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Crisis of the medically uninsured : a case study.

Jennifer R. Willand

The University of Montana

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THE CRISIS OF THE MEDICALLY UNINSURED:
A CASE STUDY

by

Jennifer R Willand

B.A. The University of Connecticut, 1992

presented in partial fulfillment of the requirements
for the degree of
Master of Public Administration
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Approved by:

Chairperson

Dean, Graduate School

Date
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>LIST OF EXHIBITS</th>
<th>iii</th>
</tr>
</thead>
</table>

**Chapter**

1. **STATEMENT OF THE PROBLEM**
   - Research Questions
   - Methodology

2. **THE STATE OF HEALTH CARE IN THE UNITED STATES**
   - A National Crisis
   - The Federal Response
   - State Level Responses
     - Vermont
     - Hawaii
   - Community Level Responses

3. **PARTNERSHIP HEALTH CENTER: A CASE STUDY**
   - The Problem of the Uninsured in Missoula
   - Partnership Health Center: Development
   - Partnership Health Center: Structure
   - Partnership Health Center: Philosophy

4. **ASSESSING PARTNERSHIP HEALTH CENTER’S SUCCESS**

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# LIST OF EXHIBITS

<table>
<thead>
<tr>
<th>Exhibit</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Partnership Health Center: Board of Directors</td>
<td>19</td>
</tr>
<tr>
<td>II. Partnership Health Center: 1994 Operating Budget</td>
<td>22</td>
</tr>
<tr>
<td>III. Partnership Health Center: Organization</td>
<td>24</td>
</tr>
<tr>
<td>IV. Methods Used to Develop and Operate PHC</td>
<td>32</td>
</tr>
<tr>
<td>V. Strategic Plan Goals</td>
<td>40</td>
</tr>
<tr>
<td>VI. Strategic Plan Objectives</td>
<td>41</td>
</tr>
</tbody>
</table>

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Almost 37 million people in the United States are not covered by medical insurance (Eckholm 1993, 5). That alarming number translates to one in every seven people. When the number of underinsured is added to the number who are uninsured, 80 million people, representing one third of the population, are at risk of losing their personal and financial health (Eckholm 1993, 177).

The consequences of such a large uninsured populous are enormous. The uninsured often do not seek medical treatment until their health care problems are very serious, and when they do seek treatment they often go to hospital emergency rooms where treatment is very expensive. Doctors and hospitals face the difficult choice of either writing off these patients’ debts or denying them service. The monetary burden falls not only on doctors and hospitals but on every tax paying citizen and insured customer. Partly for this reason, Americans pay more for their health care than any other people on earth (Williams 1994). In 1994, Americans will spend as much as $1 trillion on health care, or 14 percent of the gross national product (Samuelson 1993, 32).

The problems with the health care system are so serious that many advocate redesigning the system entirely. While the Clinton Administration and Congress continue to battle over how best to redesign the current system, many health care reformers are attempting to tackle the problem of the medically uninsured at the local
level without waiting for a federal response. In their view, health care needs cannot be put on hold while the federal government works out a solution. Providing health care to the uninsured in the interim is a vital community concern.

Communities from Massachusetts to Montana are scrambling to provide for their uninsured. One response has been to establish community health centers, or CHCs. Community health centers are federally subsidized, locally controlled clinics that target medically underserved populations. Created under the terms of the Community Health Services and Facilities Act of 1961, community health centers are governed by boards comprised of citizens, patients, representatives of community health care providers, and local government administrators. The federal government requires the clinics to advocate a holistic approach to health care by offering preventive measures in conjunction with medical treatment and wellness services. Today, there are over 600 community health centers in the nation (Twohig 1994).

Missoula, Montana, like many other communities, has had to confront the problem of insufficient access to medical care. A 1992 national study ranked Missoula 45th on a list of rural areas with large populations of uninsured people (PHC, Who Doesn’t?). In response, citizens of Missoula initiated a process that culminated in the creation of a clinic to serve the uninsured population. The process began in 1989 when Ellen Leahy, Director of the Missoula City-County Health Department, and Dr. Harold Braun, joined forces to study the problem and identify solutions. They called on Missoula’s medical community to help them in this effort. Two years later, in 1991, the Partnership Health Center (PHC) was born.

Partnership Health Center is a community health center which now serves 3,000 patients (Twohig 1994). The clinic serves uninsured and underinsured residents of Missoula County. The center is governed by a board comprised of consumers, community members, and representatives of local health care providers. It is staffed by
administrators, volunteer physicians, nurse practitioners, and case managers. Partnership Health Center is unique among community health centers because of the support it receives from local medical providers and the local Health Department. As such, it represents a valuable model for other communities searching for solutions in the absence of national policy.

The purpose of this case study is to illustrate how a community can respond effectively at the local level to what is a national problem. The study details the national problem, describes Partnership Health Center and its evolution, and assesses the value of PHC as a model for other communities.

**Research Questions**

Five research questions are addressed in the paper:

1. What health insurance problems existed in Missoula prior to PHC?
2. How was Partnership Health Center designed to address the health care problems facing the Missoula community?
3. What is the prevailing opinion regarding the success of Partnership Health Center?
4. What lessons can other communities draw from Partnership Health Center?
5. What is likely to happen to Partnership Health Center in the near future?

**Methodology**

The proposed research represents a case study of a single organization. Library research, literature reviews, and interviews with key members of the health care community were used to examine why there is a need for such programs and to assess how well Partnership Health Center is addressing those needs. Jeanne Twohig,
Director of Partnership Health Center, and Ellen Leahy, Director of the Missoula City-County Health Department, were interviewed. Jeanne Twohig was asked to provide background information as well as a personal statement on the future of Partnership Health Center under national health care reform. Ellen Leahy, a key figure in the creation of the program, was asked similar background questions and more general questions regarding community health centers. A member of the volunteer medical staff at Partnership Health Center and a representative from the Board of Directors were interviewed to provide feedback regarding program effectiveness. Finally, community health care administrators from other regions were interviewed to determine how appropriate Missoula’s model might be for other communities.

In addition, information was collected from the literature distributed by Partnership Health Center and the Missoula Health Department. Data were also secured from secondary sources such as newspaper articles. For example, articles about the program have been published in the Missoulian and the Missoula Independent. Comments from the Montana AFL-CIO Health Care Reform Forum were incorporated for state and national statistics. Additional information concerning state and national statistics and policies was garnered from journals and books.
CHAPTER II
THE STATE OF HEALTH CARE IN THE UNITED STATES

A National Crisis

Of the 37 million people in the United States who have no medical insurance, 28.5 million are low-income workers and their dependents (Eckholm 1993, 279). According to a U.S. Census Bureau study, more than one in four Americans went at least one month without medical coverage in a twenty-eight month period beginning in the late 1980’s (Eckholm 1993, 5). Half of all uninsured Americans are under the age of twenty-five (Eckholm 1993, 8). The problem of lack of insurance is particularly acute for inner city residents who are more prone to illness, epidemics and premature death (Eckholm 1993, 26).

There are several reasons why there are so many people without medical insurance in America. First, many businesses are cutting labor costs by denying medical benefits to full-time workers or by hiring temporary employees and denying them benefits. Small businesses, which employ more than half of the nation’s work force, often adopt such practices (Eckholm 1993, 18). However, not all of the blame falls on small operations. Large businesses and corporations are increasingly laying off workers and hiring part-time and temporary workers who are not provided insurance benefits.

