her sensitivity to the needs of all factions and ability to analyze all parts of the total process enabled her to reverse the negative situations.

- The Director of the Welfare Department sees herself as a visionary who used every opportunity to

motivate, encourage and obtain support from other professionals for health care for the indigent. She talks in terms of what's best for the health care industry, rather than what will gain "big bucks". She supports "The Japanese Theory Z" which socializes participants to be mission oriented versus being individualistic; that which is best for the whole is best for everyone.[18]

- The Director of the Emergency Room employed the word "suasion" to capture their approach of selling ideas. He acted as an instigator who believed sacrifices were in order for the common good and that it would be easier in Missoula than in many other areas because of high community participation and the spirit of volunteerism.

o Thorough knowledge/expertise by project organizers of such matters as: health care facility administration, operations and resource requirements; local, state, and national health care programs and policies; means to access the various sources of funding; local politics (to include informal power structures); and the availability and viability of local resources, varying from volunteer physicians, to in-kind supplies and services, to facilities.

o Strong motivations and positive, enduring attitudes--the types that will still be there "when the going gets rough"--among all key project personnel.

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[18]Robert A. Baron, Behavior in Organizations (Boston; Allyn and Bacon, Inc., 1983), pp. 524-5.

o Lastly, but far from least, the vision, foresight, and flexibility to deal with unanticipated consequences. The ideas promoted in Reinventing Government could not be more appropriate.[19] We can no longer afford to be rule bound by the traditional precepts contained in Max Weber's "rational theories"[20] or Frederick Taylor's "scientific management."[21] Administration needs an entrepreneurial spirit to rearrange preconceived ideas and experiment. It is time for imagination, creativity, uniqueness, better services delivered in more efficient ways, different sources of revenues and different solving techniques--a new flavor for doing business.

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[19]Ted Gaebler and David Osborne, Reinventing Government (Massachusetts: Addison-Wesley Publishing Company, Inc., 1992), pp. 109-37.

[20]Albert C. Hyde and Jay M. Shafritz,, Classics of Public Administration (California: Books/Cole Publishing Company, 1987), pp. 50-55.

[21]William B. Eddy, Public Organization Behavior and Development (Boston: Little, Brown and Company, 1981), pp. 25-26,30,32,119.

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