Affirming Our Commitment:

How Capacity Building and Expansion of Christian Health Ministry, Inc. May Benefit White County, Arkansas

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Abstract

As more citizens in the United States live without health insurance and lack sufficient access to affordable healthcare, communities have mobilized to create new equitable healthcare options for the working uninsured. In 2001 residents of White County, Arkansas formed Christian Health Ministry of White County, Inc. (CHM), as a faith-based, volunteer-only clinic to provide quality and affordable health and wellness services to the working uninsured. After nine years of providing basic health care and pharmaceutical services, CHM operates with limited funds, has few partners, faces a shrinking pool of volunteers, and suffers from leadership fatigue. While demand rises for expanded equitable healthcare options for the working poor in White County, Arkansas, the capacity and sustainability of CHM to meet those needs seems increasingly uncertain.

The subject of this paper is a project conducted as an unpaid service to CHM. The Project conducted an organizational assessment of CHM, including potential contributions to community economic development. The short-term intent of the Project was to examine the organization's efficiency and effectiveness and explore opportunities to build capacity. A long-term outcome of the Project was to strengthen the position of CHM as a sustainable medical and wellness option for the working uninsured of White County and to increase the number of working uninsured who make CHM their medical and wellness home.

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Part 1: Community Context

Community Profile

The Project is located in White County, Arkansas, fifty miles northeast of the state capital Little Rock and one hundred ten miles west of Memphis, Tennessee. With the second largest county landmass in the state (Metro Little Rock Alliance, 2009), White County ranks tenth in total population out of seventy-five counties (United States Census Bureau, 2008). As of 2006 White County's population is 72,560 and is among thirteen counties having experienced population increases of about 25% or more since 1980. White County is expected to exceed 100,000 residents in about a decade (Henning, 2000). White County contains sixteen incorporated communities including Searcy, Beebe, Bald Knob, Bradford, Letona, and McRae. Searcy is the county seat and the largest city in the county with a population of 21,749 (United States Census Bureau, 2008).

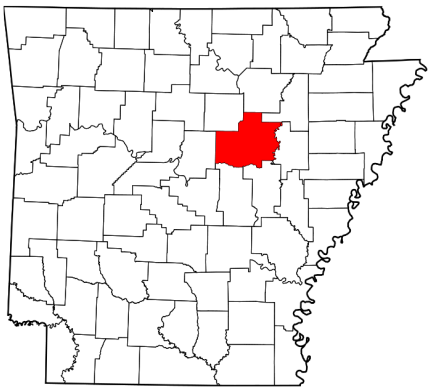

Figure 1 White County Arkansas
(Wikimedia Commons, 2006)

White County population is predominantly Caucasian (92%) with the second largest race being African American (five percent). Poverty indicators offer mixed results. While there is a smaller percentage of individuals and families in poverty in White County compared to the state of Arkansas, the county has higher poverty rates than the United States. White County and Arkansas report a notably lower level of education than the average education attainment of the United States. The Project research shows a correlation between education levels and the rate of the medically uninsured (United States Census Bureau, 2008).

Demographics at a Glance, White County, AR 2006	
Population	72,560
Households	27,454
Average Household Size	2.5
Median Age	36
Median Household Income	37,022

Table 1 Demographics of White County, AR
(United States Census Bureau, 2008)

The local healthcare industry serves the medical needs of the area and is an important economic engine in White County. In the past five years the medical community has spent more than $45 million dollars on expansions and renovations. White County Medical Center (WCMC) is the only hospital in the county, with a total of 438 licensed beds. The hospital's services include acute care, rehabilitation, geriatric psychiatry, and inpatient hospice. Offering advanced technology, WCMC has state-of-the-art equipment, including an Open MRI and a 64-slice CT. The medical staff consists of over 150 physicians representing a wide variety of specialties. WCMC is the second-largest employer in Searcy, with over 1350 associates living, working and raising families in Searcy and the surrounding communities. The hospital serves a six-county area including Cleburne, Independence, White, Jackson, Woodruff and Prairie (Searcy Chamber of Commerce, 2008).

White County has a modestly diverse economic base including two Wal-Mart distribution facilities, Land O'Frost meat products, Bryce Corporation food packaging, Road Systems freight trailers, and Yarnell's Ice Cream. Education is a major public sector employer since White County is home to Harding University and Arkansas State University (ASU) which has campuses in Searcy and Beebe (Searcy Chamber of Commerce, 2008).

Education in healthcare offers an important resource for potential employment and a potential source to improve the quality and accessibility of medical services in White County. As a two-year college, ASU offers programs at the Searcy campus that include EMT/paramedics health information assistant, and pharmacy technician. At the Beebe campus ASU offers degrees nursing and health professions that include Certified Nursing Assistant, Registered Nurse, and Clinical Laboratory Science (Arkansas State University - Beebe, 2009). Harding University, located in Searcy, is an 85-year-old liberal arts institution with notable academic offerings in healthcare including its College of Nursing, College of Pharmacy, Physician Assistant Program, and Pre-Medicine Program (Harding University, 2009).

Community Needs Assessment

Recent data indicates that the overall health of residents in White County and in the state is generally poorer when compared to the national statistics. The results of a

2005 Behavioral Risk Factor Surveillance System (BRFSS) County Adult Health Survey were compared to 2006 Adult Health Survey results of a neighboring county, and 2006 Arkansas and nationwide BRFSS data (Hometown Health Improvement , 2007). The prevalence of reported fair or poor general health was equal among adults in White

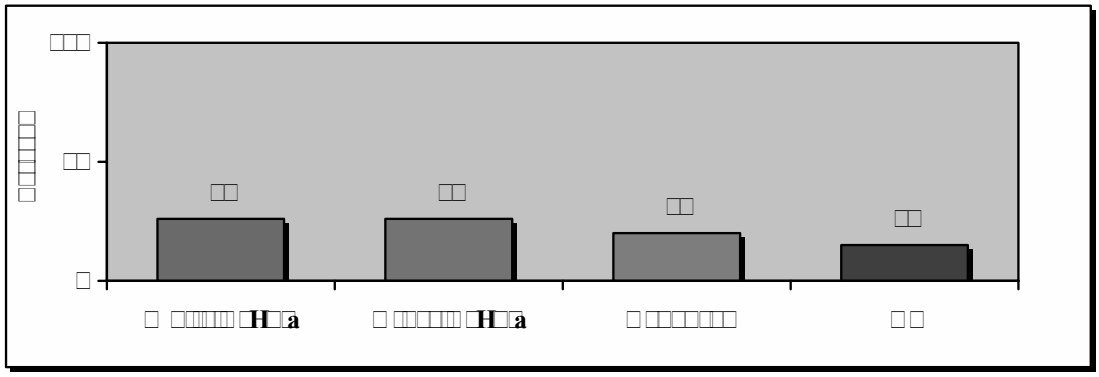

Figure 3 Prevalence of Reported Fair or Poor Health in White County, Arkansas
(Hometown Health Improvement , 2007)

County (26%) and adults in neighboring county (26%). However, the prevalence of reported fair or poor general health was higher among adults in White County (26%)

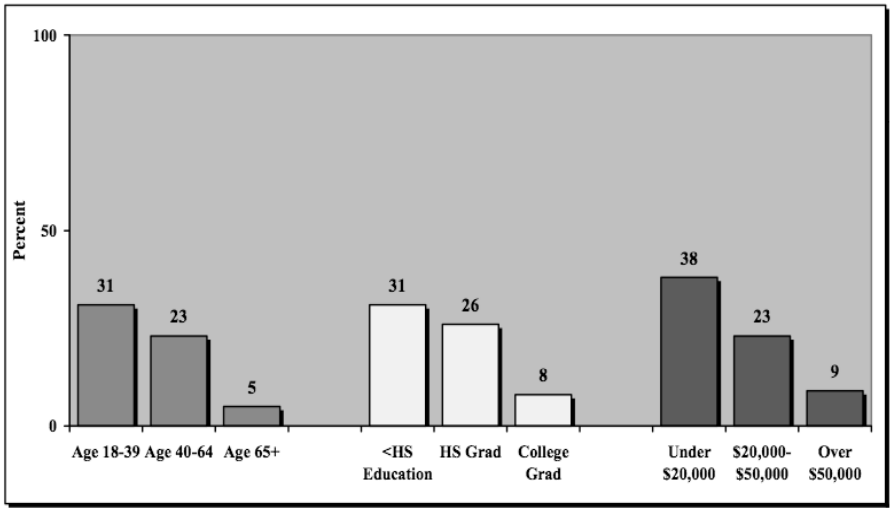

Figure 2 The Uninsured in White County, Arkansas
(Hometown Health Improvement , 2007)

than among adults in Arkansas (20%) and adults in the nation (15%) (see Figure 3). Moreover, prevalence of reported fair or poor health characteristics commonly corresponded to lower annual income and lower education attainment (high school diploma or less). The increasing number of uninsured citizens in both the county and the state further compromises the vulnerable economic and health-related circumstances of

many residents of White County and Arkansas. According to a 2005 telephone survey conducted by White County Home Health Improvement, twenty-three percent of adults in White County reported that they did not have health insurance (Hometown Health Improvement , 2007). Survey findings suggest that the population most at-risk and who lack health insurance are residents of ages 18-64 years, those with a high school education or less, and those earning less than $50,000 annually (see Figure 2). The growing numbers of uninsured citizens in White County corresponds to state and national trends (Arkansas Center for Health Improvement, 2008) (State Health Access Data Assistance Center, 2009). White County reports a slightly higher rate of uninsured than the state and considerably higher than the national rate (see Figure 4).

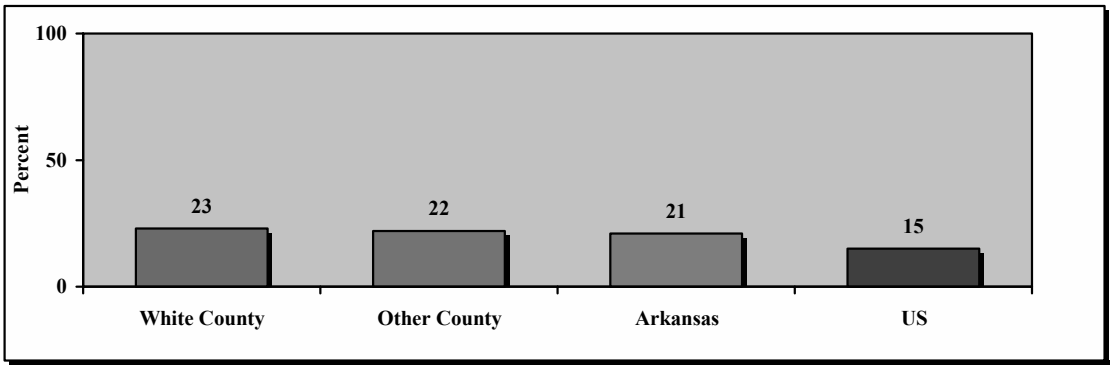

Figure 4 Prevalence of Reported No Insurance Coverage

(Hometown Health Improvement , 2007)

The largest medical provider in White County, WCMC, reported increased utilization costs related to care of the uninsured. In an interview with representatives of WCMC, approximately $52 million (or 13%) of its annual gross revenue of $400 million is attributable to care for the uninsured. Financial assistance for the uninsured or the low-income insured equals approximately 3.3% of the nearly $12 million annual budget, a figure that has doubled in the past five years (Miller & Burton, 2009).

Target Community

The target community of the Project was the organization of CHM. The Project conducted an organizational assessment of CHM, including potential contributions to community economic development. The short-term intent of the Project was to examine the organization's efficiency and effectiveness and explore opportunities to build

capacity. A long-term outcome of the Project was to strengthen the position of CHM as a sustainable medical and wellness option for the working uninsured of White County and to increase the number of working uninsured who make CHM their medical and wellness home.

Part 2: Problem Analysis

The Problem Statement

The Project examined the organization's efficiency and effectiveness and explored opportunities to build capacity, particularly in light of apparent increased demand from the growing uninsured population. CHM faces a two-fold challenge:

1. An increasing number of uninsured residents of White County, Arkansas lack sufficient access to affordable healthcare and wellness services.

2. CHM lacks sustainable capacity to sufficiently meet the growing demand for healthcare and wellness services of medically uninsured residents of White County, Arkansas.

The leaders gave voice to the limitations of the nine-year old organization. Several members of the board of CHM, who also fill critical roles in the operation of the clinic and work directly with guests/patients,[1] expressed fatigue in the following statements (Board of Christian Health Ministry, SWOT Analysis, 2009):

> "We're burned out."
>
> "Our greatest strength (as a volunteer-led clinic) is also our greatest weakness. We can't do any more than we're doing now."
>
> "In May I'm backing out of most of my volunteer responsibilities and so is another board member. We're just tired."
>
> "(This Project) is what we've needed for a long time."

Since 2000 CHM has served as a provider of basic healthcare and wellness services to uninsured residents of White County. After only two years of operation demand for services of CHM exceeded its capacity. As a result, in 2004, CHM reduced by nearly four hundred the annual number patients served in order to provide quality healthcare and

[1] To aim for clarity for the reader and because CHM prefers to call their patients "guests," this report uses the designation "guest/patient" as a reference to patients of CHM.

to maintain meaningful relationships with guests/patients. With a volunteer-only staff and an average annual revenue of less than $35,000, CHM served an average of 1950 patient visits per year since opening its doors in 2000.

The success of CHM to deliver quality healthcare and cultivate authentic relationships is heard in the following statements of CHM guests/patients(Guests/Patients of Christian Health Ministry of White County, 2009):

> "Seven years ago I learned about Christian Health Ministry from my husband's brother. (CHM) saved his life."
>
> "This clinic has found some medical problems I never knew that I had…And Bonnie (the Nurse Practitioner) is my family…(she) knows how I feel about (her)…she's talked to me and helped me out with a lot of things."
>
> "Christian Health Ministry is the only way I can get medical attention. I don't have insurance. The volunteers have helped me stop smoking…and feel better. They've helped many others just like me."
>
> "People come here just because they like to see the people (who serve here)."

The Project observed that CHM is a healthcare organization whose personnel are committed to meaningful relationships with guests/patients and to provide quality healthcare. The Project explored ways to build on these fundamental strengths of CHM in order to achieve a sustainable capacity that sufficiently meets the growing demand for equitable healthcare and wellness services for medically uninsured residents of White County, Arkansas.

Stakeholders

A successful organizational assessment requires the identification and involvement of stakeholders. The stakeholder analysis conducted by five board members provides an informative view of persons and organizations that are now active participants with CHM CHM (see Table 2) Unfortunately, CHM has suffered a loss of volunteers and seems to have struggled to engage community partners. In a Project that explored the need to build capacity, the names of persons and organizations *absent from the list* may prove equally instructive relative to future outreach required by CHM (Board of Christian Health Ministry, Stakeholder Analysis of Christian Health Ministry, Inc., 2009).

Active Stakeholders	Involvement
Board of Directors, CHM	Shape the vision and mission; provide governance for organization; and oversight of operations. Of the fourteen board members only six appear active.
Downtown Church of Christ	Board of Elders allocates essential funding and administrative support. Members provide a source of volunteers.
White County Medical Center Laboratory	Provides lab work at no charge.
Harding University	Healthcare departments or colleges provide valuable volunteer base through the Colleges of Nursing and Pharmacy, Physician Assistance Program, Counseling Program in the Psychology Department, and pre-med students in the Health Sciences program.
Guests/Patients	Provide important feedback on the effectiveness of services and advocacy to potential guests/patients and supporters.

Table 2 Stakeholders of CHM

(Board of Christian Health Ministry, 2009)

The CED-ness of the Project

An underlying value of the Project is to identify the past and potential contributions of CHM to community economic development (CED). Since during its first decade a relatively small CHM had a modest economic effect on medically uninsured residents and the medical and business communities, some believe that a more notable economic impact is possible with the expansion of CHM's capacity. In a recent focus group, guests/patients of CHM recognized the potential economic benefits of CHM (Guests/Patients of Christian Health Ministry of White County, 2009) in statements like the following:

> "[CHM could better meet my healthcare needs if they] worked with the local hospital to accept referrals and cut my hospital costs."
>
> "I wish CHM had the ability to do more testing…or work with others who provide those services. I had to go to the emergency room to get help and it cost me over $6,000 – which I don't have."
>
> "I need an EKG test but I can't afford the test and CHM can't afford the machine."

CHM needs innovative and flexible new partnerships with the local hospital and specialty providers not only to provide healthcare services to the uninsured, but also to

reduce unnecessary and costly hospital utilization. As the Project report documents, providers often realize significant cost savings through partnerships with local nonprofit community clinics. An expanded and sustainable CHM might also assist the financial bottom-line of local small businesses. Through expanded clinic hours and a more comprehensive network of providers, CHM might consider a financial partnership, similar to The Memphis Plan at Church Health Center discussed later in the Project report, where area small businesses and their employees pay a nominal fee to receive care at CHM at affordable rates. As small business owners send their workers to CHM for treatment, healthy workers might bring financial benefit to their company with fewer sick days and increased productivity. The potential positive economic impact of CHM to uninsured citizens, providers, and employers was an important aspect of the Project.

The Project was launched with confidence that the stakeholders believe CHM serves a valuable role in community economic development and desire to insure its sustainability. The challenges and opportunities of CHM are underscored through a review of literature that documented the alarming growth of the uninsured in the state of Arkansas and nationally, and highlighted the success of other charitable clinics that seek healthcare equity.

Part 3: Literature Review

In the *2005 Arkansas Fact Book: A Profile of the Uninsured*, Dr. Joseph W. Thompson, director of the Arkansas Center for Health Improvement, underscored the severity of healthcare inequities and the social and economic impact of the rising percentage of the uninsured (Arkansas Center for Health Improvement, 2005, p. 1):

> One of the biggest challenges facing our state and the nation is how we pay for healthcare that our citizens need. Nationwide, almost 46 million or 16% of Americans are uninsured. In Arkansas, nearly 456,000 people do not have access to health insurance – 17% of our state's population. *The face of the uninsured is the face of every Arkansan…*
>
> The evidence clearly indicates that individuals without health insurance delay seeking care when it is needed, obtain more expensive and less effective treatments, and die at a younger age than those with health insurance coverage. Those without insurance are less likely to receive preventive care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late stages of disease…

> The uninsured live in every community of the state…those without health insurance coverage are more financially vulnerable to the high costs of care…and frequently are forced to resort to bankruptcy as a protection against uncovered medical expenses. The detrimental effects of uninsurance on families, communities, and our state are pervasive.

The following literature review provides a summary of research relevant to the Project. Seven areas of study are highlighted:

- National Research on the Uninsured, Access to Healthcare, and Community Health
- The Economic Impact of the Uninsured
- Issues of Health and the Uninsured in Arkansas
- Health Status and Access to Health Coverage in White County, Arkansas
- Examples of Faith-Based Organizations Outside Arkansas
- Charitable Clinics in Arkansas
- Resources for Charitable Clinics

The fluid nature of the healthcare industry – rising costs of healthcare and insurance coverage and the increasing number of the uninsured – heightens the value of documented analysis relative to the function of community-based healthcare delivery and the potential of faith-based nonprofit organizations to improve healthcare equity.

National Research on the Uninsured, Access to Healthcare, and Community Health

CHM can serve as a local advocate for healthcare equity for the uninsured and communicate the value of its work by dispelling myths about the uninsured and accurately presenting the challenges faced by those without health coverage. Two helpful resources are available through the Henry J. Kaiser Family Foundation: "Myths and Facts About the Uninsured" and "Five Basic Facts on the Uninsured (Kaiser Family Foundation, 2008). Basic data about the uninsured essential to understanding how organizations like CHM might assist those without health insurance include these five facts:

- Most of the 45 million uninsured are in working families and do not have access to employer-sponsored insurance.
- More than eight in ten of the uninsured are in low- or moderate-income families.

- Most low- and moderate-income uninsured adults are not eligible for Medicaid.
- The uninsured suffer from negative health consequences due to their lack of access to necessary medical care.
- Medical bills are a burden for the uninsured and frequently leave them with debt.

Additional information about America's uninsured is provided by the Alliance for Health Reform. "A Reporter's Toolkit: The Uninsured," offers links to resources that help readers understand who lacks health coverage in the United States and the consequences of being uninsured (Alliance For Health Reform, 2007).

The United States Department of Health and Human Services is a valuable resource for statistics, reports and tools (United States Department of Health and Human Services, 2009). Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable. GRSA also provides valuable data relevant to the work of charitable clinics and their partnerships that exist to serve the uninsured (Health Resources and Services Administration, 2008).

The Center for Studying Health System Change (HSC) is a nonpartisan policy research organization located in Washington, D.C. that designs and conducts studies focused on the U.S. health care system. HSC seeks to inform policy makers and private decision makers about how local and national changes in the financing and delivery of health care affect people (Center for Studying Health System Change, 2008). Charitable clinics and their partners will find this a valuable source for perspective on the current national conversation about healthcare reform.

Health Literacy Foundation acts as a clearinghouse featuring the most up-to-date health information and strives to ensure their content is easy to read and both culturally and gender sensitive. The foundation funds health literacy initiatives, partners with community-based organizations, and connects beneficiaries with valuable resources (Health Literacy Foundation, 2008).

The Economic Impact of the Uninsured

Project Access, in Dallas-Ft. Worth, is a unique example of a collaborative that offers a safety net to the uninsured and measures outcomes and related economic impact

on the local healthcare community. Even small charitable clinics will find helpful the analysis provided by researchers with Project Access, as a way to measure the contributions medical professionals and other volunteers make to the local community (Project Access, 2008).

With thoughtful and accurate record keeping, individual clinics an report the economic effect on their local community. At least two in-state charitable clinics attempt to measure economic contributions to their local community and provide a helpful guide for other community clinics that seek to expand their influence (Mountain Home Christian Clinic, 2008)(Charitable Christian Medical Clinic, 2008). The Agape Clinic in Dallas, Texas serves as a helpful out-of-state example of a charitable clinic that tracks the economic effect on the local community (Agape Clinic and Community Care, 2008).

Issues of Health and the Uninsured in Arkansas

In the past decade leaders in Arkansas have raised awareness concerning the plight of uninsured Arkansans and their economic effect on both the healthcare and business communities. Arkansas Center for Health Improvement (ACHI) was founded in 1998 as a nonpartisan, independent, health policy center to serve as a catalyst for improving the health of Arkansans (Arkansas Center for Health Improvement, 2008). ACHI seeks to achieve its goals through evidence-based research, public issue advocacy, and collaborative program development.

In 2005 ACHI published the *Arkansas Fact Book 2005: A Profile of the Uninsured* to describe how many Arkansans lack coverage, what gaps exist in sources of health insurance, and who the uninsured are in Arkansas (Arkansas Center for Health Improvement, 2005). Several findings from their publication are relevant for the Project: nearly half a million Arkansans are without health insurance, and that figure is growing; more than 3 out of 5 uninsured Arkansans are employed; and, less than half of all private sector firms and only about 1 out of 4 small employers in Arkansas offer health insurance coverage to their employees. The report concludes, “new programs should target small employers and provide meaningful yet affordable coverage options” (p. 9).

In December 2006 enrollment opened for ARHealth Networks, an innovative program that represents one of the first true partnerships between state and federal government, private businesses, and families to make affordable health care coverage

available to uninsured workers (Arkansas Center for Health Improvement, 2008)(ARHealth Networks, 2009). As CHM seeks to expand its service among uninsured residents, a thorough understanding is needed of this unique initiative, its role in White County, and the potential lessons and partnership that may exist for CHM.

"The Public Health in Arkansas 2009 Report" was published in February 2009 for the Senate and House Public Health, Welfare, and Labor Committees as a source for quick information on selected health risk factors and outcomes of Arkansans (Phillips & Goodell, 2009). Although this publication reports a lower incidence of uninsured in White County than other surveys, its authors provide yet another set of data on the increasing numbers of uninsured residents in Arkansas.

"At the Brink: Trends in America's Uninsured" is a state-by-state analysis released in March 2009 and prepared for the Robert Wood Johnson Foundation. More nonelderly Arkansans are uninsured today than in the mid-1990's while the number of uninsured adult men (19-64 years) increased by nearly 8% to 27.2% and the number of uninsured workers (19-64 years) increased 4.6% to 23.8%(State Health Access Data Assistance Center, 2009).

In January 2009 Governor Mike Beebe and the Arkansas Department of Health issued comprehensive healthcare initiatives for the 2009 legislative session that include $25 million in funding for the state's twelve Community Health Clinic Regions and their 59 Community Health Centers that serve low income residents (Arkansas Department of Health, 2009). One of the regional systems, White River Rural Health Center, has three locations in White County and could be an important partner with CHM (Community Health Centers of Arkansas, Inc., 2004).

Charitable clinics like CHM that seek to stay in touch with statewide data may also find the Kaiser Family Foundation (KFF) a useful source. Among the six primary websites of KFF is their StateHealthFacts.org that offers a state-by-state presentation of health data that is detailed and comprehensive (Kaiser Family Foundation, Inc., 2008).

Health Status and Access to Health Coverage in White County, Arkansas

In September 2007, Hometown Health Improvement, a division of the Arkansas Department of Health, published amended results of a County Adult Survey conducted in 2005 (Hometown Health Improvement , 2007). The telephone survey used questions

from the Behavioral Risk Factor Surveillance System survey (BRFSS), developed by the Centers for Disease Control (Centers for Disease Control and Prevention, 2009). This county survey provides a current snapshot of the health and wellness of citizens in White County, compared to state and national statistics. White County's rate of uninsured residents is higher than the state or national average, with 23% of adults reporting they did not have insurance – an increase of four percent from 2004 (Arkansas Center for Health Statistics, 2004). The prevalence of reported lack of health care coverage was higher among 18-39 years (31%), those with a high school education (26%) and those with less than a high school education (31%), and respondents with an annual household income of $20,000 or less (38%). Respondents consistently reported their health status as poorer, and consequently at a higher risk, than the state and national averages.

Examples of Faith-Based Healthcare Organizations Outside Arkansas

Since the Project focused on the work of CHM, attention was given to literature that explored or explained the role of faith, particularly Christian faith, to shape the values and guide the mission of similar church-affiliated clinics. Healthcare organizations like CHM require the expertise of many professionals – physicians, nurses, nutritionists, counselors, pastors, businesspeople, and attorneys; a common value-set, however, is Christian faith. Consequently, while supporting literature of faith-based clinics may derive from many disciplines, a body of material continues to grow and evolve from Christians (whose expertise may range from clinician to theologian) who report, reflect, and advocate for healthcare and wellness as a ministry of the Church amid a changing healthcare environment and shifting population demographics.

At least three national organizations are relevant to illustrate the influence of faith in the development of charitable clinics. Christian Community Health Fellowship (CCHF) is a nationwide network of health providers, administrators, teachers and students who are involved in providing health care to underserved communities, both rural and urban (Christian Community Health Fellowship, Inc., 2009). CCHF offers two publications relevant for the Project. First, CCHF produces a quarterly journal, *Health and Development*, and holds numerous annual events - including the CCHF Conference each May - designed to educate, assist and inspire our members to provide healthcare to the poor in a way that reflects the character and message of Christ (Christian Community

Health Fellowship, Inc., 2009). Also, in 2002-2003, CCHF produced a booklet, entitled "Best Practices: Faith Based Primary Health Care Models Manual – 2002-2003," which included an overview of seventeen medical ministries, including the business plan and by-laws of each organization. As the CHM board members reviews the structure of CHM, CCHF's booklet on best practices can provide meaningful perspectives from the experiences of other faith-based healthcare organizations (Christian Community Health Fellowship, Inc., 2002-2003).

Another organization that illustrates how people of faith pursue the development of healing ministry is the North American Mission Board (NAMB), which assists Southern Baptist churches in domestic outreach, including the service of medical and dental clinics. NAMB provides helpful tools for any Christian group that seeks to launch a clinic or to expand services (North American Mission Board, 2007).