Another reason the number of uninsured is so large is the high cost of insurance premiums. The costs of premiums have escalated beyond the ability of lower and many middle class workers to afford. Family premiums doubled between 1987 and 1993,
and if the trend continues, family premiums, by the year 2000, will be $10,000 (Shea 1994). As premiums continue to escalate in price, more individuals will be forced to use emergency rooms for non-emergencies, with the resulting debts driving premiums even higher.

High insurance deductibles are a third reason many do not invest in health care. It is uneconomical for some families and individuals to buy health insurance when the first one thousand dollars comes out of their own pocket. In addition to high deductibles, many insurance plans do not offer drug reimbursement unless the patient buys the most expensive plan. High deductibles and limited coverage burden the consumer by making out-of-pocket health care costs too expensive.

Fourth, preexisting conditions are almost universally excluded in all but the most expensive individual health insurance plans. Not only are ailments such as asthma excluded, but so too are all related ailments such as bronchitis, lung failure, and pneumonia. Even if an individual does not have a preexisting condition, many health plans specify that they will only cover certain ailments or certain procedures, and usually those excluded procedures are the most costly.

A fifth reason so many Americans are uninsured is the transient pattern of employment in the United States. The increasingly transient nature of the job market today means that employer-paid insurance may not be there tomorrow if the job ceases to exist. Workers' ability to leave jobs and still be covered by the former health insurance plan is limited. Many people do not want to feel strapped to a distasteful job just to secure health benefits, but the reality is that many Americans do stay in unhappy job environments primarily to maintain their benefits. A similar pattern of dependence has developed in the welfare community. According to Senator John "Jay" Rockefeller, at least one million non-working people are on welfare because their job
opportunities do not include health care. Hence, they stay on welfare to remain insured (1994).

Sixth, more people fall below the poverty line today than just one decade ago. In fact, between 1980 and 1990, there was a 46 percent increase in the number of people below the poverty line (Leahy 1994). Some of these people are not eligible for Medicaid and Medicare, and can often simply not afford a private insurance plan. Erik Eckholm points out that, "Medicaid provides insurance for the poorest families, but covers less than half of those below the poverty line nationwide. In all but a handful of states, a family of three must have a yearly income of less than $7000 to qualify for the state-federal program" (1993, 8).

Seventh, many people experience inhibitors to medical access. For example, language barriers, cultural issues, special needs, lack of transportation, and lack of child care are some of the reasons why many people find it hard, if not impossible, to obtain medical insurance and establish relationships with traditional medical providers. People whose native language is not English often encounter problems communicating with their health care providers. Moreover, some non-English speaking people find it hard to obtain medical insurance because of the language barrier. Hence, in addition to the financial barriers to medical insurance, there are many other reasons why 37 million people remain uninsured in America.

Just as there are a variety of reasons why so many people do not have health insurance today, so too there are a variety of causes for the higher insurance rates. For one, Americans pay less of their overall medical costs today than just a few decades ago. In 1960 patients paid 56 percent of health costs out of their own pocket, while in 1991 they paid only 22 percent (Samuelson 1993, 31). Although Americans are paying a smaller percentage of their medical costs out-of-pocket, they are also spending a larger portion of their incomes towards medical costs. The costs associated with health
care are much higher than they were decades ago. Hence, insurance companies and individuals are paying more towards these costs. For example, decades ago there were no mammograms or bone scans, both of which are expensive diagnostic procedures. As the quality of health care increases, so too do the expenses of health care.

Other variables increasing the costs of health insurance include more paperwork, greed and profiteering by medical providers, unneeded surgery and procedures, and malpractice suits (Samuelson 1993, 34). Paperwork costs alone average billions of dollars each year. According to an AFL-CIO pamphlet, "Today’s maze of different insurance plans eats up 25 cents of every health care dollar. That’s $250 billion, enough to finance a national health system" (AFL-CIO, Tell Congress 1994). The costs of caring for the critically ill have also increased health expenditures. With the big money in medicine now centered on high-tech procedures, the frequency of these procedures has become alarming. Often the procedures are used defensively by doctors for protection against law suits. In fact, malpractice insurance has risen dramatically, and doctors are often bound by these insurance policies to take all possible precautions to prevent malpractice suits. According to Eckholm, "In each medical specialty there has been a shift toward ‘the highest-paying procedures’" (1993, 24).

Despite the rising costs and increasing barriers, over 85 percent of Americans do have some kind of health insurance. However, the insured also end up paying for the uninsured through higher premiums and higher costs for care.

**The Federal Response**

President Clinton ran on a platform promising reform in the health care system. One of Clinton’s most adamant goals was full coverage for every American. The Clinton Administration, however, was not the first to propose health care reform. In
fact, his is the seventh administration to make such a proposal. The first President to propose national health care was Teddy Roosevelt in 1912. President Richard Nixon was the sixth to propose a plan to reform health care. Nonetheless, the plan developed by President Clinton and Hillary Rodham Clinton is the most recent and the most ambitious national health care proposal. After an exhausting year of examining all of the pieces, Hillary and her Task Force presented the Health Security Act to Congress in September, 1993. Because of its pledge of universal coverage, the Clintons’ plan promised all Americans access to medical care. If there were universal coverage there would no longer be such a thing as a preexisting condition. In addition, workers would no longer have to worry about their insurance and their families’ insurance when they leave a job, and no longer would one-seventh of Americans go uninsured. Such comprehensive coverage is offered in every other industrial democracy in the world, and the failure of the United States to provide such coverage is a fact Clinton decries as "a national disgrace" (Goodgame 1993, 55). Unfortunately, with the Clinton Plan rejected by the 103rd Congress, and with the Republican Party now in control of Congress, any plan that is ultimately enacted is unlikely to include universal coverage.

State Level Responses

Although many states do not provide for the uninsured, a few have implemented innovative programs to care for the medically underserved. According to Erik Eckholm, a handful of states, such as New York, New Jersey, Hawaii, Minnesota, Vermont, and Washington have established innovative programs to control costs and expand insurance coverage (1993, 325). Vermont and Hawaii are two states that have developed particularly interesting health care initiatives. Vermont’s initiatives have been piecemeal proposals that add up to offer Vermont residents more comprehensive
medical coverage than most other states. Meanwhile, Hawaii’s plan offers its residents the most comprehensive medical benefits of any state in the nation.

Vermont

For over a decade Vermont has recognized the existence of a health care crisis and has implemented various legislative solutions. Most of the efforts have centered around insurance reforms. According to Stephen Schrodel, External Relations Director of the Health Care Authority in Vermont, the reforms occurred over a period of years and were initiated by the state’s legislatures. For example, a "Certificate of Need" program was adopted in 1979. This program, which expanded health care services throughout the mostly rural state, targeted hospitals and clinics in particular. The program was funded by a capital expenditure approved by the state. In 1983, the Hospital Data Council was created. The council oversees hospital budgets by reviewing all hospital accounts. In 1989, Medicaid coverage was expanded through the Dr. Dinasaer Program which guaranteed coverage for many pregnant women and children below the poverty level (1994).