The United Methodist Committee on Relief (UMCOR) offers a booklet entitled, "Introduction to Health Ministry for United Methodist Congregations." Available as a downloadable document at the UMCOR website, this short manual not only provides a valuable theological framework for health and healing ministry, but provides ideas on how a variety of Christian congregations (not just United Methodists) may engage one another and their community through health ministry (United Methodist Committee on Relief, 2009). Four basic models of congregation-based health ministry are offered to provide focus and basic structure to a congregation's health ministry. At CHM, this booklet might be useful for theological reflection on the value and purpose of healing as Christian ministry and to stimulate ideas on promoting health and healing within supporting congregations and the community.

Church Health Center, Inc. (CHC), located in Memphis, Tennessee, serves as a premier example of the possibilities for a faith-based clinic that seeks to expand its contributions in its community. Dr. Scott Morris, a family practice physician and ordained United Methodist minister, founded the CHC in 1987 to provide quality, affordable healthcare for working, uninsured people and their families. Thanks to a broad base of financial support from the faith community, and the volunteer help of doctors, nurses, dentists and others, the CHC Clinic has grown to become the largest faith-based clinic of its type in the country. Currently, CHC cares for 50,000 patients of

record without relying on government funding (Church Health Center, Inc., 2009).

In response to increased nationwide interest in their novel and effective models, CHC recently introduced a quarterly Replication Seminar to provide a thorough orientation to their history, philosophy and practice. Two Project participants attended a Replication Seminar in June 2009 and received a document that may hold great value for any future expansion of CHM. "Starting a Faith Based Health Center" is a booklet written in 1997 to introduce the CHC model and to serve as a road map for others seeking to establish a similar organization in their community (Church Health Center, Inc., 1997). For the purposes of the Project, the most useful section of the CHC booklet may be chapter one, "A People of Faith," which expresses the values, passion, and vision that continue to inspire the members of the CHC leadership and staff. As CHM considers the future shape of its organization, they might also find useful instruction in chapter three, "The Church Health Center Overview." Here is presented basic structure of a healthcare organization that has successfully managed significant growth in annual budget, staffing, and services while maintaining the valuable role of volunteers and staying close to its foundational Christian values.

Christ Community Health Services, Inc. (CCHS) is another successful approach to serving the uninsured and underserved. Located in Memphis, Tennessee, CCHS focuses on fulfilling the physical, spiritual, and emotional needs of the underserved through health centers and outreach programs (Christ Community Health Services, Inc., 2009).

Central Dallas Ministries, Inc. (CDM) is an exceptional faith-based model that has effectively built collaboration to expand its capacity in order to meet the healthcare and wellness needs of the medically uninsured. Working in partnership with groups such as the Health Texas Provider Network (HTPN), the Baylor Health Care System (BHCS) and the Dallas County Medical Society, CDM provides a network of health-related services with the aim that income is never a barrier to receiving high quality healthcare (Central Dallas Ministry, Inc., 2009). CDM is a key leader in a massive healthcare collaborative, Project Access, designed to increase access to quality healthcare for the working poor and improve functional health status among the working poor in Dallas-Ft. Worth area and reduce unnecessary hospital utilization (Project Access, 2008).

Dr. Mark J. DeHaven, a Professor of Clinic Sciences at the University of Texas

Southwestern Medical Center in Dallas, leads several significant academic research projects on the outcomes of community medicine. Three research assignments are relevant to the Project's objective of organizational capacity building; each research example valuse the documentation of outcomes and the essential role of collaborations with the local medical community (Southwestern Medical Center, 2008). First, DeHaven leads research of outcomes for Project Access, a collaborative to increase access to quality healthcare, improve functional health status among the working poor in Dallas-Ft. Worth area, and reduce unnecessary hospital utilization. Second, since the present health care delivery system devotes 95% of its resources to treating heart disease, hypertension, diabetes and obesity, and only 5% of its resources are devoted to prevention. DeHaven's initiative, called GoodNEWS (Genes, Nutrition, Exercise, Wellness and Spiritual Growth), provides education, motivation, and opportunity for adopting and practicing more healthful lifestyle practices and is based on a community medicine approach. A third research assignment is entitled, "Social Networks: Community Connections and the Flow of Health Information." Improvement of the effectiveness of health information outreach in a community requires a needs assessment that captures the multi-dimensional factors influencing the flow of health information. The purpose of "Social Network" is to identify and document how health information is disseminated within the larger social network of the community by using a scientific technique known as Social Network Analysis (SNA), which maps individual relationships and information flow. Adult participants receiving services from the CDM Food Pantry are interviewed to obtain both qualitative and quantitative data for analysis.

Charitable Clinics in Arkansas

Arkansas Department of Health published a report relevant to the Project. In November 2008, ADH issued the "Arkansas State Rural Health Plan" that describes critical health needs of rural Arkansas residents and identifies resources and programs available to address those needs (Arkansas Department of Health, 2008). Charitable clinics were described as a valuable resource in Arkansas' rural health infrastructure.

Arkansas Association of Charitable Clinics offers a list of many charitable clinics, a Fact Sheet with key statistics on the work of its members, and resources for members

(Arkansas Association of Charitable Clinics, 2009). AACC is a useful source of information on the progress and best practices of charitable clinics in Arkansas.

Project research suggests that several charitable clinics in Arkansas may provide relevant information on effective approaches to growing capacity without sacrificing the critical, relational character of a community, faith-based healthcare facility. Examples of such organizations include: Good Samaritan Clinic, Ft. Smith, AR (Good Samaritan Clinic, 2009); Mountain Home Christian Clinic, Mountain Home, AR (Mountain Home Christian Clinic, 2008); River City Ministry, North Little Rock, AR (River City Ministry, 2008); Charitable Christian Medical Clinic, Hot Springs, AR (Charitable Christian Medical Clinic, 2008); and, Shepherd's Hope Neighborhood Health Center, Little Rock, AR (Shepherd's Hope Neighborhood Health Center, 2009).

Since an important aspect of the Project was to assess the organizational capacity of CHM, the Arkansas Coalition for Excellence (ACE) is a helpful in-state association of nonprofit organizations and is Arkansas' representative in the National Council of Nonprofit Associations (NCNA). ACE provides resources to launch a nonprofit organization, build infrastructure, and create support mechanisms that can enhance accountability, sustainability, and effectiveness (Arkansas Coalition for Excellence, 2008). ACE works with nonprofits of every size and function with one goal: maximizing effectiveness so that every donated dollar results in greater impact. Members include nonprofits, foundations, businesses, and individuals committed to excellence in the state's nonprofit sector.

Resources for Charitable Clinics

The National Association of Free Clinics identifies itself as the only national non-profit whose mission is solely to address the needs of free clinics and the populations they serve. Job descriptions and manuals are available at their website, including: "Starting a Free Clinic: A Volunteers in Health Care Guide" and "Starting a Dental Project Using the Clinic Model" (National Association of Free Clinics, 2008). As CHM explores ways to expand capacity, NAFC may provide valuable resources for best practices of charitable clinics. Another helpful organization might be the Free Clinic Foundation of America (FCF). Founded in 1992, FCF published a "How-To" Manual on

starting a free clinic and a national directory of free clinics (Free Clinic Association of America).

Part 4: Project Design

The Project assessed CHM in order to explore opportunities to grow its capacity and to achieve a greater level of sustainability. When the problem of capacity is satisfactorily addressed, CHM may attend to the larger challenge of the increased number of uninsured in White County who lack sufficient access to quality and affordable healthcare.

A Logic Model illustrates (see Table 3) the Project's long-term outcome: CHM leadership inaugurates a strategic plan to grow organizational capacity in order to achieve operational and financial sustainability and to expand medical services and wellness education for uninsured residents of White County. The Project expected to achieve the short-term outcomes and assumed that intermediate and long-term outcomes extend beyond the timeframe of the Project. The purpose of the Project, however, is different than originally conceived.

Background

In the last months of 2008 the Project idea focused on workforce needs and intervention opportunities among the working poor and chronically under-employed in White County, Arkansas. Lowell Myers, a local minister and founding board member of CHM, agreed that CHM might be a constructive context for the Project, since guests/patients served by the nine-year old clinic include citizens who are often unemployed or underemployed. To explore workforce issues of guests/patients at CHM, a focus group with four board representatives occurred on January 7, 2009 and another focus group with guests/patients of CHM was held on February 22, 2009. Myers was interviewed several times during January through March, since he also serves as the administrator of CHM. On March 29, 2009, five board members conducted a SWOT analysis of the organization.

Although some board members of CHM desired to pursue new initiatives that serve CHM's target population, such as a workforce-related program, the facilitator discovered through the focus groups and interviews that CHM seemed to have reached

the limits of its service capacity. For example, when asked about problems or obstacles related to CHM that may prevent the delivery of desired healthcare services, guests/patients consistently referenced issues of capacity. "You have to call a week in advance for an appointment," one guest/patient noted. Another guest/patient observed, "CHM is only open on Sundays. [My husband] works nights and weekends and that makes it hard to get [to CHMvto see the doctor or receive medication refills]." A third guest/patient suggested that CHM "work with local hospitals to accept referrals and cut the cost of hospital bills…so patients won't be so scared to go to the hospital when they need to have surgery…and have thousands of dollars in debt that they can't ever pay" (Guests/Patients of Christian Health Ministry of White County, 2009).

Comments of board members voiced urgency about CHM's limitations and communicated uncertainty about the long-term sustainability of CHM. "Time [of our personnel] is a weakness," said one member. "Our coordinators are volunteers and lack time because they all have full-time jobs." Another board member offered a more

Long Term Outcome	Within eighteen months the board of directors of CHM inaugurates a strategic plan to grow organizational capacity that will achieve operational and financial sustainability and to expand medical services and wellness education for uninsured residents of White County.										
Intermediate Outcome	Within one year the board of directors of CHM pledges to grow the organization's capacity that will achieve operational and financial sustainability and to expand medical services and wellness education for uninsured residents of White County.										
Short Term Outcomes	#1 Board receives knowledge of CHM history		#2 Board receives knowledge of research on CHM present practices and effectiveness				#3 Board receives knowledge of best practices			#4 Board receives knowledge of members' opinions of research and analysis	
Outputs	A historical analysis is completed		Assessment of CHM practices is completed				A scan of best practices is completed			The board receives and responds to research and analysis	
Activities	Review patient database	Review budget history	Conduct Pre-Research Focus Groups	Visit clinic on Sundays	Conduct SWOT and Stakeholder Analyses	Survey patients, volunteers, partners and board members	Review literature	Board Members attend one of two conferences	Examine case studies	Present research findings and recommendations to board	Receive board response to research
Inputs	Patient database report	Budget history documentation	Sessions with board members and patients	Plan Sundays to visit clinic	Sessions with board members	Survey for each target group	Collection of relevant literature	Travel plans made	Identify comparable clinics in region	Plan session with board	Plan follow sessions with board

Table 3 Logic Model of Project

severe assessment: "We're floundering for a lack of resources." "Burnout is a weakness," a board member added. Two others quickly agreed: "Yes, burnout!" "Burnout." One board member added: "Some of us feel like we're not okay with the status quo [of CHM's organizational capacity], but by the way I'm burned out so see ya later! You can move this thing forward [but] I'm outta' here!" (Board of Christian Health Ministry, SWOT Analysis, 2009).

Project Proposal

With these perspectives in mind, the Project proposed to explore opportunities to build organizational capacity. As illustrated in Appendix A, the proposed logic model described an aggressive plan to conduct an organizational assessment *and* to pursue strategies that expand the capacity of CHM. The idea presupposed and depended upon active participation by all board members. The final design of the Project, however, focused exclusively on organizational assessment (see Table 3) since the necessary level of engagement with all board members was never realized.

Short-Term Outcomes

The final Project design included four short-term outcomes that provided additional information to the board of directors: analysis of CHM's historical records, assessment of CHM's practices, a scan of best practices, and an opportunity for board members to interact with and share opinions on the findings of the Project. For the first outcome, Linda Bearden, a 2009 summer intern with CHM, compiled a summary report of patient demographic information from the CHM database. Myers provided budget records and other important organizational documents.

For the second outcome, the Project facilitator visited CHM's Sunday clinic approximately fourteen times during the months of January through July, serving as a greeter in the waiting room. The facilitator conversed with guests/patients and family members, observed clinic operations, and visited with volunteer staff. Time in the clinic provided a general orientation to the work of CHM, its volunteers, and the people who receive CHM services. Visits to the clinic by the facilitator lasted one and a half to three hours.

Surveys were administered to gain opinions of four groups of stakeholders: guests/patients, board members, volunteers, and partners. The guest/patient survey was a

convenient sampling of 80 guests/patients who visited the clinic on six Sundays during the months of May, June, and July 2009. With informed consent, respondents completed a paper copy version of the confidential survey in the waiting room before seeing the doctor or picking up medication refills. A copy of the guest/patient survey is included in Appendix B.

The other three surveys were offered electronically through SurveyMonkey.com. Each potential participant received an email from CHM requesting his or her participation in a survey. Of the 14 board members solicited, eleven partially completed the survey and six fully completed the survey (see Appendix C). Among the 157 volunteers invited to participate, forty-nine completed a volunteer survey (see Appendix D). Nine partners received an email invitation to participate and four responded (see Appendix E). As a follow up activity, one-on-one interviews were conducted with two physicians who volunteer at CHM and are founding board members (Appendix F).

For the third outcome, the Project facilitator and Myers attended a replication seminar by a large faith-based clinic in Memphis, Tennessee. Later in the Project, and as additional relevant literature was studied, phone interviews were held with five comparable faith-based clinics in Arkansas and one large clinic/hospital partnership in Dallas, Texas (see Appendix G).

The fourth outcome is to be completed after the facilitator's presentation at Southern New Hampshire University. The facilitator intends to meet with the board of directors to present the Project's conclusions and recommendations.

Intermediate and Long-Term Outcomes

With the achievement of these short-term outcomes, the Project aimed to attain as an intermediate outcome a pledge by the board pledges to build capacity that will achieve operational and financial sustainability. The Project's long-term outcome is that within eighteen months the board of directors of CHM inaugurates a strategic plan to grow organizational capacity that will achieve sustainability and expand healthcare and wellness services.

Part 5: Methodology and Implementation Plan

Project Participants

Several persons or groups participated in the organizational assessment of CHM. Eleven board members participated in focus groups, interviews and/or a survey. Eighty guests/patients of CHM completed a survey and four attended a focus group. Eight representatives of faith-based clinics completed phone and/or email interviews. One intern of CHM gathered guest/patient data. Four representatives of partner organizations completed a partner survey. Two individuals served as third-party consultants in the creation and analysis of the surveys[2]. Two representatives of the local hospital participated in a community needs assessment interview. Myers approved the Project and served as the primary contact for CHM. Ron Cook served as the Project facilitator.

Community Role

Two representatives of WCMC, Phil Miller and Kevin Burton, were interviewed concerning their perspectives on community needs and the partnership between WCMC and CHM. Apart from this interview and the surveys of guests/patients, volunteers, and partners noted above, the Project included no other community participation.

Gantt Chart

The Gantt chart below (see Table 4) depicts the sequence of activities and outputs for the Logic Model.

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[2] The facilitator acknowledges Marty Spears who contributed advice on the design of the four surveys and Usenime Akpanudo who provided technical assistance on the analysis of the responses of the guest/patient survey.

Activities	01/ 09	02-03/09	04/ 09	05/09	06/09	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03-04/10	Outcomes
Conduct focus group of board															Assess status of CHM
Visit clinic on Sundays															Observe clinic, meet patients
Conduct focus group of patients															Learn patients' perspectives
Conduct SWOT and stakeholder analysis															Hear from key leaders
Interview with hospital reps															Economic impact data of uninsured
Draft Project Proposal															
Board members attend one of two conferences															Participants review best practices
Review patient data and budget history															Gain knowledge of clinic outputs
Research literature and case studies															Gain knowledge of best practices
Conduct/Evaluate Patient Survey															Gain knowledge of potential
Conduct/Evaluate Stakeholder Surveys															
Interview two volunteer physicians															Hear from key medical leaders
Write and Present Project Thesis															
Write report															Report complete
Present report to board															Board receives report

Table 4 Gantt Chart

<u>Color Code Logic Model:</u> Red: SNHU Deadlines; Blue: Short Term Outcome #1; Orange: Short Term Outcome #2; Yellow: Short Term Outcome #3; Green: Short Term Outcome #4.

Part 6: Monitoring

The Project facilitator collected monitoring data at each stage of the Project through meetings with Myers, focus groups, and observations made through volunteer hours in the clinic; monitoring data was also obtained through organization documents, surveys, interviews, and a literature review. Indicators of the Project's progress included:

- The facilitator conducted a community needs assessment and literature review.
- Five representatives of the board met for a focus group, a SWOT analysis, and a stakeholder analysis.
- Four guests/patients participated in a focus group.
- An interview regarding a community needs assessment was held with two representatives of White County Medical Center.
- The Project facilitator provided approximately twenty-one volunteer hours in the clinic waiting room to observe clinic operations and become acquainted with guests/patients.
- One board member and the Project facilitator attended a two-day replication seminar hosted by a large faith-based clinic in Memphis, Tennessee.
- Eighty guests/patients completed a survey.
- Eleven of fourteen board members responded to a survey.
- Forty-nine of 157 volunteers participated in a survey.
- Four of nine partner representatives completed a survey.
- Eight representatives from seven faith-based clinics and one hospital participated in phone and email interviews regarding key values and best practices.
- Four literature sources were reviewed on the formation, assessment and capacity building of non-profit organizations.
- Two physicians, who are founding board members of CHM, participated in one-on-one interviews.

Part 7: Evaluation

Evaluation of the Project was planned on two levels. First, the Project was evaluated as CHM data was compared with key values and best practices of some faith-

based organizations and with relevant discoveries from literature. This level of evaluation identified some potential limitations of the Project or potential areas for additional investigation. This first level of evaluation was the focus of the Project and the primary concern of this report.

The board of directors may conduct a second level of evaluation. The Project facilitator will provide a presentation and discussion of the Project's findings in June 2010, after the report is submitted to the faculty of Southern New Hampshire University. Board members will be asked to use the evaluative framework below as a starting point for their analysis. The desired outcome of the Project is that during the next eighteen months the board will pledge to build capacity of the organization to achieve operational and financial sustainability and to expand healthcare and wellness service.

Data was analyzed using a framework presented in *Building Capacity in Nonprofit Organizations*, edited by Carol J. De Vita and Cory Fleming (Urban Institute, 2001). As illustrated in Figure 5, a healthy mix of five basic components of a nonprofit organization is needed for organizations to survive and thrive, according to the report by Urban Institute. Each factor may be viewed as a possible intervention point to build organizational capacity. Using the De Vita/Fleming framework, the Project raised five questions regarding CHM as a means to assess the data collected:

- How well has CHM pursued its vision and mission?
- Has leadership governed effectively?
- Does CHM have adequate resources?
- Has CHM adequately engaged in outreach?
- How well has CHM delivered its "products and services?"

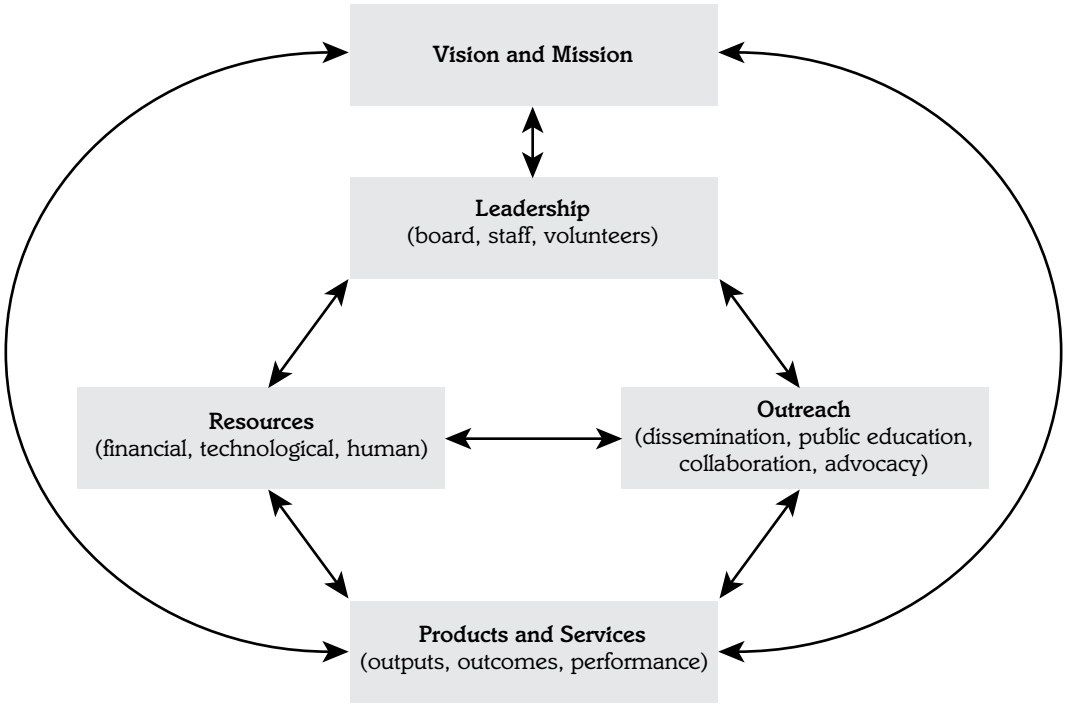


Figure 5 A Framework for Addressing Nonprofit Capacity
(Urban Institute, 2001, p. 17)

Vision and Mission: How well has CHM pursued its vision and mission?

Vision and mission answer the question of why CHM exists and provide a good starting point for assessing the organization. Also described as "aspirations" in some literature (McKinsey & Company, 2001), vision and mission define the products and services offered, determine the resources needed, and shape the forms of outreach. As with most organizations, the leadership of CHM holds the responsibility to articulate the vision and mission, determine the implications of the vision and mission in their time and place, and are the key protectors of the vision and mission (Urban Institute, 2001). The vision and mission of CHM is as follows (Christian Health Ministry of White County, Arkansas, Inc., 2010, p. 1):

> To be a faith-based, holistic outreach healthcare ministry with a mission of promoting the physical, emotional, and spiritual wellness of those who find themselves unable to pay for medical treatment, have no private medical insurance, are not receiving Medicare or Medicaid, and whose family income does not exceed clinic standards. Our hope is that the "medically disadvantaged" citizens of White County will have an opportunity to attain wellness…In turn we

> will be able to improve the overall quality of lives and assist in the overall development of better families, employees, and citizen of our county. Our desire is to walk with each of our guests on their spiritual journey and to share with them the blessings the Great Physician can bring to their lives.

Data gathered in the Project suggests that CHM maintains a clear sense of purpose. Respondents to the Guest/Patient Survey indicate a high level of satisfaction, with 73% reporting that their perception of the overall quality of medical care at CHM is "excellent" (see Figure 6).

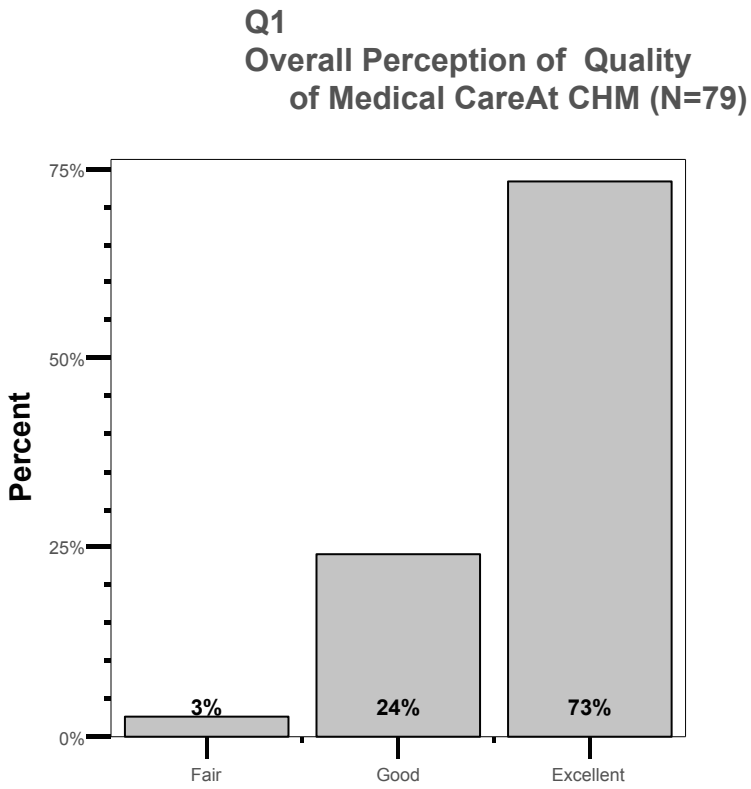


Figure 6 Guest/Patient Reported Perception of Quality of Care

In response to the survey, one respondent wrote the following:

> I really don't know what I would do if CHM wasn't here. I believe that I would not receive any medical care due to money issues. At one point I needed some mental health services and CHM put me in touch with someone who helped me a lot. I am very beholding to CHM.

A survey of volunteers indicated an overall high level of satisfaction with CHM's pursuit of its vision and mission. Of those volunteers responding 74.4% affirm that the "church's mission includes a ministry to both spirit and body" or "the church is called to

bring good news to the poor and hurting" (see Figure 7) In the survey of partners all respondents. In the survey of partners all respondents either agreed or strongly agreed their overall experience with CHM is positive. In response to the question of what is liked best about their partnership with CHM, one respondent commented, "Knowing that many are helped who may not have been able to afford medical care."

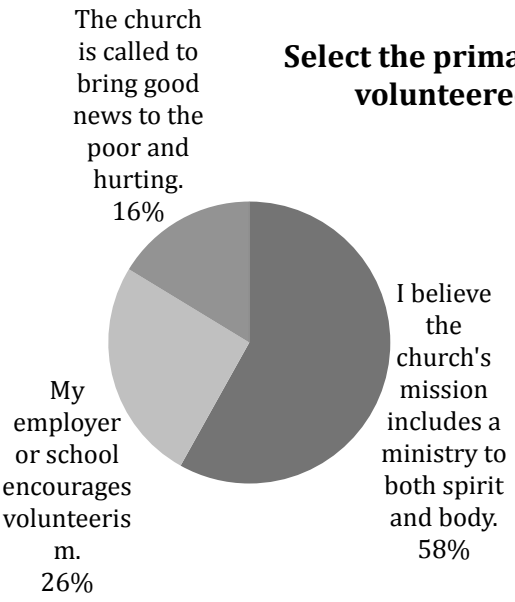


Figure 7 Volunteer Satisfaction in Vision/Mission of CHM

In a survey of board members 85.7% of respondents affirmed that they are confident or very confident that most or all board members understand the mission and vision of CHM. Board members report general agreement that the core work of CHM is providing basic quality healthcare and wellness services in the Spirit of Christ to the working poor.

Concerning the vision and mission component of CHM, data collections suggest that leaders should give attention to two areas for capacity building: review the definition of the target group and clarify how CHM is distinctively Christian in identity.

Review the Target Group

According to the data, CHM may need to clarify its target population. The mission statement reads that CHM seeks to promote the overall health and wellness of those "unable to pay for medical treatment, have no private medical insurance, are not receiving Medicare or Medicaid, and whose family income does not exceed clinic standards." The Project facilitator routinely heard a more specific description as focused on the "working poor." A survey of guests/patients, however, suggests that CHM is receiving a different population group: 71% claimed to be unemployed and about 82% claimed a gross annual income of less than $15,000(see Figure 8 and Figure 9).