The most recent reform approved by the legislature was the "small market" reform of 1991. The small group reform applied to firms with fewer than fifty employees. An insurer is required to set a community rate for a particular community and that insurer is bound to keep cost variations to 20 percent for particular age and gender groups in that community. This means the insurer is only allowed to vary insurance premiums 20 percent in a given community. People with preexisting conditions are guaranteed coverage under this system, assuming the applicant can afford the 20 percent higher premium charge. Insurers must sell to every employee and employer. There are also provisions for the non-group market, that is those people not buying through a company but who are buying individual health insurance. The
premium variation limit for this market is 40 percent, a figure which will be lowered to 20 percent on July 1, 1995. Together two firms, Blue Cross and Blue Shield and Community Health Plan, carry insurance for two-thirds of the people in Vermont. Community Health Plan is a non-profit organization with a guaranteed community rate and no preexisting condition policy. There is a six month waiting period to get covered under these plans for those who move to Vermont (Schrodel 1994).

Hawaii

Hawaii already realizes near universal health care coverage and boasts one of the lowest health care costs per person in the United States. Also, Hawaiians are more satisfied with their health care than residents of any other state (Williams 1994). Most of the 1.1 million Hawaiians, or 98 percent, have medical insurance (Eckholm 1993, 191).

Like Montana, Hawaii’s economy is predominantly small business. In fact, more than 90 percent of Hawaii’s 27,271 individual enterprises employ fifty or fewer people. In 1991, the health insurance premium for an average Hawaiian was $94 a month. By contrast, the average cost for similar benefits in California was $141 a month, $154 a month in New York, and $282 a month in Kansas (Eckholm 1993, 194-195). A typical family in Hawaii pays only $263 towards their premium, or one-half of what families pay in most other states (Eckholm 1993, 192).

Hawaii’s health care program requires employers to pay the cost of medical insurance premiums for all employees working more than twenty hours a week. The employee does pay a portion of the insurance, but it can be no more than 1.5 percent of a person’s gross wages, or half of the premium (Eckholm 1993, 193). The risk pool in Hawaii includes all state residents, which helps hold costs down. Seasonal workers and people not insured through an employer are covered with state medical subsidies.
Hawaii’s employer based health system has been in operation since 1974, and its near universal access has not led to soaring health care costs. The key to Hawaii’s success is its emphasis on preventive care. By promoting preventive care, Hawaii is able to keep insurance costs down. Hence, Hawaii has fewer hospital visits per person than the national average. This may be in part because patients visit their primary care physicians several times a year in Hawaii (Eckholm 1993, 195). By contrast, in Massachusetts, which has the highest costs per person for health care, doctors prefer to treat patients in hospital facilities because it is easier and because using hospitals provides proximity to major diagnostic equipment. Hence, the health insurance costs are much higher in Massachusetts.

**Community Level Responses**

As health care costs have soared over the past few decades, communities across the country have tackled the problem of dealing with the uninsured. Six hundred communities nationwide have established community health centers or CHCs. There are fifty centers in Massachusetts alone which provide for over half a million people annually (Brockton Neighborhood Health Center 1992).

Community health centers have a common goal of providing health care to an underserved population. They were first established in 1965 to improve health services in their communities by providing access to medical care for the poor and disenfranchised (Brockton Neighborhood Health Center 1992). These centers are usually located in city centers and in rural areas because there are often no other medical providers for the people who live in these areas.

Most CHCs are organized and operated in a similar fashion because they are supported with federal money, and with the money comes federal guidelines to be followed. For example, they must be governed by a Board of Directors. The
majority, or 51 percent, of the board must consist of patients. The CHC must make a measurable difference in the health care within a given community, and they are required to promote preventive medicine. Because of these guidelines and subsidies, CHCs represent the most common community response to the needs of the uninsured (Twohig 1994).

Another very popular community response is the health maintenance organization (HMO). HMOs generally do not cater to the uninsured, but they do make health insurance more affordable for many. Assuming that one reason many Americans remain uninsured is the high cost of premiums and deductibles, readily available HMOs provide for many who would otherwise go uninsured. Currently, forty million Americans are covered under HMOs. Many student health centers operate as HMOs and save students money while affording them proximity and easy access. Health maintenance organizations offer reduced rates and inexpensive care by emphasizing primary care and preventive medicine. Most HMOs, however, require an adequate pool of participants to keep costs low. Hence, they are not as viable an alternative as community health centers for rural areas where populations are too scarce.

Although community health centers and health maintenance organizations are viable options for communities to invest in, neither addresses the underlying anxiety still prevalent with the current insurance system. Even if a community offers a community health center or has an HMO, many Americans will still feel bound to their current jobs for the health care security associated with company plans. Spreading the risk to lower insurance rates requires large population pools. Some HMOs are large enough to offer comprehensive plans, but they are usually exclusive to paying customers. Meanwhile, community health centers successfully address the needs of the medically underserved in a given community, but do not offer much security to
Americans just barely getting by with their existing health care plans. Although community health centers are crucial for meeting the needs of the medically indigent population, they are not a cure for the national health care crisis. They are only part of the solution.
CHAPTER III
PARTNERSHIP HEALTH CENTER: A CASE STUDY

The Problem of the Uninsured in Missoula

Missoula, Montana is an urban community of 60,000 people in an essentially rural county. In addition to the University of Montana, it is comprised predominantly of small businesses and some industry. Missoula, like Montana as a whole, has a large medically underserved population. A 1992 national study ranked Missoula County 45th on a list of rural counties with large numbers of people without access to medical care. Of the 13,377 people in Missoula County below the poverty level, only 3,511 are covered by Medicaid. Most of the others have no health insurance at all. According to Partnership Health Center, one-fifth of Missoula’s population under the age sixty-five has no health insurance (PHC, Executive Summary 1992). For these individuals, obtaining access to needed medical services can be very difficult. A 1992 survey of Missoula primary care physicians’ offices confirmed that access is essentially barred for the uninsured, low-income residents in Missoula. Although some low-income, uninsured residents continue to be served by the physicians they have an established relationship with, only six percent of Missoula’s primary care physicians accept new, low-income, uninsured applicants (PHC, Executive Summary 1992).

Despite the large numbers of people without medical insurance, and therefore without effective access to medical care, Missoula took a largely reactive approach to the problem prior to 1989. For decades, Missoula doctors’ offices and the two hospital emergency rooms were swamped with the medically underserved. Many did not see a
physician regularly or practice preventive care. Although their health needs were complex, their access to health care was severely limited. Some medically underserved people found philanthropic doctors who would waive the cost of their visits. 

According to Dr. John T. Browne, "Missoula's physicians have long provided care free of charge to the indigent patient and write off a substantial portion of their charge for people who fall into the category of 150% of poverty level" (1994). But most of the uninsured, despite these instances of philanthropy, remained medically underserved. They tended to address their health needs in times of emergency, and found emergency rooms to be the only viable alternative. By the early 1980s it was clear to health care advocates that a more proactive approach was needed.

**Partnership Health Center: Development**

During the early 1980s the medically underserved population of Missoula was served by a small walk-in clinic under the direction of the Missoula City-County Health Department. The clinic was staffed by one nurse practitioner and offered only general care services. Because the walk-in clinic did not bring in revenues, it represented a significant financial drain on the Health Department's budget. The cost of caring for the medically underserved was simply more than local government could afford. When Ellen Leahy, Director of the Missoula City-County Health Department, realized Missoula could not afford to keep the clinic open, she began working with the two area hospitals to brainstorm alternatives (Twohig 1994). In 1989, a survey was distributed throughout Missoula to identify the health care needs of the community. The survey revealed that the medically indigent population was continuing to grow larger.