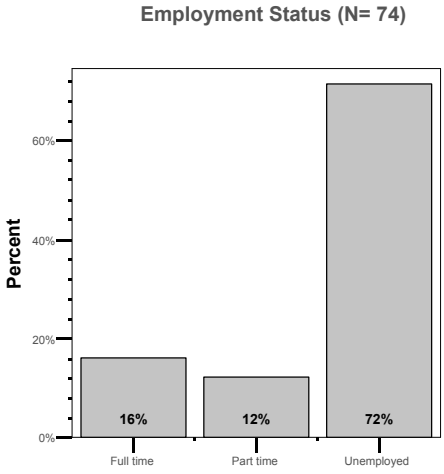


Figure 8 Reported Employment Status of Guests/Patients by Survey

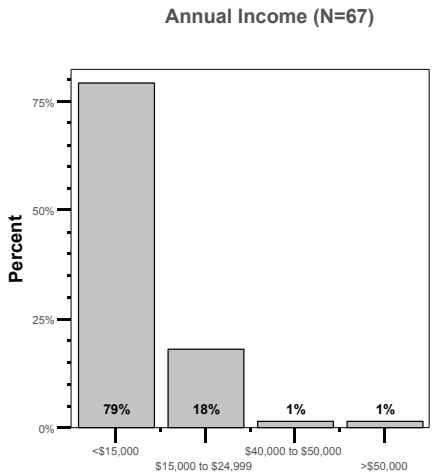


Figure 9 Reported Annual Income of Guests/Patients by Survey

Clarification of CHM's target population might aid CHM's plans for future services to guests/patients and how CHM defines itself to the community. The issue of target audience may the organization's policies and procedures, including future fee structures. Among the clinics interviewed in the Project, two charge a fee for service based on the patient's reported household size and income (Church Health Center, Inc., 2009) and (Good Samaritan Clinic, 2009). Dr. Scott Morris, founder and chief executive officer of CHC, explains the implications of their mission: "We charge a fee. We always have. We're here to serve the *working* uninsured, low-wage citizen. We believe our patients are not looking for free services but quality, reliable, and *affordable* healthcare. So we charge a fee based on family size and income. Patients experience the dignity of

paying something for their healthcare, but at a rate they can afford"(Morris, 2009). CHM may benefit by a reexamination of their philosophy and target audience and to identify implications of the vision and mission for policies and procedures.

Clarify CHM's Identity as "Christian"

Another area of concern regarding the vision and mission is the manner by which CHM is a distinctively Christian organization. This question might explore three matters.

Reexamine Theology. CHM may wish to reexamine the theology that shapes its vision and mission. What makes CHM unique from community-based organizations that are not faith-based? Does a Christian-guided vision and mission lead CHM to place Bibles in the waiting room or offer prayer? Does "Christian" imply that the volunteers agree to a statement of Christian faith, that most revenue comes from congregations and Christians, or that the board of directors claim membership of a congregation? Does "Christian" lead to a strategy for personnel to overtly share their faith testimony or doctrinal beliefs with guests/patients? While these qualities may serve as meaningful expressions of value or important Christian identifiers, the board may do well to explore more deeply how Christian theology shapes is vision and mission and imagine the implications of that theology for all components of the organization – leadership, resources, outreach, and products and services – and do so in light of CHM's particular context.

Project research found that of the clinics interviewed, only one communicated an explicit theological framework that defines its vision and mission and shapes all aspects of the organization. The CHC in Memphis, Tennessee, is a premier example of how reflective theology inspires and defines vision and mission. CHC seems to understand its vision and mission in broader, more explicitly theological terms than the other clinics surveyed, as it not only intends to provide healthcare but also "seeks to reclaim the Church's biblical commitment to care for our bodies and spirits. Our ministries provide healthcare for the poor and promote healthy bodies and spirits for all" (Church Health Center, Inc., 2009). "Jesus came to preach, teach, and heal," says Dr. Scott Morris, founder and president of CHC. "And that's the mission of the church" (Morris, 2009). Dr. Morris, who is a physician and an ordained minister with St. John's United Methodist Church, passionately describes the work of CHC: "We're not here primarily to deliver

healthcare. Our mission is to reclaim the Church's biblical commitment – a commitment to care for our bodies and spirits, and a commitment to befriend the poor among us as Jesus did" (Morris, 2009).

Since CHC's vision and mission is closely tied to the call of the church, CHC does not receive government funding, but depends upon people of faith who support CHC individually or through their organization. From the inception of CHC, Dr. Morris and his co-workers aggressively pursued adequate funding to provide quality and affordable healthcare for the working poor of Memphis. Morris received CHC's first major funding from St. John's United Methodist Church, along with grants from the local Methodist Hospital System and the Memphis-based Plough Foundation, a philanthropic entity formed by a prominent Jewish family.

Believing that healthcare is more than just prescribing pills, CHC fulfills their theological mandate through a commitment to wellness: We believe we have "a responsibility to take care of the bodies God gave us, so have been committed from our beginning to health education and prevention." (Church Health Center, Inc., 2009). CHC created its Church Health Center Wellness initiative, an 80,000-square-foot, comprehensive wellness center that offers everything from personalized exercise plans and cooking classes to group exercise classes and activities for children and teens. But its not the size of the operation that gives value to CHC's wellness center; the value lies in a theological understanding of vision and mission. CHC believes "that the body and spirit are one, and our staff recognizes the role a strong faith can play in a person's success. For many of our members, their faith – and the faith of those around them – encourages them on the journey toward a healthier life" (Church Health Center, Inc., 2009). And others have taken note of the meaningful results of their vision and mission: in 2003 the U.S. Department of Health and Human Services awarded CHC the 2003 Innovations in Prevention Award (Church Health Center, Inc., 2009).

Christian Witness. A second matter concerning CHM's Christian identity and its vision and mission relates to the clarity, intentionality, and/or effectiveness of CHM's Christian witness. This topic emerged from one-on-one interviews with physicians who serve as founding board members. Although respondents of all four surveys indicated relatively high satisfaction with CHM as a Christian medical clinic, in separate interviews

two leaders voice some uncertainty about CHM's Christian witness:

> What bothers me (is this): Am I showing them Jesus? Do they understand that what I'm doing for them I'm doing so they will see Jesus? I'm not sure I'm communicating that. Jesus helped people…but he didn't asked anything from them…yet he communicated to them. I want my patient to know about Jesus."
>
> (We can) probably could do a little bit better…(addressing the spiritual needs of patients). Certainly that's an area we can improve on. We don't have the manpower to follow up and develop relationships.

Leaders of CHM may do well to explore how their theology defines Christian witness. How might CHM communicate its faith in Christ to guests/patients? What are desirable ways CHM personnel may tell guests/patients about the transforming experiences of trust in Christ and extend Christ's invitation to entrust themselves to him?

Christian Leadership of CHM. A third matter surfaced from focus groups, interviews, and surveys as is summarized in the follow questions: which Christian congregations may participate as volunteers, work in roles of leadership of CHM, and serve on the board? Arising from the particular ecclesiastical context of CHM's founders and key supporters, the matter surfaces more foundational questions that have not been satisfactorily answered by some board members: "Is CHM "Christian" in the broad sense that includes all Christ-believing congregations; is "Christian" a reference only to those members of Church of Christ congregations; or, is "Christian" a reference only to members of the Downtown Church of Christ? Interviews reveal that some congregations have discontinued participation, apparently to protest the involvement of volunteers who hold memberships at certain congregations. Apparently, other congregations are open to supporting CHM but have never been invited to participate.

Board members consistently described this issue as troublesome, limiting, or unresolved. "There's confusion about who sponsors CHM," observed one board member. "[People wonder if] this is only a (Downtown Church of Christ) thing?" Two other board members comment: "CHM is too tied to the Downtown Church of Christ." "Probably so," another responds. One board member speaks directly to the question of vision and mission: "If we want it to be truly a community ministry, then we need to connect to the broader Christian community." Failure to address this fundamental

question not only risks further alienation of local congregations but also may undermine CHM's pursuit of its noble, explicitly Christian, vision and mission.

Leadership: Has Leadership Governed Effectively?

"Strong and effective leadership is the lynchpin of the system," write De Vita and Fleming (Urban Institute, 2001). Leaders articulate, advocate for, and protect the vision and mission. Leaders equip, empower, motivate and embolden participants to action in every level of the organization. Leaders attract other leaders. Effective leadership facilitates the acquisition and development of resources – financial, material, and human resources. Leaders shape the reputation of the organization in the community and serve a vital role in partnerships and collaborations to advance the objectives of the organization.

To build capacity in the leadership component, observe De Vita and Fleming, two factors should be considered: enhance existing leadership and develop new leadership. Cultivation of current leadership may include: the training of staff, volunteers, and board members; a review of administrative and procedural policies; board development strategies; and relationship building exercises within the leadership (p. 18). And without the development of new leadership, an organization runs the risk of becoming outdated, obsolete, or depleted. Current leadership – board members, staff, and volunteers alike – do well to intentionally mentor emerging leaders. New leaders bring fresh energy and new ideas. New leaders may bring greater diversity of talents and enrich the ethnic and cultural capacity of the organization. De Vita and Fleming observe that the ability of an organization to renew and sustain its work can only be met through the recruitment and training of new leaders (p. 19).

In what ways have the leaders of CHM embodied this form of leadership and how might they build capacity in the leadership component? The leadership of CHM recently received acclaim for its effective work in the community. In the fall of 2009 the Searcy Regional Chamber of Commerce honored Dr. John Henderson, cardiologist and founding board member of CHM, as the Medical Professional of the year (see Appendix H). CHM received the Humanitarian of the Year award (Warren, 2009). In 2005 Dr. Ron Baker, also a founding board member of CHM, was honored by the chamber for his leadership with CHM and as a family physician.

In the Project survey, guests/patients express strong satisfaction with the leadership, as exemplified by one testimony: "I started coming in 2002. My daughter saw the sign in yard and said I should come here b/c I don't have any insurance. I said, 'No baby, I'm too embarrassed.' She said, 'You're going.' So I came. This clinic has found some medical problems I never knew that I had…and [nurse practitioner/board member] Bonnie [Dillard] is my family…you know how I feel about you, Bonnie…she's talked to me and helped me out with a lot of things" (Guests/Patients of Christian Health Ministry of White County, 2009).

Board members participating in a Project survey demonstrated unanimous commitment to the vision and mission of CHM. All survey respondents reported having made financial gifts to CHM and plan to do so again. Board members consistently described relationships with guests/patients as one of CHM's greatest strengths.

In spite of its successes, the board of directors consistently expressed concern about leadership. Over half respondents to a Project survey indicated they were unsatisfied, very unsatisfied, or unsure about the board's present activities and practices (see Figure 10). Nearly three quarters of board members named the leadership of the board of directors as one of three greatest weakness of CHM (see Figure 11). Asked about the board's efforts to complete its job responsibilities, respondents to the Project survey

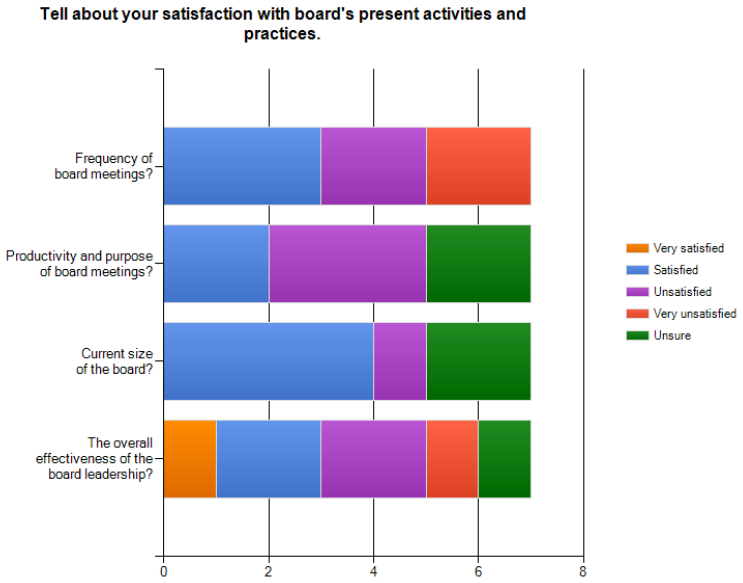


Figure 10 Reported Board Satisfaction with Its Present Activities and Practices

expressed only a moderate level of satisfaction. Of the respondents, 75% said they were unsatisfied, very unsatisfied, or unsure that the work of the board is being done well (see Figure 12). Board members expressed greater concerns about its effectiveness as a governing body (see Figure 13).

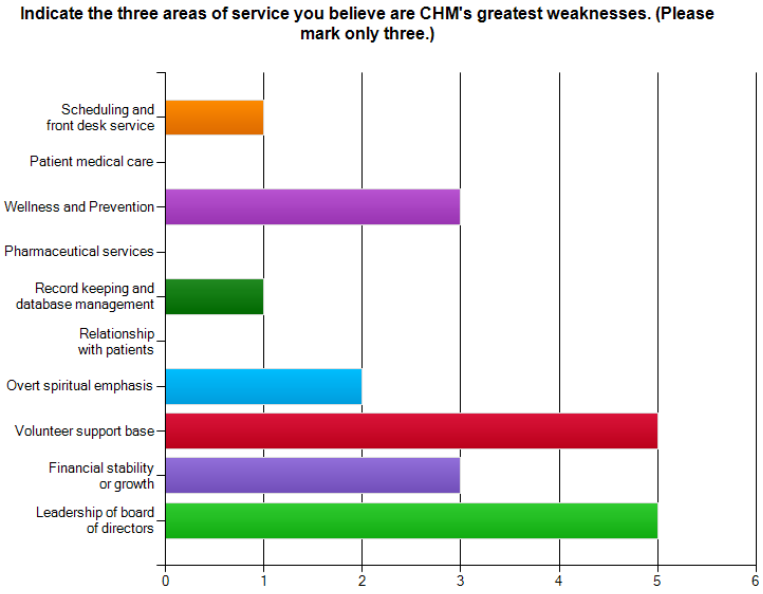


Figure 11 Board Member Responses Regarding Perceived Weaknesses of CHM

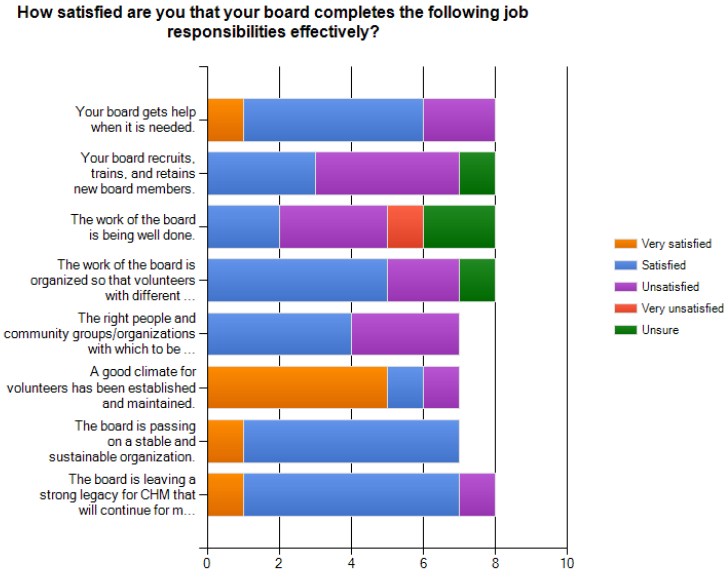


Figure 12 Board Member Responses Concerning Perceived Job Effectiveness

Data collections suggest that leaders should give attention to two areas for capacity building in the leadership component of CHM: renewed focus on strategic concerns and leadership development.

Strategic Concerns

CHM may explore strategic concerns by asking questions like "Where are we going?" and "How will we get there?" In a survey of board members, over 75% of respondents said they were not confident, not confident at all, or unsure that the board has a strategic vision for the organization or has adopted an revenue strategy to ensure adequate resources (see Figure 13).

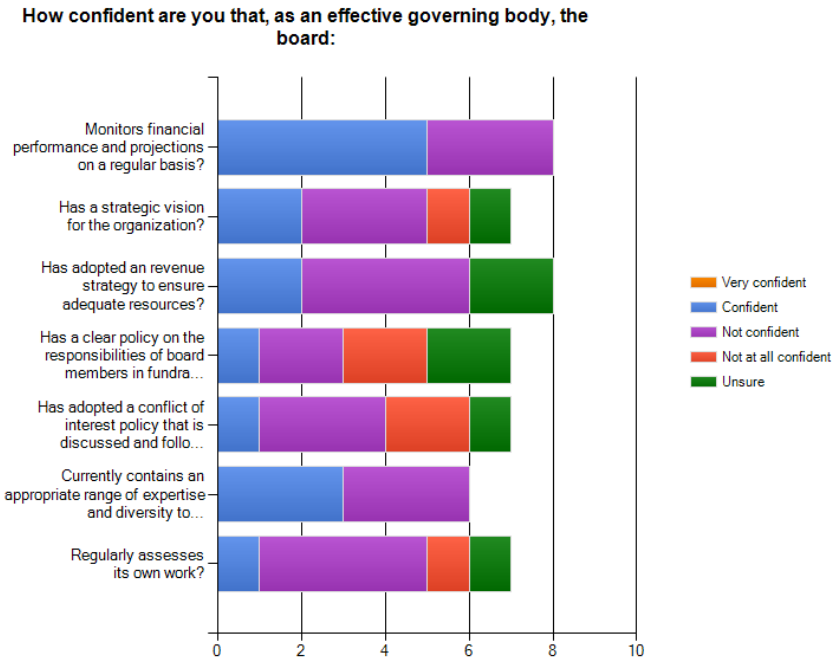


Figure 13 Reported Board Confidence as a Governing Body

In an interview, one board member pointed to the lack of attention to strategic issues: "We need people on the board who can provide [strategic] direction, insight, do fundraising and other things that can help these other [board members]…[who] are so busy on the operational side…That's where fatigue comes in." In surveys of volunteers and partners, respondents who expressed strong overall satisfaction in CHM reported lower satisfaction with the organization's communication of plans and needs.

Leadership Development

One of the most significant findings of the Project is the apparent neglect of both leadership enhancement and the development of new leadership. During the Project two board members resigned as volunteer coordinators because of time constraints and weariness from their work with CHM. In focus groups and interviews, board members consistently described fatigue, "burn out," or a lack of leadership participation (Board of Christian Health Ministry, SWOT Analysis, 2009). The following is an excerpt from a discussion during a focus group of board representatives:

> Burnout is a weakness. Yes, burnout!
>
> One of weaknesses is that we don't have [regular] meetings – I would say monthly board meetings. We haven't had a board meeting to look at the vision, direction – where do we want to go. Are we following the status quo or are we not following the status quo. If we are following the status quo then fine – let's just stay and move in that direction; if not, then fine. Some of us are okay with the status quo and some of us are not.
>
> Some of us feel like we're not okay with the status quo but by the way [I'm] burned out so see ya later! You can move this thing forward but I'm outta here!
>
> As an organization we're in a holding pattern and we're about to run out of gas.
>
> All of us (the board) went to a conference [on nonprofit organizations] one summer in Hot Springs. We attended a session on effective boards. Out of 20 criteria our board may meet two of them. We don't even meet regularly.
>
> Vision: that is a problem.
>
> How many of our board members are active – very few? Of course, if it's supposed to be an advisory board, I guess they are not supposed to be [very active].
>
> What we have now – [we] are suppose to be the board of directors? We don't have an advisory board, do we?
>
> No, we were talking about doing that the other day.

This exchange among CHM's most involved board members suggests that some members are tired, some are frustrated with the work of the board, and there are notable differences of understanding regarding the roles and functions of the board. Building the

capacity of leadership, through board member enhancement and the cultivation of new board members, may be a helpful solution to these expressed challenges.

Resources: Does CHM Have Adequate Resources?

Resources include human, physical, and financial, and are essential to an organization. They affect the organization's ability to pursue its mission and vision, attract capable leadership, and influence the organization's message to the community. De Vita and Fleming observed that capacity building often focuses on the expansion of resources (Urban Institute, 2001). While extensive resources are not always required, efficient management of resources is essential. Improved use of resources may result from training personnel, improving procedures, and upgrading technology. Effective allocation and efficient use of those resources, argue De Vita and Fleming, "are keys to the long term success of a nonprofit organization" (p. 20). Capacity building in the area of resources often involves fundraising and financial management. When funding streams are influx organizations find it difficult to maintain sustainability or stay true to the vision and mission. The unique and sometimes complex ways nonprofits generate income should require greater transparency and accountability in their financial operations, which can increase demand for efficient and accurate accounting and reporting systems.

Project data suggests that CHM enjoys several strengths in the resource component (Board of Christian Health Ministry, SWOT Analysis, 2009). First, through the gift of a supporter, the clinic's downtown facility is owned by CHM and free of debt. CHM has twice expanded its facilities to improve services and comfort to guests/patients. Second, participating board members are highly skilled professionals, particularly in the healthcare field, including two physicians, a nurse practitioner, a registered nurse, a pharmacist, and a healthcare management consultant. Also active on the board is a minister who serves as a liaison to the faith community. Third, board members observe that CHM is licensed as a charitable clinic and pharmacy, follows HIPPA, and seeks to maintain clinic professionalism. Fourth, a recent investment in database software, with electronic medical records capability and technical support, improves medical record-keeping capacity. Fifth, some board members express satisfaction that CHM is a volunteer-only organization that results in low overhead costs and may demonstrate to

guests/patients a special commitment by CHM healthcare providers. Related is the satisfaction of some board members that CHM has "never had to ask for money"(Board of Christian Health Ministry, SWOT Analysis, 2009). Sixth, the spring 2010 newsletter of CHM announced that CHM was recently awarded its first grant. The dollar-to-dollar matching grant from the Arkansas Department of Health/Office of Rural Health and Primary Care is designed to add capacity for the purchase of medications, lab services, and technology improvements (Christian Health Ministry of White County, Arkansas, Inc., 2010).

Building on such strengths, Project data collections suggest that leaders should give attention to two concerns for capacity building in the resource component of CHM: financial resources and human resources. Both concerns flow from the leadership's understanding of vision and mission.

Financial Resources

CHM leadership might do well to expand its revenue base to more fully achieve the organization's vision and mission. When asked how CHM and its board need to adjust or change to move successfully into the future, one board member observed: "We've basically kind of been treading water, because we don't get enough money. We're spending 90% of our $30,000 budget on medications. We've got to raise money to do more, but we haven't done that" (Board of Christian Health Ministry, Follow up one-on-one interviews with selected board members, 2010). The question that follows is what more is to be done by CHM? De Vita and Fleming observe that capacity building often focuses on the expansion of resources, and that effective fundraising presupposes a clear vision and mission that define the level and kind of financial resources required to achieve success (Urban Institute, 2001). .

Human Resources

Project data suggests that the leadership should explore three related questions concerning human resources:

- Should CHM add paid staff?
- How will CHM cultivate new volunteers?
- What consequences may result from increased participation of health services students from local universities?

All three questions converged in a focus group of a few board members; the following comments are an excerpt of that discussion (Board of Christian Health Ministry, SWOT Analysis, 2009):

> Human resources are a weakness. I really struggle from an office standpoint. As an office coordinator I don't have time to recruit and train. I have 4-5 volunteers; we need more. In that position it's hard to find people [since] you have to know the software. It's technical [and] it's a hectic place – answer the phone, people are in your face, and you have to make an executive decision and be firm in it.
>
> Time [of our personnel] is a weakness. [CHM] coordinators are volunteers and lack time because they work full time.
>
> That's my challenge. I don't hear from nurses [who are invited to serve] or they don't won't help because [CHM] is a Downtown Church ministry. I just don't have time to call [new volunteers]. It's easier to just get my nursing students [at Harding University] to help.
>
> The biggest weakness I see is that we don't have somebody there all the time. We need a full time person. All these volunteers [this table] have all these great ideas but [the ideas] have no legs. I think we need somebody full time [to do the leg work].
>
> I know that after every Sunday [clinic] Lowell is bombarded with referrals. At least four people need a referral each Sunday. He could be on the phone all day Monday doing that. That's a full time job.

The Question of Paid Staff and the Need for New Volunteers. In another setting, board members expressed similar concerns. In response to the question if CHM's mission can be achieved in a volunteer-only organization, one board member responded: "I don't know. We're evolving…[Historically we've been volunteer only – nothing in it for ourselves – and that means a lot to patients. [Now we] might take relationships to next level. We might need to pursue a staff position devoted to follow up. That should be one of our goals…I think we might need to raise money for staff people…if you want to grow and do some things you set out to do" (Board of Christian Health Ministry, 2010). When asked to evaluate CHM's strategy as an all-volunteer healthcare organization, another board member observed: "I think the strategy has limited us. Some paid staff would have made it easier to increase hours. Our work on Sunday flows over into week and we don't have any one to do that…or we have to remember to do it ourselves. I think it [paid staff] would have increased the effectiveness of the work. If

we had support staff (for example) it would be easier to do our work and it would improve the efficiency of the operation a lot" (Board of Christian Health Ministry, 2010).

Interviews with five faith-based clinics underscored the challenges of a volunteer-only healthcare organization. And experiences of interviewees suggest that the question of paid staff will inevitably emerge. Four volunteer-only organizations all report having one person who contributes an extraordinary number of volunteer hours, including a retired physician at one clinic. At another clinic a stay-at-home wife/mother gives an average of 60 hours per week. The question of long-term sustainability arises where a complex organization depends greatly on the volunteer service of one individual. Two clinics receive support from the staff of a partner organization. Additional reports from the clinic representatives are instructive on the strategic significance of human resource capacity and the roles of paid staff and volunteers:

- Clinics report a high investment in volunteers is required to operate a clinic, involving from 15 to 75 volunteers each time the clinic is open.
- Two "all-volunteer" organizations receive the benefit of one staff person loaned by a partner organization.
- One clinic reported the intent to hire a full-time clinic administrator sometime in the future.
- Another clinic representative stated that as an all-volunteer clinic they have "low organizational overhead and don't need [paid staff]." Later the interviewee stated that the organization had "a large but volatile pool of volunteers" and pointed to some disadvantages of an all-volunteer healthcare organization such as difficulty to train volunteers on technical aspects of clinic (including database entry) and the recruitment and coordination of volunteers. Another disadvantage of an all-volunteer organization is the potential loss of potential funds. The interviewee reported that a foundation denied the clinic's request for funding because it has no full-time paid staff. "They believe a clinic like ours should have dedicated staff. And I suppose they are right."
- All clinics interviewed in the Project that use paid staff report valuable and necessary roles for volunteers. Apparently paid staff does not diminish the value of volunteers in faith-based healthcare organizations.

Regardless of CHM's choice regarding paid staff, the Project findings suggest that CHM will do well to consider how to cultivate new volunteers.

Consequences of the Use of University Students. Regarding the role of health science students from local universities, board members report conflicting opinions. One board member supports a shift in CHM's mission in order to become a teaching facility for healthcare students (Board of Christian Health Ministry, 2010). Yet another board member expressed concern about the implications of a partnership that creates exceptional dependence upon a local university (Board of Christian Health Ministry, 2009).

An important finding of the Project relative to resources is that the leadership of CHM needs to exercise intentional capacity building in human resources, and subsequently in financial resources, if the organization is achieve sustainability and effectively pursue its vision and mission.

Outreach: Has CHM Adequately Engaged in Outreach?

Research indicates that "isolated organizations are the ones most likely to struggle and fail," according to De Vita and Fleming (Urban Institute, 2001, p. 22). An organization can have a meaningful mission, strong leadership, and sufficient resources, but unless it is known in the community, its influence may be limited. De Vita and Fleming also note that outreach is essential to strengthen and extend the work of community-based organizations. Outreach may include collaborations, alliances, partnerships, and networking, as well as community education and advocacy, marketing and public relations. The authors argue that "for capacity approaches to truly achieve their potential, attention must be given to the web of connections affecting all the persons, organizations, groups, and communities involved" (p. 21). Outreach is a part of building social capital and an important management strategy. Organizations engaged in outreach understand that to achieve their vision and mission they must share, learn, and unite on matters of mutual concern.

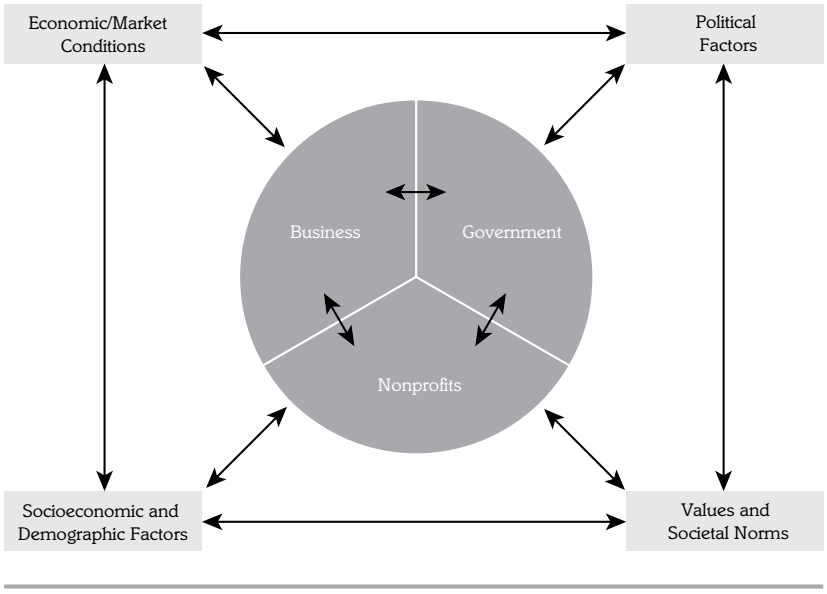


Figure 14 Environmental Systems Influencing Nonprofit Capacity Building

(Urban Institute, 2001, p. 14)

While organizations may choose how and if they engage in outreach, none can escape the influence and affects of institutions, market forces, political factors and social norms. De Vita and Fleming offer a helpful illustration of the environmental system that influences nonprofit capacity building (see Figure 14) (Urban Institute, 2001). Three key

institutions participate in the dynamic and changing environment: business, government, and nonprofit. The illustration suggests that nonprofits like CHM are always affected by the environment that is a complex association of elements including economic and market conditions, political factors, and demographic factors, values, and social norms. These environmental factors constantly push and pull institutional relationships. Nonprofit organizations also have the opportunity to influence other institutions and affect environmental factors (p. 14).

Project data indicates that CHM has many positive points of contact in the community, including the following list of complementary findings:

- CHM reportedly enjoys a positive relationship with the leadership and membership of the Downtown Church of Christ.
- In the fall 2009 Searcy Regional Chamber of Commerce awarded CHM the Humanitarian Award, an indication that many in the business community value the vision and mission of CHM and acknowledge the decade of service to White County (Warren, 2009).
- In recent surveys and focus groups, both board members and guests/patients report high levels of satisfaction in their relationships with each other. In a few cases meaningful, authentic relationships are enjoyed between CHM volunteers and guests/patients.
- In a Project survey, partners report a high satisfaction with their association with CHM. Describing what they like best in a partnership with CHM, respondents made the following statements: "I feel like I am making a difference in White County;" "[I feel that CHM is] changing the community one life at a time;" and, "I have heard positive comments from those who have visited the [CHM]."
- Of 49 volunteers who responded to a recent survey, 73.9% reported that they intend to volunteer again at CHM, and 95% stated that they would recommend to others that they volunteer at CHM.
- Although representatives of WCMC did not respond to the partner survey, CHM continues to receive free of charge from WCMC routine laboratory services. WCMC maintains their support of CHM, though CHM apparently does little to cultivate the partnership.

- An emerging partnership with health sciences departments of a local university may hold great promise for both CHM and students of the university.

Data collections suggest that leaders should give attention to three concerns for capacity building in the outreach component: the church community, the healthcare and business community, and guests/patients of CHM.

The Church Community

Project research suggests that leaders should give attention to outreach to the local church community. Although CHM is a distinctively Christian organization, it maintains surprisingly limited formal associations with local congregations. In a stakeholder analysis session board representatives identified only two congregations as stakeholders – one congregation is a supportive partner and the other is a detractor(Board of Christian Health Ministry, Stakeholder Analysis of Christian Health Ministry, Inc., 2009). A representative from only two other congregations participated in the partner survey. Data suggests that CHM may have several opportunities to build relationships with congregations in the county. In a volunteer survey, respondents claimed association with eight local Church of Christ congregations and seven congregations representing other denominations or fellowships. Of the twelve respondents in the volunteer survey who noted their employment status as students, five listed their congregation as a Church of Christ and seven from other congregations. Of the twenty-seven respondents who claimed full-time employment, six claimed a congregation other than a Church of Christ. The data does not sufficiently explain how volunteers claiming congregational membership receive invitations to serve at CHM.

CHC in Memphis, Tennessee, one of seven clinics interviewed for the Project, maintains a vibrant congregation outreach initiative called Faith Community Outreach. With a staff of volunteer "Congregational Health Promoters," CHC seeks to inspire congregations to embrace Jesus' ministry of healing body and spirit – a ministry for those in the community and for members of the congregation – through consultation and curriculum to congregations that seek an active health and healing ministry (Church Health Center, Inc., 2009).

All clinics interviewed in the Project claimed a Christian identity and report significant outreach to area congregations. Members from a diverse group of local

congregations serve on the boards, function as healthcare providers, volunteer in the clinic, and make financial gifts to the organizations. The clinic interviews suggest that the efficiency and effectiveness of faith-based healthcare organizations are enhanced through outreach to a broad collection of congregations.

Healthcare and Business Community

Data collections suggest that leaders should give attention to outreach to the healthcare and business community. A stakeholder analysis conducted by representatives of the board revealed that key leaders in the local healthcare and business communities are largely uninformed and/or uninvolved in CHM (Board of Christian Health Ministry, Stakeholder Analysis of Christian Health Ministry, Inc., 2009). A board member suggested only a need to "keep [WCMC] in the loop" if changes were made at CHM; another board member speculated that the director of a large medical clinic "probably has never heard of Christian Health Ministry." Board members reported no notable association with the local White River Rural Health Center (WRRHC), an organization that offers medical and dental care for the whole family, regardless of ability to pay (White River Rural Health Center, Inc., 2010). Its patients include those with insurance, those without insurance, and those with not enough insurance. Although WRRHC is not a free clinic, it offers discounted rates so that more residents can receive the medical and dental care that they need. WRRHC's assistance programs help families with other services, including transportation to medical appointments and Medicaid enrollment assistance.

CHM provided a list of only nine partners to survey for the Project; only four of the following nine partners responded to the survey:

- Two persons from WCMC
- Two physicians in private practice
- Three representatives from two local congregations
- Two individuals who serve as financial partners

In contrast to CHM, all seven clinics interviewed for the Project reported significant outreach to the health and business community. The reported outreach of five clinics interviewed for the Project is summarized in Table 5.

Clinic	Reported Outreach
Clinic #1	A local hospital partner provides the following to the clinic: the chief of nursing serves as the clinic's medical staff director to coordinate the clinic's volunteer schedule for the hospital's medical staff; an unlimited number of laboratory testing and x-rays are free of charge; pays the clinic's utility costs; and, provides representatives who serve on the clinic's board. A local health coalition maintains an office at the faith-based clinic and administers a prescription assistance program to community residents. Between 30 and 40 area churches provide funding and volunteers. Numerous civic groups provide varies forms of support. A local community fund provides financial support.
Clinic #2	Two congregations founded the clinic – one a large church, the other a small congregation of mostly senior citizens. The former provides primary funding and volunteers while the latter contributes the facility and volunteers. The follow is a list of network of providers that offer services at a free or reduced rate: MRI, Inc. donates two MRIs/month; a podiatrist sees one patient per week; a physical therapist is available as needed; x-rays are provided by a physician pro bono; the Quest Company donates laboratory work with 40-50 blood tests per month and 25-30 other tests per month; physicians charge one-third the normal fee and offer long payment plans as needed. Other donations were reported from various construction companies and the local Baptist Health Medical Center.
Clinic #3	The clinic's partners include the following: individuals; Rotary Club; and local congregations who made financial pledges; pharmaceutical companies through a prescription assistance program, and a local hospital that supplies laboratory vouchers. Volunteers reportedly come from area congregations, organizations, and businesses.
Clinic #4	Approximately 19 area congregations provide volunteers and funding. The local Baptist Health Medical Center provides laboratory and x-ray services in the amount of $15,000 per month (based on hospital charges, not hospital costs). Local specialists receive referrals on an as-need basis. Additional funding is provided by the following organizations: civic groups (e.g., Rotary, Lions); three local foundations; State of Arkansas Tobacco Tax; and, a local electric company. Pathology Labs of Arkansas provides up to 20 pap smears per month, which allowed this clinic to discover pre-cancer cells and prevent cervical cancer in several patients.
Clinic #5	The clinic has contracts with two local medical centers to provide services at a discounted rate, including: x-rays and laboratory services at a discount. Both centers see patients in charity care programs for a discount or sometimes at no charge. No formal agreement exists for charity care. Volunteers are recruited from congregations and friends of the clinic's staff. An ophthalmologist sees four to five patients each week and charges only 10% of the normal fees. Some specialty care is accessed via the clinic doctor who "calls a friend doctor" for assistance.

Table 5 Reported Outreach by Clinics Interviewed

The two largest clinics interviewed attribute some growth, efficiency, and effectiveness to successful outreach. CDM-CHS in Dallas, Texas, realized all three through local collaborations, including a vibrant partnership with BHCS. CDM-CHS provides quality primary healthcare for the low-income and uninsured individuals in an attempt to reduce health disparities while limiting the uncompensated healthcare delivery burden placed on hospitals (Senteio, Jackson, & Walton, 2007). Under development since 1998, the partner between CDM-CHS and BHCS has also enjoyed a strong collaborative relationship with the physician organization, HTPN. Through the Office of Community Health Improvement at HTPN, Central Dallas Ministries' senior leadership has cooperated to develop a robust approach to community health improvement. Originally conceptualized to increase access to affordable primary health care services through professional volunteerism, CDM-CHS has matured into a multifaceted community healthcare strategy. A sampling of its outreach efforts is illustrated in Table 6.

Services	Outreach
Community Medical Clinic	Baylor University Medical Center provides medical staffing and patient referrals from the emergency department.
Community Chronic Disease Management	Baylor University Medical Center's Ruth Collins Diabetes Center
Community Care Coalition	Aligned with Project Access Dallas to train and utilize community health workers who assist patients with navigation of the health care delivery system.

Table 6 Collaborative Outreach Efforts of CDM-CHS

CHC provides another illustration of the power, and perhaps necessity, of outreach for faith-based clinics that seek to build capacity. One creative example of its outreach is The MEMPHIS Plan, CHC's employer-sponsored healthcare plan for small businesses and the self-employed. Relying on a network of donated services that include volunteer doctors, area hospitals, and medical laboratories, the MEMPHIS Plan offers uninsured people in lower-wage jobs access to a network of quality, affordable healthcare (Church Health Center, Inc., 2009).

Project research suggests that the sustainability of CHM may depend upon its commitment to build capacity through outreach to the healthcare and business

community. The following sample of comments from board members suggest a desire to build capacity in the outreach component of CHM:

> We need to educate the community about who we are.
>
> An opportunity we have is to go to Baptist Hospital Systems [which is located in Little Rock but holds administrative contracts in White County].
>
> Maybe we should partner outside healthcare organizations.
>
> Perhaps we should go to employers whose employees are served by CHM.
>
> Initially we didn't want it to be just a program of the Downtown Church, we wanted [CHM] to be a community wide effort…"

Guests/Patients

Data collections suggest that a third area of capacity building in the outreach components may be among the guests/patients of CHM. According to both quantitative and qualitative data of the Project, guests/patients report high satisfaction with both the services and the perceived quality of the medical care of CHM. Except for the volunteers of CHM, few citizens experience the strengths and limitations of the organization more than the guests/patients. This group of stakeholders can positively influence the organization's vision and mission, provide valuable perspectives to the leadership, and shape the products and services of CHM. Guests/patients might serve several meaningful roles:

- Provide routine feedback regarding the services of CHM through surveys and focus groups.
- Serve on an advisory council to provide specific input to healthcare providers and the board.
- Receive training from CHM volunteers to serve as "wellness promoters" in their churches, workplace, neighborhood, or community group.
- Provide testimonies about the outcomes of CHM for present and potential partners.
- Serve as volunteers for the organization as a greeter in the clinic or with administrative duties that include large mail outs, etc.
- Actively recruit new guests/patients.

Products and Services: How Well Has CHM Delivered Its "Products and Services?"

Leaders and partners of a nonprofit organization want to know if the products and services of the organization are making a difference in society. They want to know if the resources are used effectively and if the organization operates efficiently (Urban Institute, 2001). As summarized in Figure 15, the work of nonprofits may be assessed in two ways: measurement of outputs and demonstration of desired outcomes. Outputs and outcomes, De Vita and Fleming note, are the results of "multiple and cumulative interactions of vision and mission, leadership, resources, and outreach. These components work together to create effective outputs and outcomes" (p. 23). As demonstrated in Figure 5, outputs and outcomes provide a feedback loop to the other components of the organization and "enhance or diminish their availability or capacity" (p. 23). Thus, disappointing outputs or outcomes may result in fewer available resources while positive measurements may attract additional resources.

Outputs are immediate program products that result from internal operations of the program, such as the delivery of services and tend to be quantitative in nature.
Outcomes are generally qualitative in nature and demonstrate how the program has produced desired benefits or changes.

Figure 15 Summary of Outputs and Outcomes
(Urban Institute, 2001, pp. 22-23)

Although several clinics reported only limited monitoring and evaluation of outputs and outcomes, Project research of other faith-based clinics demonstrates the value and necessity to measure outputs and to focus on outcomes. The Christian Health Center of Heber Springs, Arkansas reports that the clinic provided $1.5 in medications in first 10 months of 2009, the equivalent to $45,000 in out of pocket medication expenses. CHC of Heber Springs estimates that for every donated dollar contributed, the organization provides $10-15 of medical or mental health care. The website of one faith-based clinic in Arkansas not only reports the number of persons served but assigns a market-rate dollar value to the outputs of the organization. Mountain Home Christian Clinic estimated that the total value of services

Statistics - 2007	
Med Patient Visits 70,000+	Prescription Value $19,000,000+
Educ Patient Visits 9,900+	Medical Volunteer Days 7,500+
Prescriptions 159,000+	Non-Med Volunteer Days 16,000+

Figure 16 Reported Services of AACC Members in 2007
(Arkansas Association of Charitable Clinics, 2009)

provided during 2006 was $2,546,400 (see Appendix I). The broad effect of outputs by organizations like CHM may be seen in an annual report of the Arkansas Association of Charitable Clinics (Arkansas Association of Charitable Clinics, 2009) that lists the combined annual outputs of its membership of 25 charitable clinics (see Figure 16).

As the largest organization of its kind in the nation, CHC in Memphis invests in the measurement of outputs. Monthly and quarterly reports include the number of patient visits along with charges, adjustments, revenues, payments, and percentage collected (see Appendix J).

In a briefing on the impact of the charitable clinic "movement" in Dallas, Texas, Jenny Williams and Adam Chabira, representatives of BHCS, argue that charitable clinics are vital to the healthcare safety net for the uninsured (Williams & Chabira, 2007). By providing medical and dental homes to the uninsured, charitable clinics achieve three important outcomes, according to Williams and Chabira: improve the health of patients; reduce absenteeism at work or school; and, reduce unnecessary hospital utilization. Results of a study conducted for BHCS indicate the following results for charity clinic patients:

- Used the emergency department less that the average uninsured patient.
- Were admitted to the hospital less frequently.
- Did not stay as long when they were admitted.
- Cost the hospital significantly less the average uninsured patient. Every patient seen at the nearby charity clinic, according to Williams and Chabira, saved the hospital $203 in avoided chargers. Over an entire year charitable clinic patients would cost $380,000 less than a comparable uninsured population who did not have a medical home.

This report underscores the value of tracking outputs and outcomes as measurements of the organization's efficiency and effectiveness. Chabira offers a helpful evaluation regarding the Worth Street Clinic, operated by BHCS (Chabira, "HTPN Community Health Services Corps Baylor Family Medicine @ Worth Street", 2009).[3]

[3] Adam Chabira presents a thorough evaluation of outcomes of the Worth Street Clinic in a power point presentation called, "HTPN Community Health Services Corps -- Baylor

Dr. Mark J. DeHaven led a team from the UTSMC in Dallas, Texas to conduct a comprehensive literature review that examines the outcomes of faith-based health activities (DeHaven, Hunter, Wilder, & James, 2004). Three recommendations emerged from the study:

- Efforts (funding) promoting community-based participatory research Projects need to be increased in the area of faith/health programs (combine expertise of faculty and clergy/church leaders);
- Workshops and tools need to be developed for evaluation and educating program leaders about the need for evaluation;
- Evaluation of church-based heath programs must be disseminated through faith-based health organizations.

DeHaven's valuable analysis provides a substantive argument for the importance of capacity building of organizations in the area of products and services and may aid CHM as it considers new ways to measure outputs and focus on outcomes.

In addition to healthcare and wellness services, the clinics interviewed for the Project offer spiritual- or faith-related services. While none of the participating organizations have an intentional strategy to "overtly communicate (verbally) their faith to patients," all respondents reported a desire to address spiritual needs of patients. Reported services include:

- Prayer cards are available for patients to complete and turn in to staff who pray for their needs in the following days.
- The triage nurse asks patients if they want for someone to pray with them or wish to visit with a pastor.
- A pastor or a prayer team of volunteers is present during clinic hours to receive requests to visit or pray. In one clinic a room is designated as a "prayer room," providing a quiet place for patients to pray, meditate, and speak to a pastor or Christian volunteer.
- Follow up visits outside clinic hours are offered by pastors or counselors.

Family Medicine @ Worth Street." Relevant slides of the evaluation report are provided in Appendix K.

- Referrals are made to a partnering congregations or organization that host a Christian-oriented addiction recovery support program.
- A pastor or Christian leader may offer a reading of Scripture, share a few words of meditation, and say a prayer with guests and staff prior to or during clinic hours.
- A meal is offered for both patients and volunteers at evening clinics as a convenience and to create a natural setting for volunteers and patients to develop relationships that may later experience deeper spiritual benefits.
- Healthcare staff works with counselors and the pastoral staff to serve the whole person.

Quantitative analysis of CHM outputs was limited by the availability of data collected by the organization. Linda Bearden, a student at Harding University and summer intern for CHM in 2009, provided a summary of 18 months of data on basic service outputs. From January 2007 through June 2009, the average number of guest/patient visits numbered 35 per week, while the average number of guests/patients to see the pharmacist numbered 25 per week (see Table 7). Research suggests that CHM may have realized the limits of its capacity as early as year three (see Figure 17), followed by a consistent or plateaued level of service for four consecutive years. The number of guests/patients visits declined by approximately 10% from 2004-2009. Patient visits declined by over 20% from 2002 to 2004. Myers explained the drop in service outputs during the second, third, and fourth years of CHM as an intentional adjustment by CHM leaders to match service

Patient Database 1/2007-6/2009	
Average number of patients to see the doctor per week	35
Average number of patients to see pharmacist per week	25
Total Patients Served During Period	437

Table 7 Patient Database

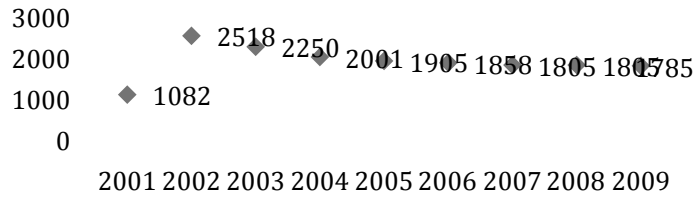


Figure 17 Total Patient Visits Per Year

output goals with the capacity of volunteer staff.

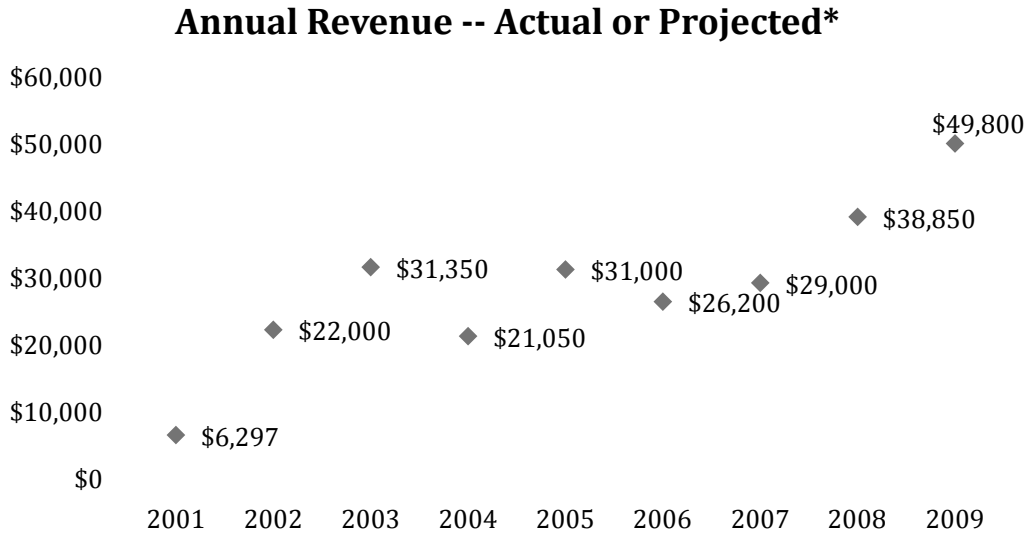


Figure 18 Annual Revenue[4]

The number of guests/patients in year two apparently grew beyond the capacity of CHM personnel.

According to the data provided by CHM, annual revenues or budgeted revenues have grown modestly through the organization's ten-year history (see Figure 18). During fiscal year 2010, CHM expects to receive its first grant, funded by the Office of Rural Health & Primary Care, a division of the Arkansas Department of Health, that will nearly double revenue compared to year 2009. In the amount of $30,000, the one-year grant is designed as a short-term investment in capacity for the purchase of medications, laboratory services, and technology improvements.

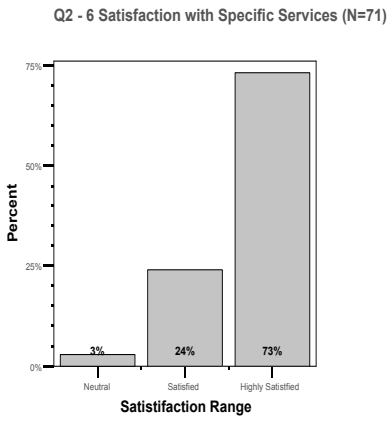


Figure 19 Satisfaction with Services

[4] Actual revenue is shown for years 2001, 2003, 2004, 2006, and 2009. Projected revenue is shown for years 2005, 2008. Estimates are provided for years 2002 and 2007.

The most recent reported outputs were published in the CHM Spring Newsletter, recording 1785 patient visits during 2009 and over 1800 volunteer hours logged (Christian Health Ministry of White County, Arkansas, Inc., 2010).

Although the quantitative data provided by CHM for the Project was limited, qualitative measurements suggested that services of CHM enjoy generally high levels of satisfaction among key stakeholders. Guests/patients responding to a recent survey reported high satisfaction in both specific services of CHM (Figure 19) and overall perception of the quality of CHM medical care (see Figure 20).

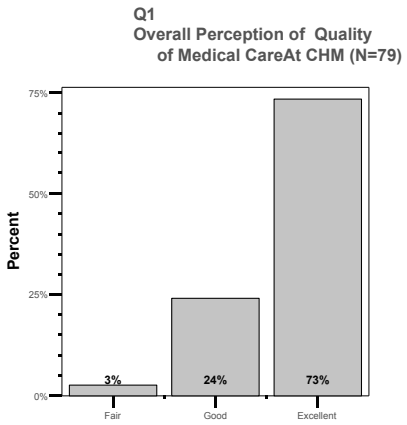


Figure 20 Guest/Patient Overall Perception of Quality

Outputs relative to CHM's participation with volunteers may be assessed qualitatively through a recent survey of volunteers. Respondents generally indicated high satisfaction concerning their volunteer experience,

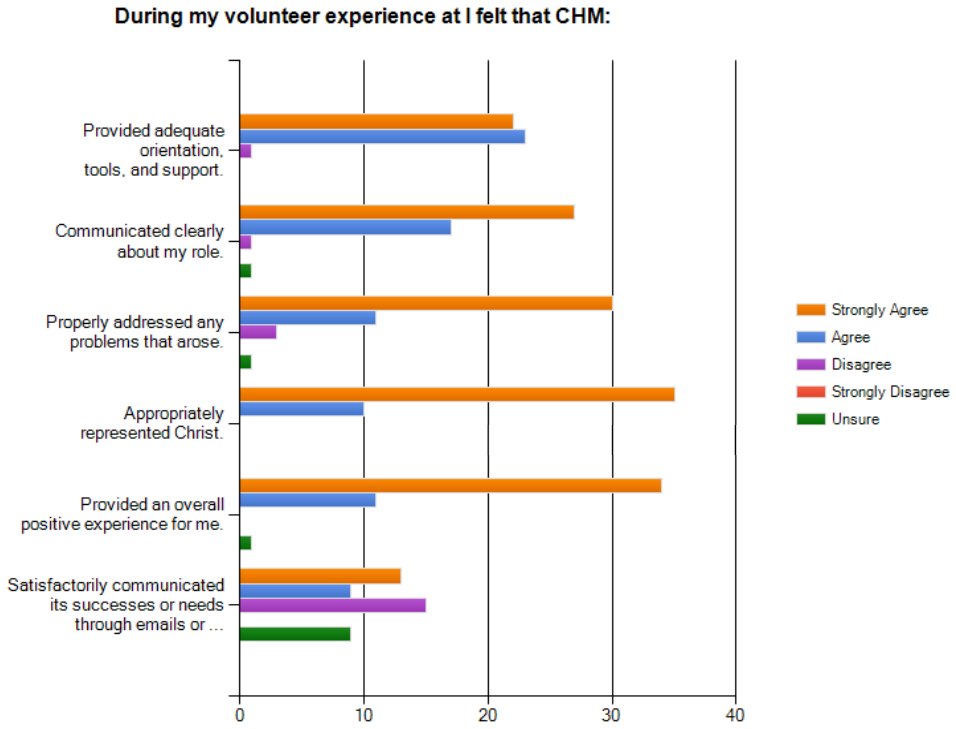


Figure 21 Satisfaction of Volunteers

except in the area of CHM's communication of "success or needs." And, in a focus group and through a survey, guests/patients consistently communicate a positive attitude toward the consistency, quality, and value of the services of CHM.

Below is a sample of written comments from respondents of a recent survey of guests/patients concerning services of CHM:

> I don't know what I would do [to advise CHM]…I am a single mom, working but barely making it. I would not be able to see a [doctor] and get my prescriptions [without] CHM.
>
> The clinic is a huge blessing to the community.
>
> In the three years I have come here I always feel welcome and cared for. That is something I never want to see change because it makes coming here worth the while.
>
> I like the service…it helps people that don't have medical [insurance] or [don't have] the extra money to go see the Doctor.

Research included a focus group of guests/patients who voiced their opinions about the services of CHM; the following statements exemplify the comments of respondents:

> I learned about [CHM] 4 to 5 years ago…I work but I make less than $12,000 per year…I realized I had a place to go.
>
> Seven years ago we learned of CHM through my husband's brother, who was a patient at there. CHM saved his life. He saw Dr. Henderson who said he needed to go to Central Hospital in the morning. They ran tests [and] did surgery. If it hadn't been for Dr. Henderson and CHM, he would have died. Then, my husband became diabetic. When he came to CHM his blood sugar measured 575. If it hadn't been for CHM, I would have lost my husband. I fell in love with everybody here.
>
> With the help of CHM and God's help, I learned my cholesterol was way over 300. In my last visit the doctor [compared the score to] the score a year ago. My total cholesterol is now 229. That made me happy. I was on cloud nine.