In 1990, Dr. Harold Braun, an opinion leader in Missoula's medical community, joined Leahy's effort to develop a more satisfactory mechanism for meeting the needs of the uninsured in Missoula. Together, Dr. Braun and Leahy
worked to form a physician group on indigent care. The goal of the group was to develop a working solution to the crisis. The group, or task force, consisted of representatives from both Missoula hospitals, local physicians, and local government administrators. Because the group of physicians and administrators on the committee knew they could not fix all of the health care problems in the community, they aimed at something "doable." They realized they could not get overwhelmed with the process. The committee knew it would not succeed if their approach pitted consumers against providers. The solution had to be a partnership, and a partnership it became (Leahy 1994).

The task force determined that an extension of the walk-in clinic would provide more appropriate care for the medically underserved population in Missoula. The facility was to remain under the domain of the Health Department. The group also developed a plan for equitably sharing medically indigent patients among participating doctors. Several local physicians offered to volunteer time and services at the central facility. Other doctors offered to be part of a volunteer referral network for the clinic. In addition, the clinic was supported financially by the city and county governments and local hospitals. The clinic was different from the old walk-in clinic in that it had physician and hospital support, a more defined structure, and more professional administration (Leahy 1994).

Partnership For Access, the clinic initiated by the task force, opened its doors to the public in Autumn 1991. Although it did much to help the target population, it was not large enough to relieve the burden on emergency rooms and doctors' offices. Partnership For Access only served completely medically indigent patients. It did not accept privately insured patients or patients covered by Medicaid. Partnership For Access did not have the funds or the proper facilities for the task it was performing.
Hence, the group had to gather again to determine ways to fund the clinic at a more realistic level.

The group studied the possibility of turning Partnership For Access into a community health center. Although some members of the group were apprehensive about losing autonomy to the federal government, the preventive care approach advocated by the federal government was congruent with some of the group’s goals for the clinic. Hence, in the summer of 1992, Partnership For Access applied for a federal grant to become a community health center.

The federal government awarded Missoula County the grant, and in September 1992 Partnership For Access officially became Partnership Health Center, Incorporated. Partnership For Access was, in effect, actually the pilot program for PHC. When the process began in 1989 no one expected that the walk-in clinic would become a community health center. However, through the cooperative effort of Missoula community’s health care providers and government administrators, PHC became the homegrown center which would care for Missoula’s medically underserved. One of the unique things about Partnership Health Center was the contribution made by the medical community and especially the doctors in Missoula County. While many CHCs have an adversarial relationship with physicians and other community health care providers, PHC is based on a true partnership between physicians, community health care providers, and the city and county governments.

**Partnership Health Center: Structure**

Partnership Health Center is a community health center, as defined by the Community Health Services and Facilities Act of 1961. It is governed by a Board of Directors, and it works in unison with the Health Department. It is federally funded, but locally controlled. Almost 200 doctors in the Missoula community offer volunteer
services or referral services to PHC. Currently, eighteen doctors offer volunteer time at the central clinic while the other 180 doctors provide support through a referral network. These 180 doctors see patients who have special problems or severe conditions which cannot be treated at the central facility. In addition, these 180 doctors consult with the PHC medical team on medical care issues. Also, the center has its own paid staff, facility, and director.

One crucial aspect of PHC's structure is the Board of Directors. As required by the federal government, 51 percent of the board consists of consumers. Twenty-five percent are community representatives and the other twenty-five percent are health care providers (Twohig 1994). The members of the Board of Directors are shown in Exhibit I (Metzcar 1994).

EXHIBIT I

PARTNERSHIP HEALTH CENTER: BOARD OF DIRECTORS

Twenty-one Members as of August 1994

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<tr>
<th>50% Patients</th>
<th>25% Medical Providers</th>
<th>25% Community Administrators</th>
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<tr>
<td>11 Consumers</td>
<td>1 Medical Doctor</td>
<td>1 County Gov't Representative</td>
</tr>
<tr>
<td></td>
<td>1 Dentist</td>
<td>1 Academic</td>
</tr>
<tr>
<td></td>
<td>2 Hospital Presidents</td>
<td>1 Chamber of Commerce Rep.</td>
</tr>
<tr>
<td></td>
<td>1 Health Dept. Rep.</td>
<td>1 Head of United Way</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 City Gov't Representative</td>
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Partnership Health Center’s Board of Directors meets, on average, two hours a month for an All-Board meeting. Federal guidelines require that minutes from board meetings are to be kept and filed. The board is divided into subcommittees to handle certain matters in more detail (Metzcar 1994).

Federal law also requires community health centers to be incorporated. As such, PHC is actually Partnership Health Center, Incorporated. Although PHC is its own corporation it is also a division of the Missoula City-County Health Department. According to the Missoulian, there are very few community health centers nationwide connected with Health Departments. Most are freestanding (Andrews 1993, C1). The connection allows PHC to offer a network of related social and health services. In other words, the association with the Health Department offers PHC access to an established health care network. In addition, PHC’s connection with the Missoula City-County Health Department means free rent and easier access to other social services.

The majority of PHC’s revenue comes from federal funds distributed as a grant under the Community Health Services and Facilities Act of 1961. Every year the center must reapply for the grant. In addition to the federal assistance, another recent grant from the Robert Wood Johnson Foundation also contributes to revenue. As mentioned above, the Missoula City-County Health Department supplies PHC free rent, access to other community workshops and agencies, and a solid infrastructure. Most of the physicians volunteer their time and services. The city of Missoula provides funding to PHC from the city budget, while the county contributes rent and in-kind donations. Hospitals and private donors also supply PHC with financial assistance. A "Medication Fund" was established through which pharmaceutical companies and doctors contribute leftover product samples to the clinic. Pharmacies contribute through an Indigent Care Program in which they fill prescriptions free of charge.
However, the Indigent Care Program does create a problem for PHC because it is a labor intensive process. More specifically, the PHC staff must write in new prescriptions every month for each patient.

Partnership Health Center has also established a framework to deal with expensive medical treatments. Partnership Health Center has an x-ray fund, a laboratory fund, and as previously mentioned, a medication fund. The two local hospitals, the radiology laboratory, and local doctors all donate to each of these funds. Patients can get lab work done at a reduced rate through the laboratory fund and they can get x-rays through the x-ray fund. However, PHC does not have a fund for surgery. Patients requiring surgery must work out an individual arrangement with the doctors and hospitals involved. Considering most of PHC's clients do work and can pay some of their health expenses, major medical treatments are usually financed through individual payment plans independent of PHC.

A small amount of clinic revenue comes from the patients. Each patient is charged per visit on a sliding fee scale between $1 to $5 for each visit. Everyone pays at least one dollar for the service because the PHC philosophy is that people should contribute to the cost of their health care, as their means permit. By contributing, people recognize how valuable health care is. Most PHC clients do work and can afford the minimal charge. As a community health center, PHC must serve privately insured patients as well as medically indigent patients. Currently only a small number of PHC patients are on Medicaid because Medicaid recipients in Montana are required to visit only doctors on a passport provider list. To date, PHC is not a passport provider because it does not have a doctor on-call. However, PHC does intend to expand its Medicaid clientele once it establishes an on-call service.

A review of PHC’s 1994 operating budget illustrates where PHC gets its revenue and spends its money (See Exhibit II). The 1994 line item budget is balanced.
at $669,112 (PHC, *Competing Continuation Grant Application* 1994, 72-78). The three local funders identified in Exhibit II are the two local hospitals and the city of Missoula.