Research also indicates that many guests/patients are satisfied with the change of scheduling introduced in 2008 – a change from a "first-come, first-serve" system to an appointment-only schedule.

Regarding the products and services component, data collections suggest that leaders should give attention to two concerns for capacity building: measure outputs and focus on outcomes.

Measure Outputs

Guests/patients, volunteers, and board members surveyed for this research indicate a strong interest in the expansion of and the improved efficiency of CHM healthcare and wellness services. The feedback of guests/patients surfaced five issues related to expanding the measurement of outputs:

- Increase the number of new guests/patients seen at CHM.
- Add hours or days of services.
- Provide additional healthcare services.
- Partner with local providers for affordable access to essential specialized services.
- Offer additional social services desired by the demographic group served at CHM.

In response to a question regarding the problems/obstacles they feel may prevent them from receiving desired healthcare services, guest/patient comments below share the common theme that CHM should expand services:

> You have to call a week in advance for an appointment. It's nobody's fault. But people who need to see the doctor or get medication refills need to remember to call ahead. CHM is so busy they just can't get to everybody.
>
> I'm unable to get Dilantan, which is very expensive to purchase and CHM can't afford to provide to patients.
>
> Time [that CHM is open] is a problem for me. CHM is only open on Sundays. My husband works nights and weekends and that makes it hard to get here.
>
> CHM might work with local hospitals to accept referrals and cut the cost of hospital bills. I went to a doctor, but couldn't afford the services. Maybe CHM could help so patients wouldn't be so scared to go to the doctor or when they need to have surgery and incur thousands of dollars in debt that they can't pay.

Of the 79 respondents to a recent survey of guests/patients, 24 expressed concern regarding the capacity of the organization. Sample comments include:

> I am blessed that I don't…have to use the clinic often…I am blessed that it is here when I need it. Sometimes though I would like to come during the week instead of getting sick on Mon or Tues and having to wait to get in on Sunday.
>
> Sometime the doctor has so many patients. They may forget to listen [to me]. The

> demand of need must be accompanied by the right amount of doctors.
>
> I'm not sure, but being open an extra day would help.
>
> [I would] like help with how to deal with an inability to work. Today I came to check on my [prescriptions] and had to have them written…I couldn't call them in last week since you were closed. There should be some kind of notice to call 2 weeks before they are [due] if there is a holiday. I went without [medications] for several days, but I'm not complaining.

Volunteers and partners surveyed for the Project expressed concerns in two areas related to the measurement of outputs: improve the organization of clinic operations and improve or expand communications. As shown in Figure 21, respondents of a volunteer survey reported high levels of satisfaction in most areas of their experience, but expressed general dissatisfaction with how CHM "communicated its needs or successes through emails or newsletters." And, in response to questions to volunteers concerning what they liked least or how their volunteer experience might be improved, the following comments illustrate their concerns:

> The chaos. The work at the front desk could be streamlined a little more... but I'm sure because of the cost, that's probably not possible. I would have liked to have been introduced to the people working in the back... nurses, pharmacists...
>
> Volunteer workforce seems unorganized.
>
> I do wish for a wider formulary from which to prescribe pharmaceutical interventions for CHM guests/patients, but I fully recognize this is often not a facet of CHM's operation that is fully under CHM's purview to alter, given the expense and the difficulty associated with procuring and providing the medications to an indigent population.
>
> Not well organized, a lot of standing around.
>
> I did not love the charting, and the medication system on the charts seemed a little confusing.
>
> Better scheduling [of volunteers]. I have never been put on a schedule; I just show up.
>
> I believe the [volunteer] situation has improved some now that the Harding [University] College of Pharmacy is sending students to serve in the clinic. It still can be somewhat stressful with only one pharmacist.

> [Provide a] short orientation file with basic information.
>
> I didn't realize it was a medical facility as well. I thought it was strictly counseling [service] in nature.
>
> Develop relationships with hospitals and clinics that result in commitments to assist in providing the diagnostic and therapeutic needs of CHM guests/patients.
>
> More training [for volunteers is desired] – time to watch and not have to work. Train during the week...not while the phone is ringing off the hook... or patients are waiting in line. It's too stressful for the other person.

Interviews and focus groups with board members revealed similar sentiments concerning CHM's need to build capacity in the services component of the organization. In response to the question of how the mission of CHM may have changed from its original intent, one board member responded (Board of Christian Health Ministry, 2010):

> We've evolved into place that provides meds for people. We see a limited number of people…I'd like to open another day to see new patients but it requires a lot of volunteers – 10 or 12 people. It seems at times that you're kind of seeing the same [patients], and you're just keeping medicines filled, and then you're not doing a whole lot else…and that's not the intent – just to provide a pharmacy for people. The intent was to not only help their physical condition or their chronic illnesses but to try to help other ways – you know, emotional, spiritual, and other ways; but we just don't have the manpower to do it.

In response to the question of how will CHM and its board need to adjust or change to move successfully into the future, a board member replied: "We've…been treading water, because we don't get enough money. We're spending 90% of $30,000 budget on [medications]. We've got to raise money to do more, but we haven't done that…We need to look at other clinics to ask what's been successful."

When asked about the success and challenges of CHM, a board member and physician at CHM spoke to the concern of limited capacity of services: "Right now I've got a note on a patient who needs to be followed up with. I saw her in the hospital. She needs to be followed up with Christian Health Ministry. She said, 'I can't get into [CHM to see a doctor].' She lives in Augusta but used to live in Heber [Springs, AR]. Right now she still drives all the way to Heber because she can't get in [at CHM in Searcy]." In response to a question about the effectiveness of an all-volunteer strategy, the same board member spoke to capacity of services and its effect on efficiency and effectiveness:

"I think the strategy has limited us. Some paid staff would have made it easier to increase hours, since work on Sunday flows over into week and we don't have any one to do that…or we have to remember to do it ourselves…I think [paid staff] would have increased the effectiveness of the work. If we had support staff it would be easier to do our work, [and] it would improve the efficiency of the operation a lot." The board member believes CHM should add more days of operation to expand both capacity and the quality of the services. Since a number of holiday closings interrupt the clinic's current Sunday-only schedule, this board members believes that additional days of operation not only compensate for holiday closings, but achieve two additional goals: other days of operation improve continuity of care for acute guests/patients and create space for additional volunteers to participate.

In a SWOT analysis board members voiced a desire to build the service capacity of CHM. The following comments are illustrative of this perspective:

> We're floundering for lack of resources.
>
> We have not done a health needs assessment – something that we really need to do – of what the needs are of our clients (socially, emotionally, [and] economically). We've never done that at CHM…Sometimes I feel like we're just sitting and spinning.
>
> We've had physicians who have volunteered to serve during [weekday clinic hours]. There's a lot of vision to expand, but not just one area alone can expand, especially if it's all volunteers. Everyone has to be on board. But everybody's already maxed out.

CHM leaders may wish to explore several questions that arise from the research and connect the products and services with the other organization components, including the following: how might the mission and vision help inform and inspire CHM leaders concerning future services? What additional leadership and resources are needed to pursue a revised vision and mission? Is a commitment to an all-volunteer organization negatively affecting the efficiency and effectiveness CHM or can it enhance the outputs and outcomes? What outreach is necessary to achieve expanded services and offer additional products? How has the merger of two local hospitals influenced the products and services of CHM? What additional feedback is needed from guests/patients to evaluate the organization's efficiency and effectiveness? Does the "$4 medications list"

now in the retail market change CHM's outputs? How might improved utilization of the new database software enhance measurements of outputs?

Focus on Outcomes

Project research discovered no systematic approach used by CHM to monitor and evaluate outcomes of the CHM services and products component. Key leaders apparently monitor and evaluate through an ad hoc approach based on direct experiences with guests/patients in the clinic. Stories of guests/patients known to the leadership are real and a valid part of measuring outcomes, but anecdotal evidence of outcomes may not answer two vital questions: is CHM realizing its vision and mission and does the work of CHM result in the desired changes of knowledge, behavior, and condition of the guests/patients? To better inform CHM leaders and stimulate further reflection on outcomes, three areas for measurement are briefly explored: health outcomes, economic impact, and spiritual/faith influence.

Health Outcomes. CDM-CHS focuses on healthcare outcomes. In a recent phone interview Keith A. Ackerman, Vice-President of Community Services & CDM's Chief Operating Officer, observed that "measurement and use of healthcare outcomes is critical" to our efficiency and effectiveness (Ackerman, 2009). Since 1998 CDM-CHS has partnered with BHCS to provide quality primary healthcare for the low-income and uninsured individuals in an attempt to reduce healthcare disparities while limiting the uncompensated healthcare delivery burden placed on hospitals (Senteio, Jackson, & Walton, 2007, p. 3). CDM-CHS measures its progress related to improving healthcare disparities for the working poor across three dimensions:

- Quality: the receipt of adult preventive health services
- Service: patient satisfaction with health care delivery
- Finance: reduction in the utilization of hospital emergency departments

"Quality is tracked and managed according to the percentage of patients who are informed of and receive preventive procedures as outlined by the U.S. Preventive Services Task Force (PSTF). These recommended preventions include screenings for hypertension, hypercholesterolemia, tobacco use, colorectal cancer, breast cancer, cervical cancer, and adult vaccines for pneumonia and tetanus. Recommendations and frequency are based on the patient risk profile as outlined by the PSTF task force"

(Senteio, Jackson, & Walton, 2007, p. 5). The patient profile is aligned with these parameters to produce an 'Adult Preventive Health Service Score,' which is a "management tool used to track quality by aggregating these various dimensions."

Additionally, CDM-CHS "service is managed and tracked according to patient satisfaction surveys, in which both the physician and front office staff are evaluated. The instrument used to track satisfaction is an HTPN tool that measures patient perceptions across the following areas: access to care, experience of the visit, care provider, personal issues, and overall experience" (p. 5).

The financial outcomes of CDM-CHS are measured by the rate at which its patients utilize the hospital services. CDM-CHS financial impact is "tracked according to the following industry-tracked variables: cost per Emergency Department (ED) visit; admission rate (per 1000); average length of stay" (p. 6). The report notes "it has been common for individuals without health insurance coverage to use EDs for episodic primary care—a very expensive and inequitable model for delivering health care services. By providing a 'medical home,' with access to affordable primary health care and a voluntary referral network for specialty care, CDM-CHS has helped to reduce unnecessary visit for primary care needs" (p. 6).

The following evaluative tools, according to Chabira, the Administrator for the Office of Health Equity at BHCS, are used to measure and report health outcomes in the three dimensions of quality, service, and finance:

- Reports and Assessments
- Institutional Matrix
- Pre and Post Analysis
- Measure increased outpatient services compared to savings in hospital admissions.

In a phone interview Chabira asserted that "the future of healthcare involves a big change for charitable clinics – from 'what do we do to keep the doors open?' to 'what measureable effects are we having on the health and wellness of our patients?' Mr. Chabira continued (Chabira, "Baylor Medical's Partnership with Central Dallas Ministries, Inc.", 2009):

> The future of healthcare includes charitable clinics linked with hospitals. This will be combined with healthcare indicator models – moving away from evaluation based only on volume of patients served [e.g., outputs] toward outcomes of hospitals and providers. With this change comes increased accountability. And accountability is complicated, since there are many more factors that contribute to a patient's health than the care given by a hospital. The concern about health outcomes is forcing creative thinking, including ways to serve the uninsured.

From the CDM-CHS/BHCS partnership that now spans 12 years, Mr. Chabira reports three key lessons relevant for the Project. First, county hospitals are overwhelmed with need and bear a lot of the burden for uncompensated care. Out of desperation, BHCS sought solutions. The environment or context forced a search for alternatives. Second, Chabira points to factors that motivate hospitals to partner with a charitable clinic? As a nonprofit entity, according to Chabira, BHCS is now mandated to provide a community benefit and "can no longer claim write-offs of uncompensated care as a community benefit; and, it is arguable how effective and efficient are health fairs to the community." Financial challenges also compel organizations like BHCS to do something different, since in Texas one in every four adults is uninsured – and the number of uninsured is rising rapidly in Texas and nationally. Third, charity clinics can help reduce the bad debt of their partner hospitals. This is achieved not because charity clinics solve the problem of overcrowded emergency departments – an idea that, according to Chabira, is a "product of the media. Pushing or referring patients away from the ED to the charitable clinic is not the way a hospital saves money. After all, how many sore throats must be treated in a charitable clinic instead of the ED to affect a hospital's bottom line? The real financial loss to hospitals relative to the uninsured derives primarily from lengthy admissions. Hospitals save big bucks when they avoid long stays by the uninsured patients" (Chabira, 2009).

Economic Impact. Another dimension of outcome measurements is the financial impact of nonprofit clinics for the benefit of individuals as well as the healthcare industry and the business community. An exceptional example of the latter is the MEMPHIS Plan – CHC's employer-sponsored healthcare service for small businesses and the self-employed. The MEMPHIS Plan is not health insurance. By relying on a network of donated services from volunteer doctors, area hospitals, and laboratories, the MEMPHIS Plan offers uninsured people in lower-wage jobs access to quality, affordable healthcare.

This includes primary and specialty care, hospitalization and other medical services.

The MEMPHIS Plan answers the need of small business owners who cannot offer traditional health insurance to employees. With the MEMPHIS Plan, employers can provide an important benefit and perhaps enhance job productivity and retain valued employees. To participate in The MEMPHIS Plan, employers must be located in Tennessee and have no more than 200 eligible employees. Employers may not drop current insurance coverage to offer The MEMPHIS Plan or allow employees currently covered by insurance to drop their coverage. Employers may offer The MEMPHIS Plan to employees who are unable to afford the insurance provided through the employer or who do not qualify. To enroll employees in The MEMPHIS Plan, employers must make sure employees meet The Plan's eligibility requirements, agree to pay at least $10 of each employee's monthly fee, collect each employee's portion of the monthly fee, and remit the total amount to the MEMPHIS Plan (Church Health Center, Inc., 2009).

To participate in The MEMPHIS Plan, employees must meet the following eligibility requirements: make no more than 200% of the Federal poverty level, which is currently $417.00 a week for an individual (employees with higher incomes may still qualify depending on family size); work at least 20 hours a week; do not have TennCare (Tennessee's Medicaid program) or private insurance coverage for at least six months prior to enrollment; have worked at least three consecutive months with the current employer; and, do not have serious pre-existing conditions that require surgery or extensive immediate care. Self-employed workers may participate in The MEMPHIS Plan if they live in Tennessee, are currently uninsured (no private or governmental insurance coverage), and make no more than 200 percent of the federal poverty level based on family income and family size as shown on their federal tax return (Church Health Center, Inc., 2009).

Although the Project could not determine if or how the CHC measures economic outcomes of The MEMPHIS Plan, the initiative is an example of the potential financial benefit in the products and services of nonprofit clinics (Larson, 1999).

The examples in Dallas and Memphis underscore the value of outcomes measurements to assess and build capacity of a healthcare organization. The charitable clinic that focuses on outcomes provides an essential feedback loop to the other

components of the organization: outcome measurements document the extent an organization pursues its vision and mission, informs and inspires leadership, retains and attracts resources, and gives focus to outreach. The Project research reveals that the work of a nonprofit organization (even an all-volunteer organization) includes the discipline and responsibility to measure both outputs and outcomes.

Spiritual/Faith Outcomes. A third area for measurement is spiritual/faith outcomes. Project research suggests CHM seeks to exist as an expression of Christian faith. The products and services of the organization are to be both a consequence of faith in Christ and a compelling invitation for others to embrace such faith. Interviews with two board members voiced both intentions – to exemplify a compassionate Christ and to invite others to follow him. A considerable percentage of volunteers responding to a recent survey affirmed the value of Christian faith as the impulse for the work of CHM (see Figure 23).

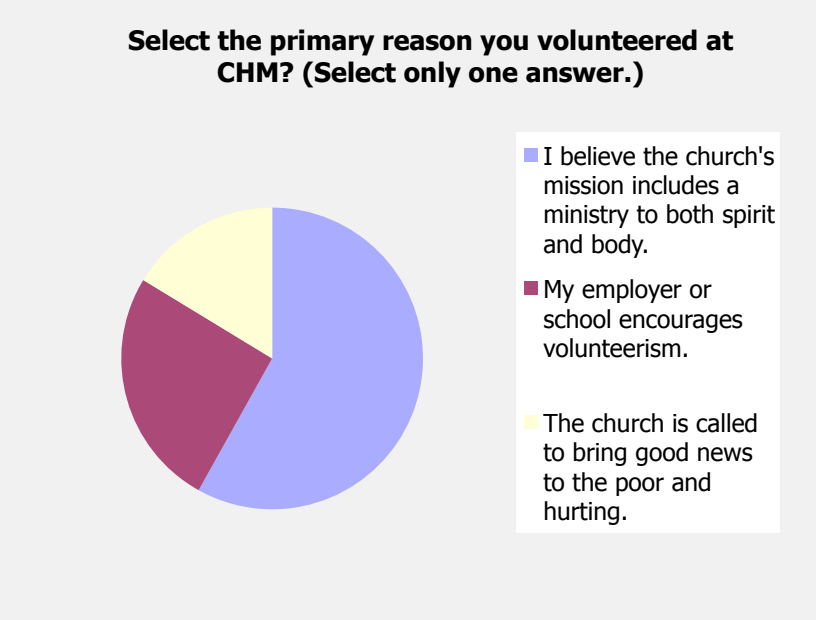


Figure 23 Why Volunteers Come to CHM

CHM communicates to guests/patients and volunteers its identity as a Christian-oriented clinic, according to Project research. Of the respondents to the volunteer survey, 100% agreed or strongly agreed that CHM "appropriately represented Christ" during their volunteer experience. In a survey of guests/patients, respondents offered positive comments relative to CHM's faith testimony. One respondent stated: "My family has used CHM for many years. You all are truly doing *God's* work and may God continue to bless CHM and the work you all do."

Respondents to the guest/patient survey, however, communicated only moderate or low interest in receiving spiritual services of CHM. While guests/patients indicated generally high satisfaction with the quality of medical care and specific healthcare services, 63% of respondents communicated moderate to low interest in CHM spiritual services (see). The reasons for this moderate to low interest is unclear; the Project suggests more research is needed to understand the faith values and spiritual needs of guests/patients.

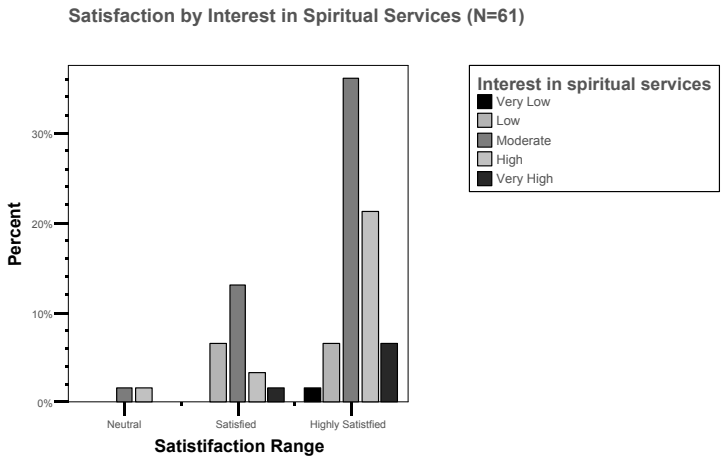


Figure 24 Guest/Patient Interest in Spiritual Services of CHM

Measuring spiritual/faith outcomes is inherently difficult, since "spiritual" and "faith" are theological notions that connote a sense of the unseen. Nevertheless, outcomes may be identified as an extension of the organization's theological framework. For illustrative purposes the following two categories are used to consider faith/spiritual outcomes: outcomes effecting groups of citizens, markets, and economic social systems and outcomes effecting individuals. By their nature, faith/spiritual outcomes tend to be qualitative in nature and may result only after several months or years of service by CHM.

A number of outcomes observable in groups of citizens, markets, and economic social systems might result from Christian faith expressed in the services and products of CHM. A few examples are listed below to encourage further reflection on potential reportable outcomes:

- Do individuals experience the healing ministry of Christ through the products and services of CHM? Do guests/patients enjoy a greater level of wellness and demonstrate a higher level of personal responsibility for their overall health?

- Just as Christ demonstrated compassion and communicated concern for justice, does the work of CHM result in increased access to quality and affordable healthcare and wellness services, particularly among the economically vulnerable?
- By demonstrating God's special concern for the most vulnerable citizens, is CHM positively influencing local market forces, social systems, or structures of power for a more equitable and just local economy?
- Does CHM increase awareness among local Christian congregations of the church's call to carry on the healing ministry of Christ? Does CHM increase awareness among local churches of healthcare disparities facing the working poor? Are more congregations mobilized to participate in the healing ministry of Christ, in the healthcare and wellness services, and to advocate for more equitable healthcare systems?

The services and products of CHM might also result in outcomes observable in individuals:

- Do guests/patients embrace new or deeper levels of faith in Christ as a result of their relationship with CHM?
- Do volunteers and leaders mature in their faith as a result of participation in the work of CHM?

As a final illustration concerning a focus on spiritual/faith outcomes, the CHC in Memphis, Tennessee provides an example of how desired outcomes and vision/mission are interrelated. Since CHC was founded in 1989 a two-hour staff meeting is held every Wednesday morning. During this session, the clinic is closed and volunteers receive phone calls so that all staff may attend. Staff meetings at CHC are special occasions to reconnect to the vision/mission. Meditations on Scripture are offered and prayers are shared – all to reflect on the purposes of CHC and on recent struggles and victories. Staff members and organizational leaders, like CHC founder Dr. Scott Morris, share inspiring stories about a patient, volunteer, or staff member. Wednesday morning meetings communicate the meaningful consequences of CHC's work and recast its vision/mission of reclaiming the Church's biblical commitment to teach, preach, and heal in the spirit of Christ.

Part 8: Sustainability

The sustainability plan for the Project has two initial steps. In the first step the Project facilitator will meet with the board of directors in Summer 2010 to present a summary of the Project. In the second step the board of directors will discuss the Project findings and recommendations and consider a plan of action.

Project research indicates that CHM has a genuine opportunity to expand beyond current level of services in pursuit of its vision/mission. The more fundamental finding, however, is that building capacity of the ten-year old organization is necessary for CHM to merely sustain its present level of service. The preceding evaluation section of this report explores in detail the nature and extent of capacity building that can lead to the long-term sustainability and growth of CHM.

Part 9: Results, Conclusions, and Recommendations

Results

This section describes the Project results relative to the anticipated short-term outcomes (see Table 8). The original proposed logic model (see Appendix A) charted a more aggressive Project that worked closely with board members to achieve short-term outcomes relative to three groups that are valuable to CHM's future sustainability:

1. Bring new knowledge to board members about CHM's history, efficiency and effectiveness, and increase board members' knowledge of industry best practices;
2. Increase the awareness of civic leaders and the general public of the history and vision/mission of CHM;
3. Bring new knowledge to leaders of the local healthcare and business communities of CHM's contributions to the community and its strategic plans.

After only two months into the Project, the initial logic model proved unrealistic for two reasons. The Project agenda was too ambitious for the timeframe, but also additional information about CHM indicated that the board had limited capacity to engage in the Project. At least two board members resigned their positions as coordinators, citing fatigue and other commitments. Several board members were inactive with CHM and the few active members had limited time to participate in the Project. As a result of these realities, the Project focused more narrowly on four

outcomes that bring new knowledge to board members concerning organization capacity building.

All four proposed outcomes assume that the research findings will be presented to the board of directors of CHM and all outcomes are based on Project research. Since the Project results will be presented to the board of CHM after its submission to the faculty

Short Term Outcomes	#1 Board receives knowledge of CHM history	#2 Board receives knowledge of research on CHM present practices and effectiveness	#3 Board receives knowledge of best practices	#4 Board receives knowledge of members' opinions of research and analysis

Table 8 Short Term Outcomes

of Southern New Hampshire University, the proposed short-term outcomes are not yet achieved.

Outcome #1: Board receives knowledge of CHM history

Information on the history of CHM derived primarily from the organization's database, reports, and financial documents provided by Myers. Only a minimal amount of quantitative data was provided because of limited patient records. A summer intern provided a basic demographic report of guests/patients from the previous two years. All planned activities toward this outcome were accomplished.

CHM might be served with more detailed and thorough record keeping. A new comprehensive database, with available technical support and trained administrators, may provide important information relative to measurement of outputs and outcomes and aid the organization's reporting and accountability requirements.

Outcome #2: Board receives knowledge of research on CHM practices and effectiveness

Two pre-research focus groups were held with representatives of the board of directors and with a sample of guests/patients. Several informal interviews or meetings were held with Myers. The Project facilitator visited the Sunday clinic on most Sundays during a six-month period. Representatives of the board conducted SWOT and stakeholder analyses. A hardcopy survey of guests/patients was conducted in the waiting room during Sunday clinic hours in the months of May through July 2009. Electronic surveys were conducted among board members, volunteers, and partners in September and October 2010. All planned activities toward this outcome were accomplished.

Most guests/patients were very willing to complete a written survey. A common statement by many participants was, "I am glad to do this if it helps the clinic." Board members participating in the focus group and the SWOT and stakeholder analyses seemed to respond forthrightly, providing the Project facilitator valuable insights into the state of the organization. Among the board members and volunteers participating in the surveys, many communicated their perspectives candidly and objectively, which aided the facilitator in the assessment process.

The survey process identifies organizational weaknesses and strengths of CHM. Of the 14 board members, 11 participated in the electronic survey and only six completed the survey. Surprisingly few partner representatives were available to survey. And, the number of volunteers available to survey was smaller than expected, including many university students who no longer live in White County.

Outcome #3: Board receives knowledge of best practices

To explore best practices of comparable or relevant organizations, information was collected about seven clinics and from literature. Five clinics in Arkansas were selected because of similarities to CHM including: target audience, demographic context of the community, organizational size and age, and/or the clinics are Christian faith-based and church-supported. Two large healthcare organizations were chosen because of their target audience, the organizations' connection to Christian faith, their successful rate of growth, and notable effectiveness in pursuit of a mission/vision similar to CHM. The Project facilitator and one board member attended a replication seminar offered by the CHC in Memphis, Tennessee, one of the two large organizations researched. Research on the other six clinics was conducted via email, phone interviews, and review of the organization's website and Internet postings. All planned activities toward this outcome were accomplished.

The Project facilitator found all clinic representatives helpful, engaging, and very informed about their organization. All communicated with professionalism and passion. Among the five Arkansas clinics interviewed, most clinic representatives were volunteers who contribute twenty or more hours each week to the organization, demonstrating an extraordinary level of commitment to the vision/mission.

A review of literature found much research at the regional and national level concerning healthcare inequities. Far less information was available concerning specific strategies and solutions, especially in the context of faith-based healthcare organizations. The Project discovered that the partnership of CDM-CHS and BHCS, and the research emerging from their collaboration, may prove valuable to both large and small faith-based healthcare organizations and their local partners.

Outcome #4: Board receives knowledge of members' opinions of research and analysis

This outcome relates to the presentation of the Project findings to the board of directors. The Project presentation will invite members to share their opinions of the Project's research and analysis. Activities related to this outcome are incomplete.

The facilitator is hopeful that activities and outputs of the Project offer CHM a constructive step toward a vision for the next decade and to build capacity to meet the coming challenges and opportunities.

Conclusions and Recommendations

Prospects of Attaining Intermediate and Long Term Outcomes

Findings of the Project research suggest that CHM can attain the intermediate and long-term outcomes (see Table 3). All five components of the organization indicate that the timing is right and potential exists to inaugurate a strategic plan to build organizational capacity that achieves sustainability. The essential vision/mission of CHM is recognized as relevant and valuable to the community and holds great potential for added contributions. The leadership, though perhaps fragmented and fatigued, has demonstrated a consistent commitment to bring necessary resources and capable governance for a stable and viable organization. The potential for increased human and financial resources is significant when combined with an expanded commitment to outreach. The environmental system that influences nonprofit capacity building (see Figure 14) seems to value the role of an organization like CHM. Research suggests that CHM consistently produces quality products and services and holds valuable experiences essential to the expansion of healthcare and wellness initiatives.

To achieve of the Project's intermediate and long-term outcomes, the board of directors should re-imagine the purpose of CHM's existence, gain renewed cohesion from the vision/mission, and be infused with fresh energy and enthusiasm from both

current and new members. Without this rejuvenation of the board, the intermediate and long-term outcomes will not likely be achieved.

Sustainability and Replication

The Project explored the need to build organizational capacity of CHM in order to achieve greater operational and financial sustainability, and to expand medical services and wellness education for uninsured residents of White County. The following recommendations are offered as a summary of the Project's findings. Recommendations highlight strengths and weakness of CHM, based on Project research, and are organized around the five components of a nonprofit organization. Each component serves as a point of intervention to build organizational capacity but is interrelated with all other components (see Figure 5). Thus, the recommendations for each component have implications for all other components.

Vision and Mission. Project research reveals that the vision/mission of CHM remains clear and vital. Stakeholders voiced little confusion or conflict regarding the value or necessity of CHM's vision/mission. This clear sense of purpose is a strength that creates exciting potential for the future of the organization.

An area for potential growth lies in the need to imagine again the implications of the vision/mission for this reputable organization and the significant social, economic, and spiritual potential inherent in the vision/mission. From this renewed imagination, current and potential stakeholders may be inspired to join in pursuit of the noble cause that promises a healthier and whole community.

Leadership. Research points to a leadership that consistently demonstrated a commitment to the vision/mission through an investment of time, energy, finances, and influence. The leadership of CHM maintains a strong sense of value and commitment to the purposes of CHM. Perhaps the fragmentation and fatigue of the current board may result from a tenacious dedication to the weekly operations of the clinic, a focus that may have come at the expense of the less urgent – but equally essential – capacity building concerns related to vision/mission, resources, outreach and leadership development.

The area of growth lies in leadership development. CHM needs an aggressive plan to *enhance* and *expand* leadership. Current leadership may benefit from designating a time and place to celebrate the decade of achievement through CHM – the services

rendered and the relationships enjoyed. This celebration can result (both serendipitously and intentionally) in opportunities to improve communication among board members and regain the board cohesion required for CHM to move positively into the future. A celebration of CHM's decade of service may also stir the leadership to re-imagine the potential implications of the vision/mission.

In addition to the enhancement of current board members, new members of the board are needed to rejuvenate the organization, add expertise in areas the leadership is now deficient, and provide additional personnel to attend to the capacity building of CHM.

Resources. While many nonprofit organizations struggle with volatile revenue sources or suffer from undisciplined spending habits, CHM has demonstrated the ability to maintain funding streams and live within its means. CHM has proved itself to be a frugal and responsible charitable organization that seeks to operate efficiently and to wisely manage risk.

Project research suggests, however, that CHM needs to build capacity through the development of human and financial resources, and that failure to do so may jeopardize the organization's sustainability. An enhanced and expanded leadership must address the question of staffing for both the current level of service and future expanded services: will CHM pursue a new, more sustainable course as an all-volunteer organization or will it add paid staff positions as a function of an innovative long-term strategy? Decisions related to the capacity building of resources derive from a specific understanding of the vision/mission and the capability and commitment of the leadership.

Outreach. CHM enjoys a positive reputation with most community members who are familiar with the organization. Many leaders of the community, as well as those who receive direct benefit from CHM products and services, value the work of CHM.

To gain a level of sustainability, CHM should involve more individuals and organizations at all levels of CHM and improve its overall engagement with the community. The vision/mission of the CHM seems to demand a new level of collaboration and cooperation. To maintain CHM's credible place in the Christian community and its valuable role in the healthcare and business communities, CHM leadership must address questions of involvement: What are the qualifications of board

members? What partnerships are required to broaden and deepen the efforts of CHM? What collaborations are needed to improve efficiency and effectiveness? Without answers to these questions of involvement, CHM risks the loss of credibility in the community and the sustainability of current levels of services.

Products and Services. For ten years CHM has demonstrated a commitment to provide quality and affordable healthcare services. The organization enjoys a strong reputation for excellence in compassionate care, which may aid efforts to expand products and services.

Results of the Project indicate a need for CHM to improve measurements of outputs and to focus on outcomes. What vital information is needed to measure the organization's efficiency and effectiveness? What data is needed to determine success or failure? The vision/mission of CHM is too vital to measure success primarily by "keeping the doors open." Without conscientious measurements of outputs and serious attention to outcomes, how does CHM – or the people who support it – know that citizens are healthier, access to quality healthcare and wellness education has increased, the healing ministry of Christ continues in meaningful ways, or the church has been significantly influenced and mobilized? Thorough reporting of outputs and attention to outcomes is an essential characteristic of a responsible and accountable organization.

Personal Thoughts

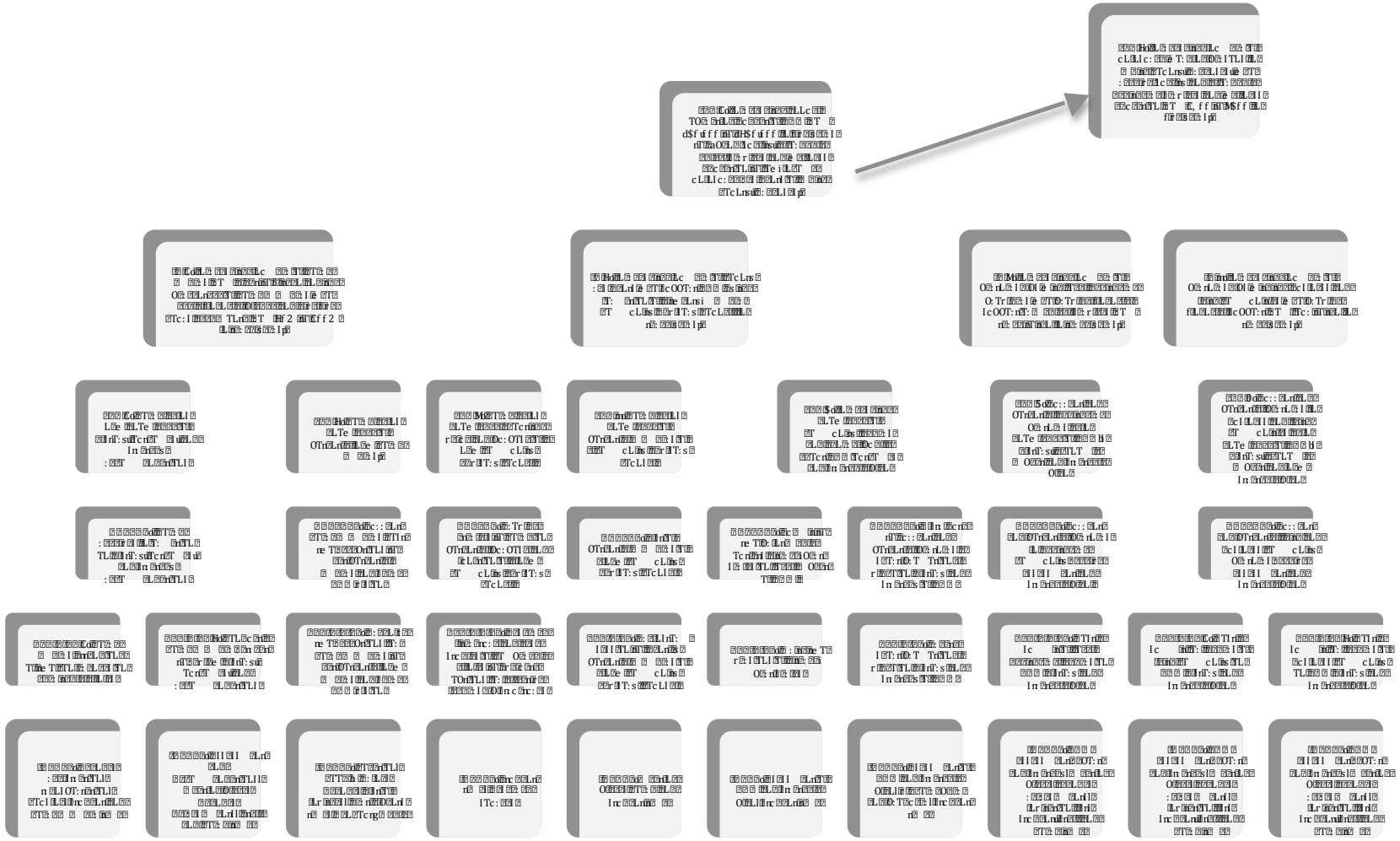
The Project research reminded the facilitator of the potential of faith-based, healthcare and wellness organizations to achieve community economic development. People of shared values (e.g., Christian faith) who collaborate to achieve a more equitable healthcare system can cultivate and empower a community (a community of Christians, healthcare providers, and/or the uninsured). Such collective efforts may bring economic benefit: individuals who lack access to healthcare or opportunities for improved wellness gain affordable care and realize a reduction in the risk of mounting healthcare costs that threaten their already-vulnerable financial condition. Potentially lower hospital utilization costs can hold down overall local healthcare costs for consumers; and, a healthier workforce takes fewer sick days and reduces the potential burden to employers.

For the facilitator, the Project is also a lesson on the value of an organization's vision/mission. That lesson comes in two related principles. First, the vision/mission of

an organization is usually larger than one person's commitment. Usually an individual's enthusiasm and a willingness to serve are not sufficient to achieve the long-term vision/mission of an organization, particularly if (or when) enthusiasm is dampened by fatigue or one's willingness to serve is outmatched by the need. The second principle is that competing ideas of how to pursue the vision/mission are not the same as the vision/mission, and are usually not as important. This principle is difficult when passionate, well-intentioned persons hold opposing ideas. Wisdom is required to insure that commitments to personal ideas do not displace the vision/mission of the organization. The facilitator shares experiences with both principles and is well served by the lesson provided by CHM.

The Project facilitator is thankful to CHM for the opportunity to explore its story of service. Today, hundreds of residents in central Arkansas enjoy increased access to quality and affordable healthcare because of the contributions and sacrifices of the people of CHM. The facilitator hopes that the Project supports the vision/mission of CHM and results in social, economic, and spiritual benefits for its community.

Appendix A Original Proposed Logic Model



Appendix B Guest/Patient Survey

A Guest Survey for Christian Health Ministry

Do not write your name on survey

Welcome back to CHM! This Guest Survey seeks to understand your overall experience as a Guest (Patient) of CHM. Your comments are very important to us as we seek to provide quality and affordable healthcare services to our neighbors. This survey will take about 10 minutes to complete.

Instructions: *Check only the answer that best fits your overall experience as a Guest of CHM. Your answer should represent not only today's appointment, but also all your visits to CHM.*

	Excellent	Good	Fair	Poor	Very Poor
1) I feel the medical care at Christian Health Ministry Clinic (CHM) has been	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
2) I feel the doctor or nurse practitioner addresses the primary reasons I come to CHM.	☐	☐	☐	☐	☐
3) I feel my physical needs are met at CHM.	☐	☐	☐	☐	☐
4) I feel my needs for health and wellness education are met at CHM.	☐	☐	☐	☐	☐
5) I feel that my spiritual needs are properly addressed at CHM.	☐	☐	☐	☐	☐
6) I feel that the counseling services now offered through CHM meet my emotional needs:	☐	☐	☐	☐	☐

Instructions: *Check each answer(s) that best fits your overall experience as a Guest of CHM. You may check more than one answer. Your responses should represent not only today's appointment, but also all your visits to CHM.*

7) Do you have a doctor that you see *besides* the one at CHM?

___ Yes ___ No *If Yes*, what doctor do you most often see? _____

Turn page over. Questions are on both sides of the page.

8) Where do you obtain medication other than the pharmacy at CHM? (Check all that apply.)

___ Full price retail pharmacy
___ $4 prescriptions retail pharmacy
___ Online
___ Prescription Assistance Program
___ Only CHM

9) When you need to see a doctor Monday thru Saturday where do you receive medical care? (Check all that apply.)

___ Local ER
___ PrimeCare
___ White River Rural Health
___ White County Health Dept
___ Family Doctor
___ Wait to go to CHM
___ None

10) Please check the *top three* (3) health reasons you visit CHM:

___ Infection
___ Cholesterol
___ Diabetes
___ High Blood Pressure
___ Depression (Nerves)
___ Asthma
___ Weight Problems
___ Pain
___ Other _____

11) If CHM were open other days of the week, what day(s) would you prefer to come to CHM? (Check all that apply.)

___ Monday
___ Tuesday
___ Wednesday
___ Thursday
___ Friday
___ Saturday
___ I would come on Sunday only

12) If CHM were *not* available, where would you seek medical care:

___ Local ER ___ Medical clinic ___ Go without care

13) Have you ever been to the local ER?

___ Yes ___ No
If Yes, how recent was your visit? _____

A Guest Survey for Christian Health Ministry ***Do not write your name on survey***

If *Yes*, how long was your wait time in the local ER?

___ Less than an hour 1-2 hours ___ 2-3 hours ___ 3-4 hours

14) How do you pay for your visit at the local ER?

___ Payment plan ___ Credit card ___ Cash ___ No Pay

15) What health and wellness services would you like CHM to offer? (Check all that apply.)

___ Stop-Smoking Classes
___ Movement & Exercise Program
___ Access to exercise equipment
___ Dealing-With-Stress Classes
___ Diabetes Support Group
___ Other_____
___ Weight Management Classes
___ Classes on Nutrition and Cooking for Healthy Living
___ Grief Recovery Support Group
___ Addiction Recovery Classes

16) In addition to the basic healthcare CHM now provides, what additional medical services *or* referral arrangements do you feel CHM should offer? (Check all that apply.)

___ X-Ray
___ Dermatology (Skin Care)
___ Cardiology (Heart Health)
___ Orthopedics (Bone Care)
___ Urinary and Digestive Systems
___ Vision Care
___ Dental (Oral Health)
___ Mental and Emotional Health
___ Other _____

Instructions: *Check only the answer that best fits your overall experience as a Guest of CHM.*

	Yes – absolutely!	**Yes – hopefully**	**Unsure**	**No – thank you**	**No – no way!**
17) I would attend a prayer group hosted by CHM.	☐	☐	☐	☐	☐
18) I would attend a Bible reading group hosted by CHM.	☐	☐	☐	☐	☐
19) I would fill out prayer cards provided in the waiting area.	☐	☐	☐	☐	☐
20) I would attend a recovery support group meeting hosted by CHM.	☐	☐	☐	☐	☐

Turn page over. Questions are on both sides of the page.

21) Please use the space below to offer comments or advice about how the services of CHM may be improved or expanded.

22) The following section is optional, but will provide CHM valuable information. Please tell us about yourself, but do *not* write your name:

- In what town or community do you live *or* live closest to? _____
- Race:

  ___ African-American ___ Hispanic

  ___ Caucasian ___ Other: _____

- Gender: ___ Male ___ Female
- Marital Status: ___ Divorced ___ Married ___ Single ___ Separated
- Employment Status: ___ Full-Time ___ Part-Time ___ Unemployed
- Gross Annual Income: ___ Over $50,000 ___ $40,000-$50,000 ___ $25,000-$40,000

  ___ $15,000-$25,000 ___ Less Than $15,000

Appendix C Survey of Board Members of CHM

Confidential Survey of Board Members for Christian Health

1. Your Experience on the Board

To begin this confidential survey please provide feedback about your experiences as a board member for Christian Health Ministry (CHM). Mark the appropriate answer for each question.

1. How long have you served as a board member for CHM?

- ○ 1 Year
- ○ 2 Years
- ○ 3 Years
- ○ 4 Years
- ○ 5 Years
- ○ 6 Years
- ○ 7 Years
- ○ 8 Years
- ○ I was a founding member of the board

2. In what areas have you served for CHM? (Mark all that apply.)

- ☐ Patient Care
- ☐ Volunteer Coordinator
- ☐ Patient Database Management
- ☐ Receptionist/Waiting Area
- ☐ Pharmacy
- ☐ Financial Advise or Management
- ☐ Legal Advise or Direction
- ☐ Fundraising
- ☐ Community or Church Relations
- ☐ Facility and Grounds

Confidential Survey of Board Members for Christian Health

2. Board Checklist

The following statements are based on basic responsibilities common to many boards. Mark the answer that best corresponds to your opinion for each statement.

1. How satisfied are you that your board completes the following job responsibilities effectively?

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	Unsure
Responsibility for the financial management is appropriately assigned.	○	○	○	○	○
Federal and state requirements for filing are met.	○	○	○	○	○
The organization is adequately insured.	○	○	○	○	○
An appropriate person is assigned to monitor legal compliance.	○	○	○	○	○
A general organizational direction for the next few years has been determined.	○	○	○	○	○
Your organization does the job it has set out to do and makes itself accountable to stakeholders.	○	○	○	○	○

2. How satisfied are you that your board completes the following job responsibilities effectively?

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	Unsure
Your board gets help when it is needed.	○	○	○	○	○
Your board recruits, trains, and retains new board members.	○	○	○	○	○
The work of the board is being well done.	○	○	○	○	○
The work of the board is organized so that volunteers with different gifts and different levels of commitment are involved.	○	○	○	○	○
The right people and community groups/organizations with which to be in contact have been identified.	○	○	○	○	○
A good climate for volunteers has been established and maintained.	○	○	○	○	○
The board is passing on a stable and sustainable organization.	○	○	○	○	○
The board is leaving a strong legacy for CHM that will continue for many years.	○	○	○	○	○

Confidential Survey of Board Members for Christian Health

3. Board Self-Assessment

Rate your assessment of the board's performance. Mark the answer that best represents your response to each statement.

1. How confident are you that, as an effective governing body, the board:

	Very confident	Confident	Not confident	Not at all confident	Unsure
Monitors financial performance and projections on a regular basis?	○	○	○	○	○
Has a strategic vision for the organization?	○	○	○	○	○
Has adopted an revenue strategy to ensure adequate resources?	○	○	○	○	○
Has a clear policy on the responsibilities of board members in fundraising?	○	○	○	○	○
Has adopted a conflict of interest policy that is discussed and followed?	○	○	○	○	○
Currently contains an appropriate range of expertise and diversity to make it an effective governing body?	○	○	○	○	○
Regularly assesses its own work?	○	○	○	○	○

2. How confident are you that most or all board members:

	Very confident	Confident	Not confident	Not at all confident	Unsure
Understand the mission and purpose of CHM?	○	○	○	○	○
Are adequately knowledgeable about the organization's programs?	○	○	○	○	○
Intentionally and routinely act as ambassadors to the community on behalf of CHM and its constituencies?	○	○	○	○	○
Follow through on commitments they have made as board members?	○	○	○	○	○
Understand the role that volunteers play in CHM?	○	○	○	○	○
Are appropriately involved in board activities?	○	○	○	○	○

Confidential Survey of Board Members for Christian Health

4. The CHM Board Right Now

The following questions explore additional perspectives you have on the current state of the board and your present experiences as a board member. Mark the responses appropriate for you.

1. Tell about your satisfaction with board's present activities and practices.

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	Unsure
Frequency of board meetings?	○	○	○	○	○
Productivity and purpose of board meetings?	○	○	○	○	○
Current size of the board?	○	○	○	○	○
The overall effectiveness of the board leadership?	○	○	○	○	○

2. How satisfied are you with your current function(s) on the board?

- ○ Very satisfied
- ○ Satisfied
- ○ Unsatisfied
- ○ Very unsatisfied
- ○ Unsure

3. Have you ever given financially to CHM?

○ Yes ○ No

4. Do you plan to make one or more financial gifts to CHM in the near future?

- ○ Yes
- ○ No
- ○ Unsure

5. When is your board membership commitment concluded? (Type the approximate month and year in the corresponding boxes below.)

Month
Year

Confidential Survey of Board Members for Christian Health

6. Do you wish to continue to serve again on the board -- beyond the current term (if the by-laws allow)?

- ○ Yes
- ○ No
- ○ Unsure

Confidential Survey of Board Members for Christian Health

5. The Future of CHM

The following questions ask for your opinion on the future of CHM.

1. Indicate the three areas of service that you think are CHM's greatest strengths. (Please mark only three.)

- ☐ Scheduling and front desk service
- ☐ Patient medical care
- ☐ Wellness and Prevention
- ☐ Pharmaceutical services
- ☐ Record keeping and database management
- ☐ Relationship with patients
- ☐ Overt spiritual emphasis
- ☐ Volunteer support base
- ☐ Financial stability or growth
- ☐ Leadership of board of directors

Other (please specify)

2. Indicate the three areas of service you believe are CHM's greatest weaknesses. (Please mark only three.)

- ☐ Scheduling and front desk service
- ☐ Patient medical care
- ☐ Wellness and Prevention
- ☐ Pharmaceutical services
- ☐ Record keeping and database management
- ☐ Relationship with patients
- ☐ Overt spiritual emphasis
- ☐ Volunteer support base
- ☐ Financial stability or growth
- ☐ Leadership of board of directors

Other (please specify)

Confidential Survey of Board Members for Christian Health

6. Your Comments

This is the last page of the survey! The following questions invite your comments. This is a confidential questionnaire, so please be specific and detailed. Type your response in the box following each question. Use as much space as needed.

1. What information would you like to help you better serve as a board member (for example, information about CHM, healthcare for the uninsured, nonprofit management, nonprofit boards, etc.)? (Use as much space as needed.)

2. When you joined the board, did you have ideas on how you would help CHM that haven't happened? If so, tell about your ideas in the box below. (Use as much space as needed.)

3. What do you like best about the board's current role and work? (Use as much space as needed.)

4. Describe how the board's role and work may need to change or improve. (Use as much space as needed.)

Appendix D Survey of Volunteers of CHM

Confidential Survey of Volunteers for Christian Health Ministry,

1. CHM and You

To begin this confidential survey of volunteers of Christian Health Ministry (CHM), please answer questions about your association with CHM. Mark the appropriate answer for each question or statement. Remember, your identity remains anonymous.

1. How did you first become a volunteer with CHM?

- ○ Church
- ○ Workplace
- ○ As a Patient
- ○ A Friend Introduced Me to CHM

Other (please specify)

2. What year(s) did you volunteer with CHM? (Mark all that apply.)

- ☐ 2000
- ☐ 2001
- ☐ 2002
- ☐ 2003
- ☐ 2004
- ☐ 2005
- ☐ 2006
- ☐ 2007
- ☐ 2008
- ☐ 2009

3. Approximately how many total times did you serve?

- ○ 1-2 times
- ○ 3-4 times
- ○ 5-7 times
- ○ More than 7 times

Confidential Survey of Volunteers for Christian Health Ministry,

4. In what role(s) did you serve as a volunteer? (Mark all that apply.)

- ☐ Receptionist
- ☐ Waiting Room Greeter
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Pharmacy Tech
- ☐ Pharmacist
- ☐ Data Entry
- ☐ Volunteer Coordinator
- ☐ Administration

Other (please specify)

Confidential Survey of Volunteers for Christian Health Ministry,

2. CHM and You - continued

Mark the appropriate answer for each statement or question.

1. Select the primary reason you volunteered at CHM? (Select only one answer.)

- I believe the church's mission includes a ministry to both spirit and body.
- My employer or school encourages volunteerism.
- The church is called to bring good news to the poor and hurting.
- I value CHM because I know first hand the challenges of living without health insurance.

Other (please specify)

2. Have you contributed financially to CHM?

Yes No

3. Do you plan to make a financial gift to CHM in the future?

Yes No Unsure

Confidential Survey of Volunteers for Christian Health Ministry,

3. Your Experience with CHM

Instructions: Select the answer that best represents how you feel about each of the following statements.

1. During my volunteer experience at I felt that CHM:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure
Provided adequate orientation, tools, and support.	○	○	○	○	○
Communicated clearly about my role.	○	○	○	○	○
Properly addressed any problems that arose.	○	○	○	○	○
Appropriately represented Christ.	○	○	○	○	○
Provided an overall positive experience for me.	○	○	○	○	○
Satisfactorily communicated its successes or needs through emails or newsletters.	○	○	○	○	○

2. As a result of my volunteer experience with CHM,

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure
I intend to volunteer again with CHM.	○	○	○	○	○
I will recommend to others that they volunteer at CHM.	○	○	○	○	○

Confidential Survey of Volunteers for Christian Health Ministry,

4. Your Comments

The next three questions ask for your confidential comments about your experience with CHM. Make your answers as specific, honest, and detailed as possible. Use as much space as you need.

1. What aspects of your volunteer experience did you like best?

2. What aspects of your volunteer experience did you like least?

3. To help CHM volunteers better serve in the future, how might CHM improve the experiences of volunteers like you?

Confidential Survey of Volunteers for Christian Health Ministry,

5. About You

You're almost done with this confidential survey! The next section provides CHM valuable information about CHM volunteers. Please tell us about yourself.

1. Select the town or community you live in or near.

- ○ Bald Knob
- ○ Beebe
- ○ Judsonia
- ○ Kensett
- ○ Pangburn
- ○ Rosebud
- ○ Searcy

Other (please specify)

2. Select your gender.

- ○ Female
- ○ Male

3. Select your employment status.

- ○ Full-time
- ○ Part-time
- ○ Student
- ○ Not employed

If you are employed, in what field do you work? (for example, retail, manufacturing, healthcare, education, etc.)

4. Are you a part of a congregation?

- ○ Yes
- ○ No

If Yes, what is the name of the congregation?

Appendix E Survey of Partners of CHM

Confidential Survey of Partners with Christian Health Ministry, Inc.

1. Your Partnership with CHM

To begin your confidential survey, tell us what you think about your or your organization's experiences as a partner with Christian Health Ministry, Inc. Mark the appropriate answer for each question. Remember that the identity of survey participants is confidential.

1. Indicate the kind of partner are you or your organization:

- ○ Church
- ○ Healthcare provider
- ○ Healthcare organization (non-provider)
- ○ Business (non-medical)
- ○ Individual

Other (please specify)

2. What year(s) have you or your organization served as a partner with CHM? (Mark all that apply.)

- ☐ 2000
- ☐ 2001
- ☐ 2002
- ☐ 2003
- ☐ 2004
- ☐ 2005
- ☐ 2006
- ☐ 2007
- ☐ 2008
- ☐ 2009

3. How many times have you or members of your organization visited CHM during Sunday clinic hours?

- ○ One time
- ○ Two or three times
- ○ Four or more times
- ○ No one from our organization has visited CHM during clinic hours

Confidential Survey of Partners with Christian Health Ministry, Inc.

4. What kind(s) of support do you or your organization provide CHM? (Mark all that apply.)

- [ ] Financial support
- [ ] A source for one or more volunteers
- [ ] Medical services at reduced or no cost
- [ ] Medical supplies
- [ ] Pharmaceutical supplies
- [ ] Other supplies or in-kind gifts
- [ ] Technical support (IT, medical, pharmaceutical, etc.)

Other (please specify)

Confidential Survey of Partners with Christian Health Ministry, Inc.

2. Your Experience with CHM

Select the answer that best represents how you and/or members of your organization feel about each of the following statements.

1. Based on my or my organization's experiences as a partner with CHM, I feel that

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure
CHM clearly explains my role as a partner.	○	○	○	○	○
Any problems or questions that arise regarding my partnership are properly addressed.	○	○	○	○	○
During my time as a partner CHM seems to appropriately represent Christ.	○	○	○	○	○
CHM's communication with me (through phone, email, or newsletter) is satisfactory.	○	○	○	○	○
My overall experience as a partner with CHM is positive.	○	○	○	○	○
I intend to continue my partnership with CHM.	○	○	○	○	○
I will recommend to others that they partner with CHM.	○	○	○	○	○

Confidential Survey of Partners with Christian Health Ministry, Inc.