### EXHIBIT II

**PARTNERSHIP HEALTH CENTER: 1994 OPERATING BUDGET**

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Revenue</td>
<td>$99,911</td>
</tr>
<tr>
<td><strong>Local Support</strong></td>
<td></td>
</tr>
<tr>
<td>Local Funders 3 @ $18,000/ea.</td>
<td>54,000</td>
</tr>
<tr>
<td>County Basic Needs Assistance Program</td>
<td>76,000</td>
</tr>
<tr>
<td>County Inkind</td>
<td>27,543</td>
</tr>
<tr>
<td>Physician Inkind</td>
<td>14,198</td>
</tr>
<tr>
<td><strong>Total Local Support</strong></td>
<td>171,741</td>
</tr>
<tr>
<td>Federal</td>
<td>397,460</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>669,112</strong></td>
</tr>
</tbody>
</table>
EXPENSES:

Personnel 453,233
Equipment 2,000
Supplies 35,390
Travel 7,551
Contractual 61,525
Other 109,413
Total Expenses 669,112

Eighteen doctors provide services at the central facility on a volunteer basis. Most of them are primary care physicians, although a cardiologist also serves patients at the clinic every Monday. In addition, 180 area doctors participate in the program by providing medical services on a referral basis. Referrals are often used for serious cases that cannot be treated at the clinic, such as problems associated with podiatry. For example, if a patient needs to see a specialist she or he will be referred to one of the appropriate 180 doctors. The 180 doctors average several pro-bono visits for PHC patients a month. Also, these doctors consult on a regular basis with the center. In addition, many of the 180 doctors agree to see patients for primary care visits in their own offices instead of at the central facility.

Other members of the PHC team include salaried nurse practitioners, physician assistants, case managers, medical assistants, administrators, and clerical workers. More specifically, the clinic is budgeted for one medical doctor, three nurse
practitioners, one and one-half case workers, one half-time social worker, one receptionist, one secretary, one clinical assistant, one-tenth pharmacist, one-tenth Russian interpreter, one-tenth Hmong Interpreter, one full-time director, three-tenths time medical director, and a business manager (PHC, Organizational Chart). As shown in Exhibit III, the Director of Partnership Health Center is Jeanne Twohig and the Medical Director of Partnership Health Center is Dr. Curtis Blake.

**EXHIBIT III**

**PARTNERSHIP HEALTH CENTER: ORGANIZATION**

<table>
<thead>
<tr>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% Patients</td>
</tr>
<tr>
<td>25% Medical Providers</td>
</tr>
<tr>
<td>25% Community Administrators</td>
</tr>
</tbody>
</table>

**Partnership Health Center Director (1.0)**

Jeanne Twohig

**Medical Director (0.3)**

<table>
<thead>
<tr>
<th>Clinical Services</th>
<th>Case Management</th>
<th>Support Staff</th>
<th>Ancillary Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.0) MD</td>
<td>(1.5) CHN</td>
<td>(1.0) Receptionist (0.1) Pharmacist</td>
<td></td>
</tr>
<tr>
<td>(3.0) FNP</td>
<td>(0.5) MSW</td>
<td>(1.0) Secretary (0.1) Russian Interpreter</td>
<td></td>
</tr>
<tr>
<td>(18.0) On-site Volunteer MD's</td>
<td></td>
<td>(1.0) Clinic Assistant (0.1) Hmong Interpreter</td>
<td></td>
</tr>
<tr>
<td>(180.0) Referral MD's</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Partnership Health Center's marketing approach is also part of its structure. New clients are accrued mostly by word of mouth. Hospital emergency rooms and doctors refer medically indigent patients to PHC. This referral service is part of the partnership between the local medical community and PHC. In fact, it is a cyclical relationship. The doctors and hospitals refer patients to PHC and then, depending on the patients' needs, they are referred back to the doctors and hospitals. The key point is that once a patient is affiliated with PHC that patient has a wider variety of medical options to pursue. Missoula's medical community spreads the burden of medically indigent patients through PHC.

**Partnership Health Center: Philosophy**

Partnership Health Center's approach to medicine focuses on preventive and primary care. The key to good health, according to this philosophy, is to maintain a healthy lifestyle. The center practices preventive medicine through patient education and vaccinations and by emphasizing the importance of regular check-ups. The minimal fee for service helps drive home the importance of good health care. A pamphlet distributed by PHC describes its approach as follows:

Partnership Health Center is a community health center. Our approach is simple: we want you and your family healthy today and healthy tomorrow. We treat the problems that bring you to us in the first place, and we are also interested in immunizations for your kids, in wellness checks, in reducing stress in your life, and in good eating habits and healthier lifestyles. A healthier community means healthier individuals. (Introducing Your Health Care Team)

Partnership Health Center also emphasizes holistic health care. This means PHC strongly believes physical health is tied to mental health. PHC provides for this
holistic approach by offering social services as well as medical services. Case workers and public health nurses work with patients on their other needs, such as Food Stamps.

In terms of its relationship to the larger community, Partnership Health Center emphasizes citizen involvement. According to this philosophy, the community must work together to solve the problem of the uninsured; it must work as a partnership. Partnership Health Center is a private/public partnership, combining the efforts of private physicians and the Department of Health. In fact, there is a dual partnership. The process part of the partnership is the physicians' partnership with PHC. The structural part of the partnership is the bond between the Missoula City-County Health Department and PHC. In other words, while the doctors provide the process and care, the Health Department supplies a framework and structure.

There is also an active administrative relationship between PHC and its patients. Although the center was not highly consumer oriented when it was first established, it is now committed to the concept of citizen involvement. As noted earlier, 50 percent of the Board of Directors are consumer representatives.

Partnership Health Center also is committed to taking affirmative steps to ensure that its targeted population is aware of the services it provides. Marketing strategies include word of mouth, social service referrals, emergency room referrals, doctor referrals, and stories in the local, state and national press (Twohig 1994). Most of the press PHC has received has been positive. In fact, several local and national articles hailed PHC as a success.
CHAPTER IV

ASSESSING PARTNERSHIP HEALTH CENTER'S SUCCESS

In the four years since it was established, Partnership Health Center has provided services to one-fifth of its target population, expanded its capacity, and increased revenue sources. Partnership Health Center's target population consists of 9,300 medically underserved people in the Missoula community (Browne). PHC now holds 3,000 patient charts and handles 7,500 visits per year for an average of 2.5 patient visits per year (Twohig 1994). In 1992, PHC saw 1,498 patients for a total of 4,096 primary care visits (Browne).

Seventy percent of the clinic’s patients are below the poverty level. Another eleven percent are a few dollars a month above the poverty level (Bloomer 1994, 11). There are very few PHC patients who earn more than 200 percent of poverty level. Seventy-five percent of the clients are adults, and twenty-five percent of the patients are children (Andrews 1993, C1). Most of Partnership Health Center’s patients do in fact work, but they are not provided insurance from their employers (Metzcar 1994). Another six percent of the patients are from the homeless population in Missoula (Bloomer 1994, 11). Partnership Health Center recognizes that homeless patients have a unique set of needs, such as treatment for mental illness, and Partnership Health Center tries to address those needs by referring patients to mental health providers. In fact, the center is currently researching opportunities to affiliate with mental health providers on a more institutionalized basis.
Soon the center expects to hire a full-time doctor, which will increase the clinic’s capacity to handle patient loads. The full-time doctor is critical to PHC for several reasons. First, it is a stipulation of the federal grant that all community health centers have a full-time doctor. In addition, the full-time doctor will offer PHC continuity in care. Previously, the PHC medical staff had to consult with referral doctors for medical advice. Although the referral network will remain a vital service, routine consultations will now be handled by the in-house doctor.

Partnership Health Center has successfully recruited 180 doctors to participate in the program; a figure which represents eighty-five percent of the physicians in the Missoula area (Leahy 1994). There is a sense of peer pressure that keeps doctors committed to helping the medically underserved in the Missoula community. In part, this peer pressure was instilled because Dr. Harold Braun, an admired Missoula physician, was so personally dedicated to the program. The success of the clinic is not only indicated by the number of doctors associated with PHC, but also by the true level of commitment these doctors bring to their work with PHC.

The clinic itself is currently seeing as many patients as it can, given its capacity and facility. Although the number of exam rooms has increased from three to five over the last few years, the clinic continues to operate at full capacity.

Partnership Health Center attempts to ensure that access is not an inhibitor for its services. The clinic is located in the city center for easy access to public transportation. It also recently added a handicap-accessible table to one of the examination rooms. In March 1994, the clinic started offering evening hours to increase access for patients with conflicting schedules. The evening hours run twice a week. As well, the clinic added Saturday hours. In addition, interpreters are available for Russian and Homing speakers. One reason the clinic is successful in reaching its target population is this adherence to the removal of typical access barriers.
As for the evidence of its success, the Director of Partnership Health Center cites the positive press PHC has received, and the many calls from other communities searching for a community health center model to follow. Articles on Partnership Health Center have appeared in the Missoulian, Missoula Independent, Good Housekeeping, and Medical Economics (Twohig 1994). In addition, Partnership Health Center received positive media coverage in a PBS television show (Metzcar 1994).

Beth Metzcar, the President of the Board of Directors for Partnership Health Center, believes that the clinic has been very successful in caring for the medically indigent of Missoula. She states that Partnership Health Center is reaching its target population. With current staff limitations, however, the number of available patient appointments is limited. According to Metzcar, the center is meeting the needs of the medically underserved population as well as it can, and the center is always trying to improve (1994).

Dr. Beth Thompson of the Blue Woman’s Montana Clinic has been volunteering half a day a month at Partnership Health Center for over a year. Dr. Thompson also works in the emergency room at one of the local hospitals. She believes the center has done a moderately good job in reducing the pressure in the emergency rooms. She said that the center itself is very busy and that patients must wait for an appointment. Dr. Thompson said it is too soon to tell whether the center has been successful with its preventive care approach, but she did stress that she has seen specific health problems managed at the center. As far as the impact health education has had on patients diet and overall health, it is too early to tell. She also noted that there are problems with having a volunteer physician staff because it delays follow-up. More specifically, follow-up delays accrue because a patient’s acting physician is only available on occasion for follow-up treatment. Although other physicians can provide the follow-up treatment, some conditions are best monitored through a steady patient-physician
relationship. She asserted that the patients she has seen have received very reasonable care they otherwise would not have access to (1994).

Generally speaking, those interviewed viewed PHC as a success. Far more of the medically underserved are now receiving medical care than before PHC was created. Nonetheless, there are parameters to PHC’s success. Only one-fifth of the medically underserved are currently benefiting from PHC, and patients often must wait for appointments. Demand clearly exists for expanded services.

As previously stated, PHC serves approximately twenty-five percent of Missoula’s medically indigent population. The other seventy-five percent of medically underserved people in Missoula seem to fall into certain groups. These people either do nothing about their health until it is too late, get care through the emergency rooms, or they find a philanthropic doctor who is willing to do pro-bono work. Many of Missoula’s doctors still see patients on a pro-bono basis. Though only six percent of Missoula’s primary care physicians accept new, low-income, uninsured patients (PHC, Executive Summary 1992), there are many doctors who continue to see patients they have been serving for years on a pro-bono status. Still, there are many advantages for both doctors and patients to joining PHC. For example, doctors can share the burden of the medically indigent through PHC while patients can tap into an established social service network with PHC.
CHAPTER V
PARTNERSHIP HEALTH CENTER AS A MODEL

The founders of Partnership Health Center did not follow any particular model when organizing PHC’s structure, nor did PHC follow a model when it began operating (Braun 1994). Nonetheless an operational structure does exist today which may have value for other communities. Outlined in Exhibit IV are some of the methods used to establish and maintain Partnership Health Center.

As outlined in Exhibit IV, Partnership Health Center took a systematic approach to development and delivery of services from the beginning. It began with a survey to assess the community’s health care needs, and it is now routinely maintained by new ideas and fresh data from additional surveys. The task force then set twelve goals and objectives which became part of the organization’s mission statement. The goals and objectives were established to provide the committee with a framework within which to work. After the task force identified the twelve goals and objectives, they were approved by the city-county government and Health Department. Before more planning was implemented, it was crucial for the city-county government to accept the goals and objectives in order to insure that the clinic would have local government support. The third phase, establishing a model, was inherited from the preexisting clinic’s Indigent Care Model and adapted to better suit the community. The Indigent Care Model was chosen for its adherence to the twelve goals and objectives. For example, the Indigent Care Model targets the same medically underserved population addressed in the goals and objectives.
### EXHIBIT IV
**METHODS USED TO DEVELOP AND OPERATE PHC**

<table>
<thead>
<tr>
<th>Directive</th>
<th>PHC Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment</td>
<td>1. Survey: Identify Need</td>
</tr>
<tr>
<td>2. Mission Statement</td>
<td>2. Set 12 Goals &amp; Objectives</td>
</tr>
<tr>
<td>3. Model</td>
<td>3. Indigent Care Model</td>
</tr>
<tr>
<td>4. Implementation</td>
<td>4. Implementation Stages</td>
</tr>
<tr>
<td></td>
<td>a) Pilot Year</td>
</tr>
<tr>
<td></td>
<td>b) Partnership for Access</td>
</tr>
<tr>
<td></td>
<td>c) Acquire Funding</td>
</tr>
<tr>
<td></td>
<td>d) Adapt Original Model:</td>
</tr>
<tr>
<td></td>
<td>Change from Indigent Care Model to Competition Model</td>
</tr>
<tr>
<td>5. Ongoing Evaluation</td>
<td>5. Multiple Evaluation</td>
</tr>
<tr>
<td></td>
<td>a) Reexamine Grant For:</td>
</tr>
<tr>
<td></td>
<td>b) Evaluate Program For:</td>
</tr>
<tr>
<td></td>
<td>c) Survey For:</td>
</tr>
<tr>
<td></td>
<td>1) Measurable Plan with Objectives</td>
</tr>
<tr>
<td></td>
<td>2) Day to Day Operation</td>
</tr>
<tr>
<td></td>
<td>3) Health of Patients</td>
</tr>
<tr>
<td></td>
<td>1) Patient Satisfaction</td>
</tr>
<tr>
<td></td>
<td>2) Reidentify Need</td>
</tr>
</tbody>
</table>
The fourth phase, the implementation phase, consisted of the development of Partnership for Access and the early years of Partnership Health Center. The fifth phase, evaluation, is accomplished on a continuous basis through surveys, questionnaires, and the application process for the annual federal grant. The ongoing evaluation is important to ensure that PHC is continually reaching the target population and providing appropriate care.

At each of these stages, physician support was crucial for the success of the project. Local physicians donated time and resources during all stages of the process. Specifically, doctors sat on the initial task force, helped identify program needs, established goals and objectives, and serviced the center with volunteer time and resources. Physician support is a critical part of the model. Also, medical opinion leaders, like Dr. Harold Braun, played a critical role in recruiting other physicians from the community. The prestige of the founding doctors and peer pressure from program participants worked together to rally the local medical community around PHC. Hence, not only is physician support crucial to the success of Partnership Health Center, but so too physician commitment promises to keep the center active.

**Unique Qualities of PHC as a Community Health Center**

Although federal guidelines ensure symmetry among community health centers across the nation, some community health centers have unique features that affect their degree of success. Partnership Health Center is unique in two key respects: its partnership with physicians and its partnership with the Health Department.

Most community health centers are created through a community effort to address a local health care problem, but many have encountered local physician resistance because they have been perceived as a threat. In Missoula, by contrast, doctors supported Partnership Health Center from the onset. In fact, doctors started
Partnership Health Center. This feature alone is one of the most unique aspects of PHC’s inception. As previously stated, in many communities doctors feel threatened by the establishment of community health centers, but in Missoula, physicians recognized the need and identified the solution. Today, eighty-five percent of Missoula area physicians participate in the program. The support PHC receives from local doctors results from a professional sense of responsibility. There is an underlying ethic among Missoula’s medical providers to give back to the community. In fact, Missoula’s finest and most prestigious doctors are more than just participants in PHC, they were its founders and they are its leaders.

Physician support is a unique feature of Partnership Health Center. For example, the People’s Clinic in Boulder, Colorado, is one community health center which experienced physician hostility when it was founded in 1970. The People’s Clinic was established over two decades ago as a "Hippie Free VD Clinic." Initially, there was resistance from the physicians in the community to the existence of the clinic. The prevailing mentality of the doctors, at the time, was that the clinic would take paying customers away. The doctors felt threatened by the center (Wasserman 1994). Two decades later the clinic serves many more people than just the hippies of the 1970s. The clinic’s current target population is the group below 250 percent of the poverty line, but the clinic is available to everyone. It serves 10,000 patients from Boulder City which has 28,000 residents below or at poverty level. The clinic has been generally successful in treating the uninsured.

Boulder, Colorado has the unique advantage of housing three community health centers. Together, they care for the 28,000 residents below or at the poverty level. All of the centers are at full capacity. The centers work closely with the medical community and the hospital. The physicians in the community are now receptive and appreciative of the centers. As well, the emergency room staff and hospital are
appreciative because the centers relieve them of a large burden. The People's Clinic has had a solid relationship with the community's physicians for eight years. Once the doctors recognized that the clinic did not threaten economic competition, the relationship improved (Wasserman 1994). Basically, the clinic is a community resource. It handles people who can not afford to go the doctor. Boulder boasts a community effort to handling this community problem.

As the Boulder example illustrates, physician resistance is a factor community health centers may encounter. Another problem faced by many community health centers is lack of a facility. Some clinics must wait for a facility to become available, while other clinics must pay high rents that drain resources that otherwise would go for direct patient services. The Brockton Neighborhood Health Center in Brockton, Massachusetts, had to operate from a mobile unit for its first year in operation. Because of the limited size of the mobile unit, the center was confined to seeing only twenty patients a week (Joss 1994). On the other hand, Partnership Health Center enjoys free rent and a stable central facility through its close relationship with the local Board of Health. Because of it, PHC also enjoys an established social service network and patient workshops sponsored by the Health Department. As well, the Health Department provided an infrastructure that was vital in the nascent stages of planning. The Missoula City-County Health Department also affords PHC with administrative assistance. For example, PHC administrators are county employees and eligible for county benefits through the Health Department. It is worth noting that the federal government is opposed to a model where the public Health Department helps the community health center. The federal government likes to retain some element of control. The federal government offers a large amount of funding, and when that funding is supplemented by local government funding, control over the center must be shared. This is why many community health centers are discouraged from associating
with public Health Departments. Hence, the partnership between the Missoula City-County Health Department and Partnership Health Center is rare among community health centers. This unique feature represents a source of financial and structural support for PHC.

Similarly, Beth Metzcar suggested that the managing relationship between the Health Department and Partnership Health Center’s governing board is unique (1994). Not only is it unique that the Health Department contributes funding and space, but the cooperation between the Board of Directors and the Health Department offers a unique governing structure. In essence, the Missoula City-County Health department has a role in governing PHC. The union with the Health Department also affords PHC easier access to a wide variety of social services.

There are still other reasons why Partnership Health Center is unique among community health centers. For one, the city and county governments are in partnership with the private medical center. Also, Partnership Health Center did not originate as a community health center, and as such, it retains a measure of autonomy granted it when it was not federally guided. In addition, PHC brings physical health care together with mental health care. This comes not only from patient education, but also from the network of social services. Case managers work with patients. They keep patients in tune with other programs vital to their health needs, such as Food Stamps, Medicaid, and Medicare.

**PHC as a Model for Other Communities**

Ellen Leahy believes that PHC is an appropriate and valuable model for other partly rural and partly urban communities. However, she warned that another community should not attempt to replicate what PHC has done exactly. The key to the model lies in a process in which community resources are mobilized to resolve unique
community problems. Leahy emphasized the need for a community to come together to solve a problem (1994).

Great Falls and Helena are considering creating community health centers. Both communities have been in touch with Partnership Health Center in Missoula to study the PHC process. In fact, Leahy said that both Helena and Billings already have plans to establish a health center along the lines laid out by Partnership Health Center (1994).

Partnership Health Center has received national publicity and many communities, particularly communities in California and Ohio, have inquired about it. The process is unique, and to date it has been very successful. PHC did not have to endure the animosity of the medical community as Boulder, Colorado's People's Clinic did for years. Also, by joining resources with the Health Department, PHC had an infrastructure in place at its inception, unlike the Brockton Neighborhood Clinic which had to operate out of a mobile unit until it could move into its permanent facility.

There may also be lessons PHC can learn from other communities. Beth Metzcar suggests that one thing Partnership Health Center could learn from the experience of other communities is how to increase the amount of paying customers and thereby create the capacity to increase its staff (1994). Once the staff is increased, ideally the clinic will be able to serve more medically indigent patients as well.
CHAPTER VI

THE FUTURE OF PARTNERSHIP HEALTH CENTER

The Future of Community Health Centers

Community health centers are secured a spot in the future of medical care in the United States. Whether or not universal health insurance is enacted there will remain a need for community health centers. Community health centers are experts at meeting the needs of the medically indigent more comprehensively than most other medical providers. Community health centers, such as PHC, make connections for people. They provide case workers, case managers, social workers, and public health nurses. Community health centers offer a more holistic approach to health care delivery. Ellen Leahy remarked that if PHC did not offer such a holistic approach it would be a "McDonald's type health care" (1994). In other words, without a holistic approach, medical service would be generalized and individual conditions would be lumped into general treatment categories. Susan Joss agreed with Ellen Leahy. She also said that there will continue to be a need for community health centers because of other access barriers such as language (1994).

Indigent care is usually not a market that doctors want to be in. As such, there will remain a need for community health centers in city centers and in rural areas (Twohig 1994). Migrant and rural health centers will be especially secure in the future (Metzpras 1994). Rural areas usually have limited funds to work with and limited numbers of doctors available. In short, community health centers will remain essential community providers because they are specialists in dealing with the medically
underserved (Twohig 1994). In addition, community health centers will continue to play a pivotal role in providing health care access to the medically indigent across the nation. As health care reform is postponed farther into the future, community health centers will remain a viable option for the millions of medically uninsured in the United States. However, community health centers do not represent a cure for the ailing health care industry in the United States. Because community health centers are dependent on support from physicians and federal grants, they cannot represent the final solution. National and state policy makers will have to address the problems of access to quality medical care and health care security.

The Future for Partnership Health Center

The immediate future of Partnership Health Center will bring a larger staff with the addition of a paid full-time physician. Also, dental and mental care are on the horizon. Partnership Health Center's Board of Directors continually participates in surveys of the community to determine the needs of the medically underserved. The board then redirects policies according to the needs identified in the most recent survey (Metzcar 1994).

As stated above, most of Partnership Health Center's clients are employed, but do not receive health insurance from their employers. In fact, many are small business employees (Metzcar 1994). As Missoula is a small business community, this trend is likely to continue until reform is implemented. In the absence of universal coverage, these individuals will not be able to purchase medical services on their own, and they will remain dependent on organizations such as PHC.

Partnership Health Center has developed a Project Plan to take it through 1995. The plan highlights the goals and objectives of the center for the next year, as well as
the successful strategies the center will continue to employ. The goals established in
the Strategic Plan are shown in Exhibit V.

EXHIBIT V
STRATEGIC PLAN GOALS

1. To assure Partnership Health Center's effectiveness by improving its
   organizational structure.

2. To appropriately position Partnership Health Center as a community-
   oriented provider within its defined service area.

3. To implement a data management system for tracking, reporting and
   analyzing information.

4. To acquire an adequate facility, including necessary equipment and supplies,
   to meet expanding needs of Partnership Health Center.

5. To respond to PHC patient needs, within the context of comprehensive
   primary care and the financial capabilities of PHC, by expanding present
   services, developing new programs, and ensuring access to other agencies and
   organizations through referral.

6. To meet or exceed all clinical standards as defined by Partnership Health
   Center's Principles of Practice (PHC: Competing Continuation Grant
   Application 1994, 49).
The plan also outlines the strategic objectives for meeting these goals. As shown in Exhibit VI, these objectives are grouped into six categories: Need Assessment and Planning, Governance, Management and Finance, Clinical Management and Staffing, Clinical Quality and Services, and Clinical Plan by Life Cycles.

EXHIBIT VI
STRATEGIC PLAN OBJECTIVES

Needs Assessment and Planning

Objective I. To strengthen involvement of key PHC stakeholder groups, including the original funding partners, consumers, physicians, and health care providers.

Objective II. Continue the annual planning cycle, including regular review of the annual plan, on-going assessment of the plan, and completion of quarterly progress reports.

Objective III. Achieve patient balance as appropriate to meet community needs and federal requirements and to fulfill Partnership Health Center’s mission as a community health center.

Objective IV. Develop an image that reflects the professionalism and mission of Partnership Health Center.

Objective V. Actively engage in local, regional and national health care reform initiatives.

Objective VI. Reinforce PHC’s philosophy of partnership.

Objective VII. Anticipate and prepare for the impact of health care reform on Partnership Health Center as a federally funded community health center.
Governance

Objective I. Achieve full participation by the Partnership Health Center Board of Directors.

Objective II. Continue to reassess co-applicant status of Partnership Health Center with the Missoula City-County Health Department.

Objective III. Provide additional training to the Partnership Health Center Board of Directors.

Management and Finance

Objective I. Assess the PHC organizational model to assure the appropriate number and mix of staff necessary to accomplish agency goals and reduce staff overload.

Objective II. Provide an environment of staff development and support

Objective III. Ensure reliable funding to support PHC’s existing and expanding services.

Objective IV. Fully activate a management information system and provide management reports.

Objective V. Identify short term solutions to the current facility problems of Partnership Health Center, in concert with the Health Officer.

Objective VI. Plan for the acquisition of appropriate building space, in concert with the Health Department.

Clinic Management and Staffing

Objective I. Refine all aspects of PHC’s patient management system.

Objective II. Provide services to an increasing number of patients until capacity is reached in terms of staff, space, and financial resources.

Objective III. Secure and retain additional, appropriate, and consistent professional provider coverage in the PHC clinic.
Objective IV. Develop and strengthen PHC’s capability as an educational training site.

Clinical Quality and Services

Objective I. Assess, revise and approve PHC’s Quality Assurance Plan.

Objective II. Assess patient needs by continuing customer satisfaction survey.

Objective III. Assure that PHC’s services are accessible to patients.

Objective IV. Expand services through program development and increasing referral opportunities in response to patient needs and PHC’s mission of providing comprehensive primary care.

Objective V. Address patient and community health risks by participating in health promotion / disease prevention initiatives with other community agencies.

Clinical Plan by Life Cycles

Objective I. Achieve goals set forth by PHC in the Clinical Outcome Measures, by educating staff to the indicators and refining internal systems for charting. (PHC: Competing Continuation Grant Application 1994, 49-68)

As these strategic objectives suggest, PHC fully expects that medically underserved individuals will continue to be dependent upon it well into the future. Because of that expectation PHC has taken steps to expand its role in the community.
CHAPTER VII
CONCLUSION

The medical industry in the United States is suffering from its own set of ailments. One of the byproducts of our ailing system is the fragile state of health insurance. Eighty million Americans are medically indigent. Many more Americans are insecure about their health insurance future. While the federal government is stalling on health care reform, many communities are attacking the problem themselves.

Missoula, Montana is one community which has rallied together to care for its medically underserved members. Local medical providers and community representatives worked together to establish a clinic designed to meet the needs of the medically indigent. After almost four years in operation, Partnership Health Center has successfully targeted the medically underserved population. Although the center is limited by space and staff, it utilizes 100 percent of its current operating capacity to meet the needs of those without access to medical services. Partnership Health Center has relieved the local hospitals and physicians to some extent from the burden of caring for the uninsured. At the very least, it offers the uninsured an effective alternative to the hospital emergency room.

Partnership Health Center’s success can be attributed to its unique foundation and strong relations with the Health Department and local physicians. Both elements offer Partnership Health Center resources many community health centers are still
struggling to obtain. Recommendations to other communities searching for medical alternatives for the uninsured are as follows:

* Follow the PHC process of community-based development, but not necessarily the specific model established by PHC.
* Adopt a model appropriate for the community and the needs of its medically underserved population.
* Involve community medical providers in the process of development and clinic operation.
* Integrate social services, such as case management, with medical services to provide patients with holistic health care.
* Make the effort a proactive initiative and not just a reactive response.
* Cooperate with the local Health Department to better access social services.

The process by which Partnership Health Center was developed, and the unique partnership between doctors, citizens, and government administrators, represents a useful model for other communities to follow. Missoula has realized success targeting the needs of its uninsured population. However, there are still many people in Missoula unable to meet their health care needs. To address the increasing medically underserved population, PHC will soon expand to improve service capacity. In an age when the health care needs of many people have not been met, the Missoula community has made great strides in increasing access for the medically underserved.
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