3. Your Comments

The next four questions of your confidential survey ask for your comments. Make your answers as specific, honest, and detailed as possible. Use as much space as needed.

1. Why do you partner with CHM?

2. What do you like best about your partnership with CHM?

3. What do you like least about your partnership with CHM?

4. How might your partnership with CHM be improved or expanded?

Confidential Survey of Partners with Christian Health Ministry, Inc.

4. Communication from CHM

In the last two questions below you may tell us how to maintain or improve our communication with partners like you.

1. What are your preferred ways to receive communication from CHM? (Mark all that apply.)

- ☐ Email or E-newsletter
- ☐ Phone call
- ☐ CHM website
- ☐ Newsletter in the mail
- ☐ Personal visit

Other (please specify)

2. What information about CHM would you like to know? (Mark all that apply.)

- ☐ Testimonies and stories
- ☐ Statistics on services
- ☐ Financial summaries
- ☐ Photographs
- ☐ Videos

Other (please specify)

Appendix F Sample Physician Interview Questions

The Mission and Leadership of CHM
Interview Questions for MD Board Members

I'm visiting with you today because you are both a board member and a physician. I invite you to talk about CHM from both roles in play at CHM.

Introduction

1. How long have you served on the board?

2. In what areas of CHM have you served?

History

3. In your own words, what was the mission of CHM at its inception?

4. Based on that initial mission, has CHM succeeded? How or Why not?

5. Looking back, what role did the board play in achieving that success?

6. In what areas did CHM fall short of the initial mission?

Present

7. Consider the present day activities of CHM (not intent, but activities): how has the mission changed?
8. How satisfied are you with the present mission of CHM? Explain.

9. What concerns do you have about the present mission and CHM's capacity to pursue the mission?

Future

10. Describe what you believe may be the best mission of CHM in the future.
11. How will CHM and its board need to adjust or change to move successfully into the future you see for CHM?

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #1: Mission Outreach of Northeast Arkansas, Inc.	Clinic #2: Shepherd's Hope Neighborhood Health Clinic	Clinic #3: Eureka Springs Christian Health Clinic	Clinic #4: The Christian Health Center of Heber Springs, Inc.	Clinic #5: Good Samaritan Clinic
Location and Website	Paragould, AR http://www.missionoutreachnea.com/index.htm	Little Rock, AR http://shepherdshopelr.org/	Eureka Springs, AR http://echofreeclinic.org/	Heber Springs, AR http://www.chcheberspring.org/	Ft. Smith, AR www.good-sam-clinic.net
Interviewee					
Name, Contact Information, and Role	Heather Parson Assistant Director of Mission and Clinic Administrator hparson@missionoutreachnea.com 870-236-8080 Ext. 304 (Office) 870.240.3210 (Cell)	Pam Ferguson Volunteer Coordinator pam@shepherdshopelr.org 870.260.6171 (Cell) 501.614.9523 (Clinic) Mike Ferguson, Husband and Executive Director	Suzie Bell Clinic Administrator echo@hbeark.com 479.253.5547 (Office) 4004 E Van Buren Eureka Springs, AR 72632 479-253-5547 (Office) 479-363-6200 (Fax) clinicadministrator@echofreeclinic.org	Dr. Bill Wells Retired physician Medical Director President of Board Frmr Pres of Board of AACC panacea@suddenlink.net 501.362.3292 (Home) 501.362.2252 (Clinic)	Brenda Hook Clinic Manager Good Samaritan Clinic 615 North B Street Ft. Smith, AR 72901 Phone: 479.783.0233 Fax: 479.494.7248 brenda@goodsamaritanclinic.net
Date of Phone Interview	November 12, 2009 via phone 9:45a-10:40a	November 11, 2009 via phone 4:30-5:15p	Thursday, November 19, 2009 via email November 20, 2009 9:00-9:25am	November 10, 2009 via phone 12:20p-1:05p	Friday, November 20, 2009 via phone November 23, 2009 via Email
Operations					
Start Date	Clinic opened in September 2007 Mission Started in 1982	August 2006	November 2005	August 2001	Clinic began 1988 July 2003 became a 5 day/week clinic
Who served	Adults19 years and over in NE AR having no insurance and < 150% of federal poverty guidelines; almost all white race; a few African Americans drive over from Trumann, AR	Based on income of those who live in 72204 zip code of "Midtown area" with boundaries of I-630, Asher, University, and Woodard St.. The uninsured and working poor. Primarily African-Americans, though Hispanic population visiting clinic up 80%, "crowding out local Af-Am population; trying to address this issue by starting new clinic for Hispanic to open Feb 2010 in SW Little Rock to be operated by a different organization;	A faith-based clinic for uninsured, low income adults You qualify for clinic services if you * do not have any medical insurance, including Medicaid and Medicare * have household income that falls below 125% of the Federal poverty guidelines	19-64 yr old adults without insurance and having HH income of < 200% of federal poverty guidelines	Primarily serve working uninsured adults base on household size and income.
Services Provided	Provide primary medical care Smoking secession classes Diabetes education patient by patient Dental services by referral (5 dentists see 1 patient/month) conducting only extraction procedures in case of abscessed teeth Lab on site to draw blood; tests conducted at hospital PAP open daily to community provided by partner, Crowley's Ridge Rural Health Coalition, which maintains office at Mission. Pharmacy open each clinic night and 1 other day to process orders; directed by retired pharmacist Launched with an interest to help patients avoid bad and expensive experiences of receiving care at ER	Pharmacy licensed to receive donated meds from nursing home; requires that clinic ask patient for proof of income to receive meds (or have proof on file) based on <200% of federal poverty guidelines based on household size. Provide interpreters for Spanish-speaking clients. First come, first serve with 20 patient slots per night. Ask patients for verification of address to give priority to neighborhood residents Dental clinic to open – a 2 Chair full clinic – by January 2010. Facilities: OFUMC bought house next door and offered to clinic a 5 yr, $1/year lease, expanding clinic to two buildings, now with breezeway connecting. MRI = donates 2 MRIs/month Podiatrist = 1 patient / week Physical Therapist = as needed X-Rays = physician "completes it pro bono" Quest = donates lab work with 40-50 blood tests/month and 25-30 other tests/month Physicians charge 1/3 costs with long payment plan "Small pharmacy" write prescriptions off the $4 list or on a PAP	Mission Stmt: Joyfully provide the best health care possible to individuals in need, so that all feel God's love through the experience. Vision Stmt: Establish & operate long term a faith-based, ecumenical free health clinic for those in need, staffed by volunteers, that brings glory to God and wins souls for Christ. "At our new clinic we will be operating by appointments," explained Clinic Administrator Suzie Bell. "Our office will be open every Tuesday and Thursday of every week from 1:00 p.m. to 4:00 p.m. to process eligibility. This new process begins this week. So Patients will need to call beforehand, arrange for an appointment to be seen, and work out out all eligibility issues before clinic nights. This will take a bit of effort initially but will streamline the clinic nights and cut down on waiting time at the clinic." **Medical Care** Physician Evaluation & Treatment Routine Laboratory Tests Diabetes Care Vouchers for Necessary Tests Off-Site Vouchers for Physical Therapy **Medication Assistance** Pharmacy On-Site Patient Assistance Program (PAP)	1. CHC "provides basic primary care services for the uninsured adults living in and around Cleburne County" including basic medical, mental health, pastoral, laboratory services, and medications. 2. Soon to begin: apply new Tobacco Tax Grant toward purchase of dental services. 3. Referrals as needed on case-by-case basis. 4. Laboratory services and x-rays: Prior to Baptist governance, hospital administrator agreed to provide $400/month in lab work and x-ray *charges* (not hospital costs). Confusion resulted regarding $400 hospital charges; grew to $30,000/month in hospital charges donated by hospital. Baptist governance required a reduction to now $15,000/month in hospital charges (not costs).	Provided primary healthcare and use volunteer specialist as needed, including: ENT Cardiologist OB-GYN Gastroenterology Chiropractic Ophthalmologists Optometrists No dental services since another local clinic provides dental. Pharmaceutical services include: Samples PAP with paperwork completed by volunteers (DAP and MAP?) Provide life saving meds Generic $4 list meds "We try to encourage responsibility" Lab work completed on site; draw blood; some lab equip on hand to do a variety of tests. X-Rays provided at a discounted rate Not much predetermined special services available except Ophthalmologists who sees 4-5 pts per week to charge only 10% Some specialty care accessed via the clinic doctor 'calling a friend doctor" or through hospital's charity care programs

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #1: Mission Outreach of Northeast Arkansas, Inc.	Clinic #2: Shepherd's Hope Neighborhood Health Clinic	Clinic #3: Eureka Springs Christian Health Clinic	Clinic #4: The Christian Health Center of Heber Springs, Inc.	Clinic #5: Good Samaritan Clinic
			Arkansas Health Care Access Foundation (AHCAF) **Spanish Translation Aid** **Community Resources** Counseling Social Work Assistance Agency Referral **Spiritual Services** Prayer Team Local Clergy **Free Hot Meal** Supplied by local churches and organizations **Child Care**		
When	1st and 3rd Thursday 6-9pm plus one other day for pharm to process orders	Basic family practice every Thursday evening with 1st and 3rd Tuesday as follow up clinic and 2nd and 4th Tuesday as women's OB/GYN nights	Tuesday and Thursday evenings	**Clinic:** Thursdays 6p-10p of scheduled clinics to see provider or mental health counselor **"Refill Clinic":** Pharm open 1st and 3rd Tues **Diabetes Clinic:** soon to begin on one Tues/month with pharm, diabetes clinician, 2 physicians	Good Samaritan Clinic is open 8:00 am – 5:00 pm, Monday through Friday, with extended hours on most Tuesday evenings until 7:00 pm.
Patient Fees (see explanation below)	No fees	No fees The Good Samaritan Act prohibits charging a fee; accept donations from "a few"	No fees	No fees; request non-required $5 administrative fee	Fee charged after services rendered based on household size and income; fees range from $5 to $35. $7 charge for first visit. Most patients pay only $5 per visit. Accounting tracks amounts owed by patients.
Data collected	Demographics Contact information Household income verification Form to/from DHS that verifies income/benefits (that they don't receive or qualify for Medicaid) reviewed annually Dates of clinic visits Diagnosis entered into Access Database (do not use diagnostic codes); Track referrals and services provided Pharmaceutical information Dept of Health grant just received to purchase new software to process medical records, incudes pharmacy software	Zip Codes Primary Illnesses (no codes used) Patient information/demographics Income level Liability release Medical history	Uses DataNet Services Software for Financial Records Status Demograhics SS Card DL# Medical Bkgd Social history (social worker available) Use diagnostic codes Record referrals Scan records	1. Patient demographics 2. Patient contact information 3. Visit dates and number of visits 4. At least one diagnosis by Code 5. Track smokers and success of cession plans 6. Referrals 7. Use of hospital lab and x-ray services	Use an "antiquated" database from 2003; plan to buy a program soon to track medical records and use medical codes.
Number served in 2008	In 2009 – as of 11/12/09: Visits: 883 Rx: 2457 2008: Visits: 903 Rx: 1790 Medications prescribed: 6000-8000 / month	In 2008: 170 patient visits/month 65 new patients/month Now hold over 1000 patient files	Since mid-2003, the Clinic has treated more than 8,000 patients.	Patients served: 760 Patient visits: 3000	2009: 1800-2000 patients on file/year 600 average patient visits per month (2008 stats not applicable since no one working full time during first 6 months of 2008)
Staff					
Roles	Consider themselves an "all –volunteer staff" since clinic pays no staff; Office staff service clinic T/W/Thurs in afternoons Heather is considered a clinic volunteer Chief of Nursing at Hospital serves as medical staff director to coordinate medical staff	All Volunteer staff. Started by 2 physicians after attending a Chicago seminar; finances forced them to choose an all-volunteer organizational system rotating doctors Since August 2008, Pam serves as Clinic Director and Volunteer Coordinator overseeing "every aspect" of clinic including	All-volunteer staff. See website for details of roles and responsibilities. Each area of responsibility has a team leader and an assistant. Teams leaders meet quarterly to problem-solve, address issues, brainstorm. Clinic administrator holds ultimate organization authority ("has the final say") regarding operations and volunteer staff. We follow a "chain-of-command approach." Organization is "staff-driven."	All-volunteer staff: Medical Director (physician) Clinic Manager 4 Volunteer Coordinators ** All volunteer organization first chosen "for financial reasons."*	Paid Staff Include: Clinic Manager (FT): I oversee all operations of the Clinic. Personnel, fundraising, volunteers, grant-writing, public relations, etc. Top paid staff. Receptionists (2 FT): Receptionists schedule appointments, review financial information to determine if someone qualifies to be a patient, check-out patients/accept payments. 1 Phlebotomist (FT) (lab tech?): Draws blood,

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	schedule for clinic; Pharmacist Director Heather: Coordinates volunteer pharmacy workers and "lay volunteers"	fund raising. Contributes approximately 60 volunteer hours per week. Husband, Mike, on staff at FBC, is the Exec Dir with one weekday dedicated to the clinic. Day to day operations led by Leadership Team of 6-8: 1-2 Doctors 1-2 RNs 1 Pharmacist Phar coordinator Office coordinator Executive Director Staff roles: 1. Volunteer and Clinic Director 2. Medical Director 3. Exec Director 4. Facility Director = a physician	Intend to hire a full-time clinic administrator sometime in the future. Team leader meetings must involve collaboration and listening		performs EKG's, has significant "other duties as required" – check pt in / out; conduct pt history. Registered Nurses (2 PT): Schedule visits outside clinic with other providers, assist with patients, answer phone questions from patients, etc. LPN (1 FT): Assists medical providers, oversees volunteer nurses. Donor Relations Coordinator (PT): Posts donations, mails Thank You letter/card and receipt within 24 -48 hours of GSC receiving donation, etc. Most medical care is provided on paid contract basis with local AHEC clinic. Faculty and resident physicians provide care 4 ½ days per week.
Sources	Hospital; medical community; Mission; congregations	FBC Work of mouth in Christian community	Area churches, organizations, and businesses	Christian community	Most medical care is provided on paid contract basis with local AHEC clinic.
Strengths	Not asked	Evident passion Involvement limited to 1 night or 3 hours / month	Paid staff is good because they can and will accept decision making responsibilities Volunteer staff strength is they want to be there	Low organizational overhead "Don't need [staff]."	In our case, as a 5-day-a-week clinic, it would be impossible to adequately staff a clinic exclusively with volunteers. Even when GSC started and had a paid Executive Director and paid Medical Director, it was difficult to have adequate nursing staff. We have one "daily" office volunteer who has been here for 6 ½ years every day. That is rare….. GSC briefly (for only about 2 months after opening in July 2003) had a paid ED and MD. From that, went to Office Manager, one nurse, one lab tech. Then hired another part-time nurse and a bilingual receptionist. Next staff was paid part-time Donor Relations Coordinator (to ensure donors were kept happy!!). Having a certain amount of paid staff ensures continuity of care for our patients. Everyone except the current Donor Relations person has been here for at least 3 ½ years… They know the patients well.
Weaknesses	Not asked	Difficulty maintaining the continuity and adequacy of office procedures of filing, record keeping, etc.	Matter of commitment "cuts both ways;" only commitment keeps them there and personal commitments can change from day to day, month to month All volunteer org can lack stability Hard to "stay on top of" grant writing.	1. Difficult to train volunteers on technical aspects of clinic (including database entry); 2. Recruitment and coordination of volunteers difficult to maintain; 3. Loss of potential funds: Robert Wood Johnson Foundation denied request because CHC has no full-time paid staff. Wells: "They [RWJF] believe a clinic like ours should have dedicated staff. And I suppose they are right."	See above for implications of answers. Otherwise, this question *not asked.*
Board					
Number	Up to 15; currently 14	Currently 6 members with representation from sponsoring churches: 3 FBC and 3 OFUMC	12	19	Up to 30. Currently 23 serve.
Role and Responsibilities	A governing board Guides both the Mission and Clinic Working board w/ committees: Executive Public Relations Finances Human Resources Projects and Services	Not required to give money Represent their congregation Provide wisdom for fundraising, vision, mission	Actively volunteer. Provide leadership. Make financial contributions. Be Christian and prayerful. Each mbr in charge of a different committee: "public relations, fundraising, operations, hospitality, etc." Meet quarterly to focus on "big picture" of clinic.	Broad strategic decision making and financial oversight	Unfortunately, our board meets monthly but most are not active. Many have not been inside the Clinic more than once or possibly twice. Only a couple are actually volunteers during our hours of operation.

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

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		Since August 2008, budget is $1700/month.	Opened a new thrift store to supplement revenue to clinic. See http://www.carrollconews.com/story/1591274.html		
Economic Impact	None measured	None measured	"Definitely keeping ER visits down…the hospital is very happy." Cf David Wheeler in E.S., AR	Provided $1.5 in medications in first 10 months of 2009, equivalent to $45,000 in out of pocket medication expenses	We haven't formally measured the economic impact.
Dollar of service per donated dollar	None measured	None measured	None measured	Estimate that for every donated dollar CHC provides $10-15 of medical or mental health care (combined estimated cost of time of provider plus estimated cost of medications)	None measured
Other comments	XX	XX	"We desire to be self-sufficient in the future and even support mission health care across the globe." Renovating new facility	XX	XX
Spiritual services/Christian faith shared					
How might personnel overtly communicate (verbally) their Christian faith? Via Email February 8, 2010.	At Mission Outreach Charitable Clinic, we have a pastor come each clinic and do a short devotion. Then, as patients are triaged they are asked if they would like to pray or talk to the pastor.	Shepherd's Hope does not have a written clinic philosophy about sharing our faith. Our mission is to serve the people of MidTown, Little Rock, spiritually, mentally and physically. So you see it leaves our avenues of sharing wide open. As ministry partners, we are all reminded each clinic day, through prayer, that we are to REFLECT Christ to everyone we come in contact with at the clinic. Our staff is encouraged to interact as the Lord leads them to talk, hug, pray etc. with each patient. They are encouraged to be "Jesus with skin on" to the patients. As the nurses take the reason for their visit, they will normally come to me and let me know if someone seems very burdened. If the nurse is comfortable speaking with them, then I encourage them to take the lead. If not, I will go in and ask if I can pray for them and their family. (I have never been rejected.) This opens the door for discussion. I allow the Lord to lead the way in the discussion. Sometimes the situation will call for a followup outside the clinic. We have a retired pastor that will make visits into their homes or take them for breakfast on a Saturday morning. Sometimes the situation will call for us connecting the patient to the Celebrate Recovery at Fellowship Bible Church. We have had several people attend and really be blessed with this resource. See above: Counselor on staff	It is our policy to not get "in your face" about God to people when they come to the clinic. With that being siad, we have prayer teams that are there praying during the entire clinic. Every patient knows that. There are prayer request forms at every table that may be filled out - nopressure. There is always a pastor on clinic night who simply blesses the food and tells people he or she is there for the evening if any one wants to come and visit. Patients understand they can go to the prayer room and pray with some or one of the prayer team members. They are identified by their name tag being a blue color as opposed to the white of the regular volunteers. As we personally interact with patients it is a natural response to give God glory for the clinic or anything that we happen to be conversing about. But it is never pushed. We invite people to church only if the occasion occurs naturally and comfortably. More than anything, we let them know we are there because God loves us and we are called to serve. Patients say over and over they never feel pushed or forced in anyway. Our intent is to show the love of Christ in action	We do not have a clinic policy (philosophy) regarding the personal interaction between providers and patients. That is pretty much left up to the individual. However, we do have a clinic policy established by our ecumenical board of directors that professing Christian faith or being overtly recruited to profess Christian belief is NOT a requirement for patient care at the clinic. We have a minister from our local ministerial alliance (or any Christian minister who wants to volunteer) present during each clinic session. We make known to each patient that ministerial counseling is available. Many of the ministers offer a small sermonette and/or a prayer once an hour during the evening. Most of us feel that actions speak louder than words and that as we treat all comers in a Christ-like, humane manner, we are conveying to them that Christianity is not such a bad deal. The patient has one on one contact with an interviewer (new patients only), clinic nurse during triage, providers during the medical visit, pharmacy staff when receiving medications, clerks when signing in and when making appointments for future visits. Our clinic personnel MIGHT communicate their personal beliefs during these times of contact, but I doubt that that happens very often. This is a very individual thing and , of course, would depend on the individual and their level of comfort in discussing religion with anyone. Short answer: No clinic policy that either dictates or restricts what the individual volunteer might share with a patient, except to be very clear that profession of faith is NOT a requirement for care.	No response
Values					
	Not asked	Not asked		Not addressed in visit	Not asked
References					
	Not asked	Not asked		Not addressed in visit	Not asked

* Regarding the NO FEE: Like many states, AR provides some shelter from liability when healthcare professionals provide voluntary care in the context of a charitable organization that provides services to those unable to pay.

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
Location and Website	Memphis, Tennessee http://www.churchhealthcenter.org/ http://www.hopeandhealing.org/	Dallas, TX http://www.CentralDallasMinistries.org	Dallas, TX http://www.baylorhealth.edu/bestcare/healthequity.htm
Interviewee			
Name, Contact Information, and Role	Linda Nelson Special Assistant to Executive Director Church Health Center 901.272.7170 ext. 1404 April Crowder Church Health Center of Memphis Assistant Director of Integrated Health - Clinic 1196 Peabody Avenue Memphis TN , 38104 901-272-0010 Ext. 1141 (work) 901-301-1641 (cell)	Keith A. Ackerman, LMSW VP of Community Services & COO Central Dallas Ministries 409 N. Haskell Avenue Dallas, TX 75246 Office: (214) 823-8710 x119 FAX: (214) 824-5355 www.CentralDallasMinistries.org KAckerman@centraldallasministries.org Oversees healthcare, food, central operations at CDM	Adam Chabira, Administrator Office of Health Equity 972.860.8681 (Office) AdamCh@BaylorHealth.edu *Cynthia Araceli Solis* Administrative Assistant Baylor Health Care System Office of Health Equity 8080 North Central Expressway Suite 1700, LB 83 Dallas, Texas 75206 P: 972.860.8629 F: 972.860.8601 cynthiso@baylorhealth.edu
Date of Phone Interview	Replication Seminar 6/25-26/2009;	November 20, 2009 via phone 2-3pm	November 19, 2009 10-11a
Operations			
Start Date	1987	CDM started 21 years ago; began providing some form of service the first year	See narrative below
Who served	Mission: CHC seeks to reclaim the Biblical and historical commitment of the Church to care for the poor who are sick. "Does CHC exist to serve the underserved? No, but to provide a place for the people of faith to participate in the healthcare of others. This is key!" (Mike Sturdivant, RN and Dir of Integrated Health and Frmr Dir of Clinic). CHC provides quality and affordable comprehensive healthcare and education to the growing number of working poor, homeless, children, and elderly of Memphis. The center began as a clinic, but not as a *free* clinic, for the working poor. CHC worked with the whole patient – body, mind, and spirit. Patient Requirements **Requirements to be a walk-in patient** You must be uninsured and need immediate care. **Requirements to be an established patient** You must live in Shelby County. If you are age 17 or younger or are still in high school, you must be uninsured or have TLC TennCare. If you are 18 or older, you must be working and uninsured. Men must work at least 30 hours per week. Women must work at least 20 hours per week. If you are the sole care-giving parent of a child six years old or younger, you do not have to meet the work requirements. Those who are homeless may also qualify to become patients.	80% Hispanic females Spanish speaking only; other 20% Afr-Am, White, Asian; many pts undocumented;	See narrative below
Services Provided	Center is open at night and weekends to provide: Primary healthcare, dentistry, optometry, pastoral counseling and psychiatry, physical therapy, social services, health education, and dispensary. The Center has grown to become the largest faith-based clinic of its type in the country. Currently, we care for 50,000 patients of record without relying on government funding. A no-appointment walk-in clinic with a set fee for minor illnesses. The MEMPHIS Plan is an employer-sponsored healthcare plan for small business and the self-employed. By relying on donated services from volunteer doctors and area hospitals and laboratories, the MEMPHIS Plan offers uninsured people in lower-wage jobs access to quality, affordable healthcare.. Faith community outreach provides the support, consultation and education	Services include medical, dental and pediatric care for low-income, uninsured people who would otherwise go without care or rely on local Emergency Departments (EDs) for care. Provide family practice/general practice medicine; we are a "chronic disease management clinic." Provide wellness education: Family Night to include cooking, parenting, relaxation; dietician, crock pot cooking, etc. Dance lessons, walking clubls, salsa lessons; Class D Pharm: Partnership with AmerisourceBergen http://www.amerisourcebergendrug.com/ a pharm wholesaler	See narrative below Pharmacy uses funding to provide meds not available through low cost programs; use generic formularies; administer PAP

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Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
	to start or strengthen health ministries in congregations. Wellness ministry called Hope and Healing now offers everything from personalized exercise plans and cooking classes to group exercise classes and activities for children and teens. CHC Wellness is open to the entire community with fees charged on a sliding scale based on family size and income. Dispensary: PAP $245,000/month		
When	Walk-in clinic for acute care walk-ins: 1st come 1st serve 7a-Noon; "Open Access" = we'll see you today or tomorrow for urgent or emergent need; include walk-in uninsured pts and established pts. Center open 7 days per week 7a to 9:3pm; available services vary by day; 5:30-9:00pm staffed by volunteers on a 1:1 ratio 2 to 3 times per month; we don't ask vol to do too much.	5 days/week M/W/F 9-5 T/Th 9-7:30pm	See narrative below
Patient Fees	Fees are charged on a sliding scale based on income. The average visit costs about $20. No Medicare or Medicaid accepted. Most pts are self-pay. "We're not free, just affordable."	Not answered	Not answered
Data collected	"We look at both visit data and A/R data monthly. I will attach a copy of our monthly dashboard report. We also look at demographic data elements on a regular basis. The demographic data we look at most often is Age, Gender, Race, % of poverty level figured using household size and income, and insurance status. We have done patient surveys on occasion and I also attached the last survey form that we used. I am not sure about staff, volunteer, or other shareholder surveys, as I am not involved in that area. Linda may be able to dig that information up for you however." – April Crowder, via email 7/29/09 Electronic records system has its pos and neg. Use HER practice management system (Cerner; Kansas City, KS); cf. alos QSI which owns NextGen and includes dental and medical.	Measurement and Use of Healthcare Outcomes is critical Examples of healthcare indicators might be: reduction of diabetic symptoms or events; less dependence upon meds for hypertension; use the Quality of Life Matrix, the Gold Standard for United Way funding, that is concerned with evaluating everything between outputs and outcomes. Cf: http://www.uic.edu/orgs/qli/ http://www.unitedwaydallas.org/united2020/Health.html	See narrative below
Number served in 2008	About 50,000 patients on record About 36,000 patient visits per year Over 100,000 visits to the Hope and Healing Center are recorded annually Over 4000 individuals on The MEMPHIS Plan **April-June 2009 Visits** Medical 7183 Dental 1499 Optometry 352 Counseling 725 Getting Started 856 (new regular patients) Social Work Contacts 370 Physical Therapy 591 "New patient demands are up 70% in last 9 months [because of job and hour reduction in weak economy." – Scott Morris 7/25/09	Presently, 2009: 2000 patients used CDM as their "medical home." Website states that CDM "expects to host over 17,000 patient visits in 2009"	See narrative below
Staff			
Roles	Clinic staff includes (not an inclusive list!): Medical Director 5 Physicians offering 24-40 hours/wk of care 1 Nurse Practicioner 8 RNs Business or Financial mgr preferred early in org history Legal and technical roles Fundraising and Volunteer coordination: have 10 staff members in "Development" Argue for salaries and benefits to be set at market rate to promote longevity and stability and high quality, not adopt an organizational mentality that "this is ministry" so salaries should be kept low.	most staff bilingual With a team of three full-time doctors supported by a staff of nearly 20 other medical professionals	See narrative below

Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
	Dispensary: 1 staff to procure plus 10-12 volunteers Paid Medical Assistant key to relationship with volunteer physicians. "[Paid] staff exists to serve patients, volunteers, and donors." Staff roles required: Passionate leader Providers Board: passionate, functioning, involved, advocates Receptionist Administration Fundraising		
Sources	Not asked	Not answered	See narrative below
Strengths	Not asked	Not answered	Not answered
Weaknesses	Not asked	Not answered	Not answered
Board			
Number	Up to 25; prefer size of 15-17 members	Not answered	Not answered
Role and Responsibilities	"Support the work of the called people." "Have ultimate fiduciary responsibility." A functional board – about getting job done, not about names, notoriety. Does NOT raise money, but they DO give money and do work for CHM. A Development Board organized to raise funds. "I assumed board members would stay on for life. So we didn't institute a rotation off policy. Losing board members risks losing institutional history/memory. First board members can be forever loyal. Today, 3 year service then take a year off, but we suspend rules when needed. Responsible for: finances, physician and dentist recruitment, human resources, insurance, church engagement Maintain a "Founding Board" or "Emeritus Directors" who hold organizational history and wisdom, meet routinely, receive minutes of meeting of Board of Directors, mentor new board members, communicate organization memory Need board members who represent medical and faith communities in their respective diversities; gov't healthcare entity; hospital reps; HR in corporate community; PR, real estate and property; accountant; Provide CHC "connections" in the medical and faith community.	Not answered	Not answered
Meetings	Quarterly	Not answered	Not answered
Relationship with staff	"Volunteers (board members) making operational decisions is a recipe for disaster." Board members don't get involved in day-to-day operations	Not answered	Not answered
Membership requirements	See above comments regarding board	Not answered	Not answered
Volunteers			
Roles and Numbers Needed	Over 600 physicians volunteer each year Every hospital and laboratory in Memphis participate More information not available.	Not answered	Not answered
Sources	Not asked	Not answered	Not answered
Total Volunteers in 2008	Not asked	Not answered	Not answered
Partners			
Kinds and Functions	Partnerships are the essence of CHC's capacity. Hospitals Medical Society Practice communities CFO's of medical organizations Retail pharmacies College or schools training healthcare professionals Other non-profit organizations – meet monthly with "safety net organizations"	Partnership with AmerisourceBergen http://www.amerisourcebergendrug.com/ a pharm wholesaler Collaborations and Partnerships are "invaluable"; must get in front of the right people; must be able to speak *their* language, including, "send your frequent flyers to us" and " here's how much we can save you" and will you give us 5% of your savings in services?" If your local hospital is a 501a, capitalize on relationships with government representatives to whom, in effect, the hospital is accountable.	Not answered

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
		Dallas County Medical Society is a major partner; broker pro-bono specialty healthcare; administer Project Access Connect with the area's Association of Charitable Clinics to participate and benefit from the network of social change agents Partners donate medical supplies and medications	
Finances			
Annual operating budget	$13 million annual budget with $7 million per year in "new asks"	CDM: $700,000 Baylor: $700,000	See CDM column
Economic Impact	One example: The MEMPHIS Plan is the Church Health Center's employer-sponsored healthcare plan for small businesses and the self-employed. However, it is not health insurance. By relying on donated services from volunteer doctors, area hospitals and laboratories, the MEMPHIS Plan offers uninsured people in lower-wage jobs access to quality, affordable healthcare. This includes primary and specialty care, hospitalization and other medical services. **The MEMPHIS Plan provides healthcare for uninsured working people who fall through the cracks of the current healthcare system** because they earn too much to qualify for state or federal programs. It also answers the need of small business owners who care about their employees but cannot afford to provide traditional health insurance. With the MEMPHIS Plan, employers can now provide an essential benefit while enhancing job productivity and retaining valued employees.	Regarding United Way organizations, see also: http://www.unitedwaydallas.org/1.3/DollarBuys.pdf Re CDM health clinic: In 2006, the Health Texas Provider Network determined that their support of our CHS program saves nearly Baylor Hospital over $203 for every patient that we see (based simply on decreased utilization of the Emergency Department).	Clinic provides a valuable "return on investment."
Dollar of service per donated dollar	Not asked.	See narrative; other relevant documents:	Not answered
Other comments	NA	Background: 1997 Jim Walton recognized "Volunteer in Medicine" with volunteers providing a few hours /wk and a few days/wk By 2003: with permanent executive loan to DCM: Three physicians 1 practice administrator, 1 NP 1 SWorker Plus medical assistances, front and back office include 15 staff members Christ Family Clinic started to serve domestic workers	Not answered
Spiritual services/Christian faith shared			
How might personnel overtly communicate (verbally) their Christian faith? Via Email February 8, 2010.	No response to emailed question.	We have Pastoral Counselors on staff during all hours of operations who are available to pray, address spiritual needs, provide case management type assistance, etc. They work closely with the Doctors to address "Whole Person" needs along with our Social Workers, Pharmacy Staff and Chronic Disease Educators.	No response
Values			
	Believe in a unity of mind, body, and spirit. Healing is a call of the church CHC seeks to reclaim the fundamental call of disciples to health the sick, not to solve the healthcare problems in the USA. Seek to engage today's church in healing ministry as a part of our answer of the call of discipleship. We are church-based and church-centered; "all about the church." We went to where the need was greatest: the working unisured poor. "If you work hard in our community, if you are digging my latrine, serving my food, cleaning my clothes…(etc.) and you get sick, we think you should get to the front of the line…If you lose your job, we'll give you at least six months to find new employment." Our standards for "working" are generally 30 hours/week for men and 20 hours/week for women		10 years ago Baylor encouraged an increase in physician volunteerism. Most chose to volunteer at Central Dallas Ministry (CDM). From these volunteer experiences led a conviction to "do more." In 2001, Baylor employed a physician to serve at CDM. Today Baylor deploys seven physicians, 1 social worker, 1 Nurse Practitioner; clinic is administered by Baylor in a 50/50 partnership with CDM: Baylor provides staff and administrative expertise; CDM provides support staff, location, and supplies. Clinic grew from introduction stage to 2 x's / week; then added physician 20 hours or more/week; then offered a regular provider presence; now provider available a minimum of 2 or 3 times / week in clinic. CDM 4 blocks from Baylor Hospital providing a convenient opportunity for

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
[redacted]			volunteerism. Began consulting relationships with non-profit and community clinics; began exploring how to replicate model of CDM partnership. Patients at CDM coming from community with little capacity to receive hospital referrals. Meantime, "no direct pipeline from hospital to clinic." Baylor Family Medicine created the Worth Street Clinic http://worthstreetclinic.com/ This clinic has a "much tighter relationship with Baylor" than CDM since 90% of [funding] comes from Baylor Hospital. This is the most expensive model for Baylor. Seek to replicate elsewhere. Expect to expand from 1 to 6 clinics in 2 years. "Worth Street Model is the future…the future of healthcare includes charitable clinics linked with hospitals." This will be combined with healthcare indicator models – from evaluation based on volume of patients served to outcomes of hospitals and providers. With this comes increased accountability. And complicated – since there are many more factors that contribute to a patient's health than the care given by hospital. Concern is forcing creative thinking…ways to serve the uninsured. Future involves a big change of charitable clinics: from "what do we do to keep the doors open?" to "what measureable effects are we having on the health of our patients?" Another example is Christ Family Clinic is a subsidiary of CDM http://www.christsfamilyclinic.org/ . Adam prefers the Baylor/CDM model b/c of the good relationships in the community; "better not to go it alone" Baylor administration helps develop solutions for clinics; "regardless of insurance [status] all patients need care." Re a 50/50 partnership, hospital asks: • does organization have the fundraising power to carry their load? • Board committed to making contribution? • Can it be a reciprocal relationship – financial support for provider, lab, imaging, etc. • How will the relationship be managed? How will patients be referred? Who will refer patients? Why types diseases/conditions will be seen at clinic? What will get most bang for the buck? Analysis includes: Reports and Assessments Institutional Matrix Pre and Post Analysis Look for increased outpatient services compared to savings in hospital admissions. Need to address specialty areas Project Access: Dallas area is largest of its kind in nation Providers pledge a predetermined number of patients Develops network or relationships Key lessons learned, per interviewee: 1. County hospitals are overwhelmed with need and bear a lot of the burden for uncompensated care; 3 facilities greater than county hospitals; out of desperation Baylor sought solutions. Environment or context forced a search for alternatives. 2. Why help? Baylor is a nonprofit; required to provide a community

SURVEY OF FAITH-BASED CLINICS, FALL 2009 Notes By Ron Cook

Organization	Clinic #6: Church Health Center	Clinic #7(a) Community Health Services Central Dallas Ministries, Inc.	Clinic #7(b) Baylor Health Care System
[redacted]			benefit. Can no longer simply claim write-offs of uncompensated care as a community benefit. Benefit is now mandated; arguable how effective and efficient simply hosting health fairs is to the community. Also, Baylor has a history as an organization with a Christian mission; Also, financial reasons constrain us to do something different since in TX 1 in 4 are uninsured – and that is probably lower than actual level of uninsured. 3. Charity clinics can help reduce the bad debt of the hospital. How? First, idea that clinics help solve overcrowding ED and costs the hospital money is largely a product of the media. Pushing or referring pts away from ED to clinic is not the way to save hospital money. Afterall, how many sore throats treated in ED are needed to effect the bottomline of the hospital? The real financial loss comes from uninsured admitted for hospital stays. Hospitals save big bucks when they avoid stays. Baylor's clinics demonstrate that they don't primarily serve sore throats but are a *medical home* to provide treatment of *chronic diseases – the "Big 4:" diabetes, COPD, heart disease and hypertension.* Baylor's clinics are moving to this philosophy of being a *medical home* not just benevolent or relief healthcare (although they do that, too). Dr Walton with Baylor 16 years; provides vision. Adam served for 4 years
References			
[redacted]	Not asked	Not asked	Not asked

Appendix H Article Announces Chamber Award to CHM

The Daily Citizen

NEWS > LOCAL

Grow business, chamber told

Published:
Tuesday, November 24, 2009 5:48 PM CST

Zook: Health care reform could set back growth

By Warren Watkins

The Daily Citizen

Small businesses are the key to Searcy's economy, a state leader in economic and community development told participants Monday at the annual fundraising banquet for the Searcy Regional Chamber of Commerce.

Attendance at the banquet, held at the Sullards Annex of Searcy High School, was 365 and keynote speaker was Randy Zook, president and chief executive officer of the Arkansas State Chamber of Commerce and Associated Industries of Arkansas.

Dr. John Henderson was honored as the medical professional of the year and the Christian Health Ministry of White County was singled out for the humanitarian of the year award.

Zook shared his views on what was happening on the national level with issues and concerns that may affect Searcy, focusing on business matters. The nation's current high unemployment rate is unacceptable, Zook said.

"The only way to cure that is by growing the business sector of the economy," Zook said. "Two out of three new jobs in the U.S. always come from small business and that's what we have to stimulate."

Washington's current debate on health care reform will impact Searcy and White County, Zook said in the form of possible added costs to small businesses.

"Someone has to pay for this," Zook said. "You can't add 30 million people without adding costs."

The real solution for health care reform is to reduce inefficiency, not letting the government take over health care and the health insurance industry, Zook said.

"I think there's a tremendous concern that the plans being discussed are going to have a negative impact on the business community," agreed Buck Layne, the chamber's president and chief executive officer.

Energy efficiency is also impacting Searcy, Zook said as he promoted using more natural gas in place of oil.

The Searcy Regional Chamber of Commerce does its economic development through its companion organization, the Searcy Regional Economic Development Commission.

"The chairman and vice chairman of our board serve on our economic development board," Layne said. "The idea there was that the chamber staff works for both those boards. I think it's very seamless, although outside looking in you can't see the difference sometimes."

The Searcy chamber has 656 members, and according to ArkansasBusiness.com ranks 17th of 50 in the state for membership size.

Chambers of commerce are noted for doing community development work, increasing the quality of life, while on the economic development side they try to increase wealth and increase the tax base, Layne said.

"Everybody's trying to do the same thing," Layne said, "making our communities better, more desirable and conducive to raise a family."

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Appendix I MHCC Outputs Report 2006

MHCC

Mountain Home Christian Clinic
421 West Wade
*870-425-5010 * Fax 870-425-5020*

Services Provided by the MHCC to Persons In Need in 2006

Medical Visits:
1796 patient encounters by volunteer professional care providers were accomplished.
Estimated value of medical visits $145,700

Referrals to medical specialists for surgeries, etc. performed at reduced cost or on a pro bono basis are not included.

Pharmacy Services:
The MHCC pharmacy filled prescriptions written by practitioners for clinic visits. As well as obtaining and dispensed long-term medications to indigent persons. The MHCC Medicare pharmacy assistance program obtained and dispensed long-term medications to those on Medicare.

Total Value of Medicine dispensed $2,204,000

Laboratory and X-Ray:
The Baxter Regional Medical Center provided lab and X-ray services thru the MHCC.

Estimated value of services performed $61,800

Optical Services:
The MHCC provided 365 eye examinations and eyeglasses to 96 persons.

Estimated value of glasses provided $32,000.00

Dental Services:
The dental program of the MHCC provided emergency dental services to 358 persons.

Estimated value of dental services provided $90,000

Total Value of Services Provided in 2006: $2,546,400.

Value of support, counseling, and personal involvement: Invaluable

Because we are a volunteer service the MHCC was able to provide these services for an operating expenditure of about $135,000 in 2006. Said another way $1.00 invested in the MHCC provided services to persons in need with a value of more than $18.86 in 2006.

Appendix J Church Health Center 2nd Quarter Report 2009

Total Medical Visits	2922	April 2009					
		charges	adjustments	revenue	payments	% collected	%NC/NS
Medical	2519	$265,703.70	$206,907.96	$58,795.74	$51,282.86	87.22%	2.77%
Dental	504	$0.00	$0.00	$20,853.25	$19,365.46	92.87%	10.71%
Optometry	137	$9,760.00	$5,075.50	$4,684.50	$4,208.60	89.84%	
Counseling	266	$10,149.00	$7,090.40	$3,058.60	$2,247.10	73.47%	
Getting Started	298						
Social Work Contacts	129						

Total Medical Visits	2441	May 2009					
		charges	adjustments	revenue	payments	% collected	%NC/NS
Medical	2138	$197,875.30	$149,437.79	$48,437.51	$43,062.53	88.90%	2.46%
Dental	455	$0.00	$0.00	$16,905.30	$18,337.85	108.47%	10.33%
Optometry	110	$7,962.00	$4,162.00	$3,800.00	$3,754.90	98.81%	
Counseling	193	$6,950.00	$5,195.00	$1,755.00	$2,050.06	116.81%	
Getting Started	307						
Social Work Contacts	112						

Total Medical Visits	2897	June 2009					
		charges	adjustments	revenue	payments	% collected	%NC/NS
Medical	2526	$254,541.52	$196,218.82	$58,322.70	$52,348.23	89.76%	2.07%
Dental	540	$0.00	$0.00	$17,485.45	$18,811.81	107.59%	10.56%
Optometry	105	$8,875.00	$4,710.00	$4,165.00	$3,855.39	92.57%	
Counseling	266	$9,919.00	$6,678.00	$3,241.00	$2,118.25	65.36%	
Getting Started	251						
Social Work Contacts	129						

Total Medical Visits	8260	Quarter Four					
		charges	adjustments	revenue	payments	% collected	%NC/NS
Medical	7183	$718,120.52	$552,564.57	$165,555.95	$146,693.62	88.61%	2.43%
Dental	1499	$0.00	$0.00	$55,244.00	$56,515.12	102.30%	10.54%
Optometry	352	$26,597.00	$13,947.50	$12,649.50	$11,818.89	93.43%	
Counseling	725	$27,018.00	$18,963.40	$8,054.60	$6,415.41	79.65%	
Getting Started	856						
Social Work Contacts	370						

6/20/09

Appendix K Outcomes Report of Worth Street Clinic Dallas Texas

9/16/09

HTPN Community Health Services Corps
Baylor Family Medicine @ Worth Street

September 16th, 2009

1

Patient "Home Run" Stories

Patient A:

- 49 year-old African-American male with Type 1 Diabetes was seen at BUMC then later referred to Worth Street for outpatient care in January 2009. Since his treatment at Worth Street, his A1c has gone down from 14 to 6.9 and his LDL went from immeasurably high to less that 100. He is now working and making a decent leaving

Patient B:

- 60 year old female whose husband lost his job after 30 years of work, had diverticulitis with a sigmoid perforation and was seen at BUMC where part of her colon was resected and received a colostomy. She was referred to Worth Street for her Diabetes and Hypertension. Since her treatment began at Worth Street, her A1c has gone from 9.6 to 5.9 and has not been back to BUMC. She can't say enough good things about Baylor's help in her time of need

2

Baylor Family Medicine @ Worth Street

BHCS Hospital Utilization Analysis

3

Analysis Methodology

Goal:

- To compare BHCS hospital utilization by Worth Street patients prior to and after initiation of care at the clinic within the study timeframe:
  - 270 days (9 months) pre and post initiation of care
- Estimate cost savings to BUMC from reduction in uncompensated care

Selection Criteria:

- Roster of unduplicated patients from BFM @ Worth St. was matched to hospital database to identify patients with visits at BHCS hospitals (1600 pts on roster, 1294 matched to hospital data, 81% match)
- Patients had to be an established patient for at least 270 days and had some form of hospital utilization within the study timeframe

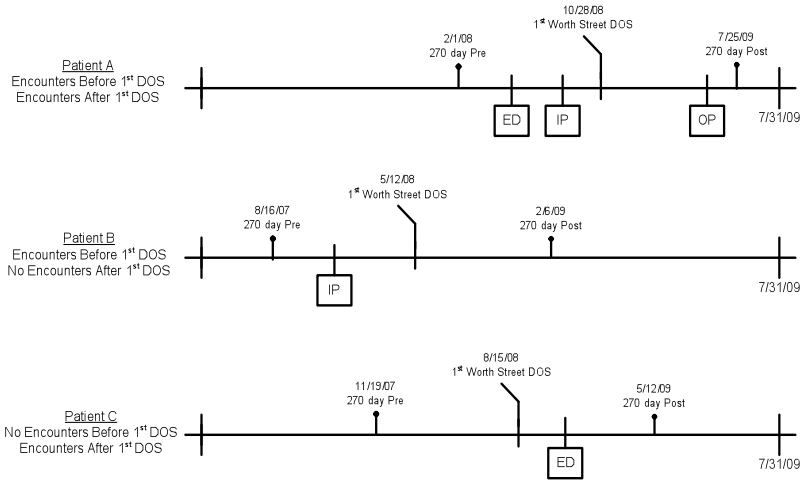
Analysis Includes:

- Patients established at Worth St. between 7/1/08 and 11/3/2008 (331 patients)
- Hospital Utilization thru 7/31/09
- Inpatient, Emergency Department, Outpatient, and Cumulative Totals
  - Number of Encounters
  - Uncompensated Costs
    - Defined as Total Costs (Direct plus Indirect) minus any payment received

*Note: Encounters with no associated financial data listed (i.e. "no shows" for a scheduled procedure/visit) or encounters where payment received was greater than total were excluded from analysis

4

Example of Selection Criteria: 270-day Pre and Post Initiation of Care Analysis



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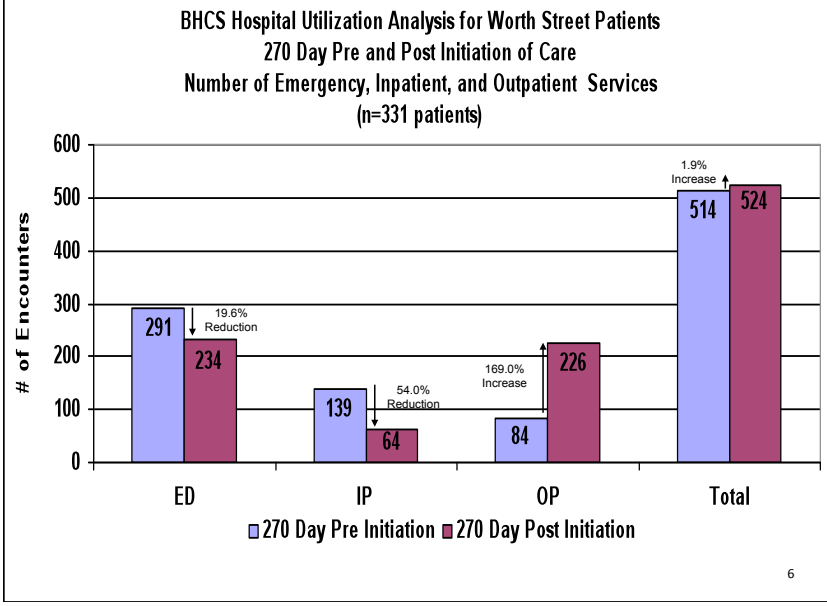

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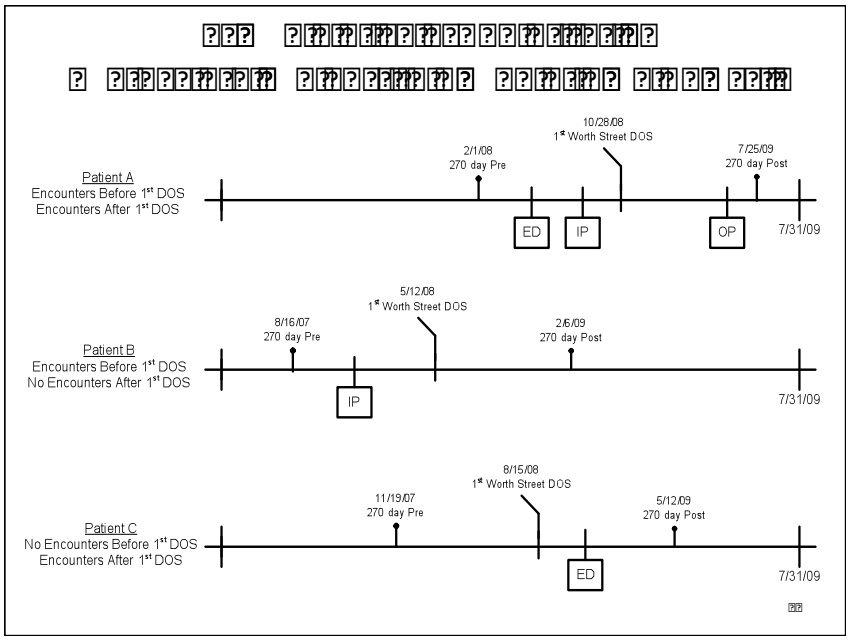
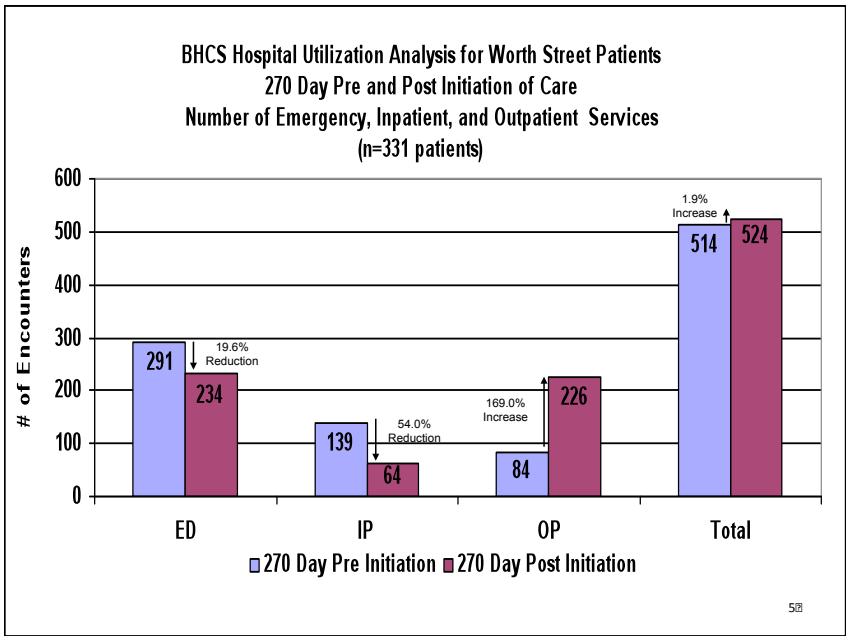
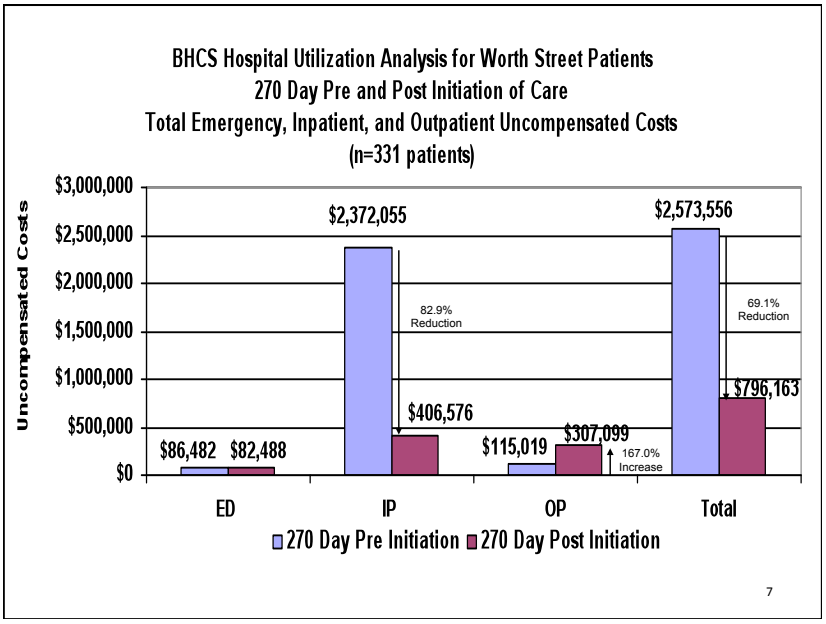
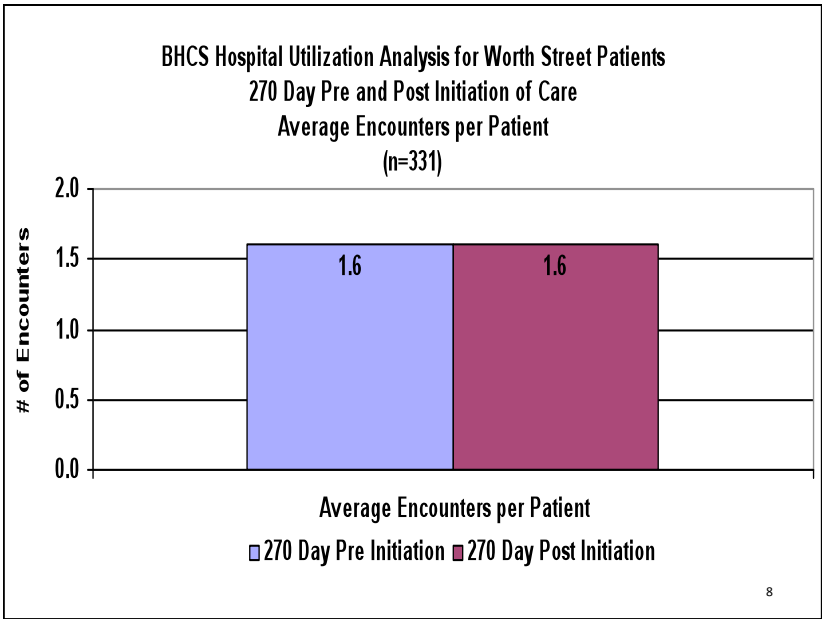
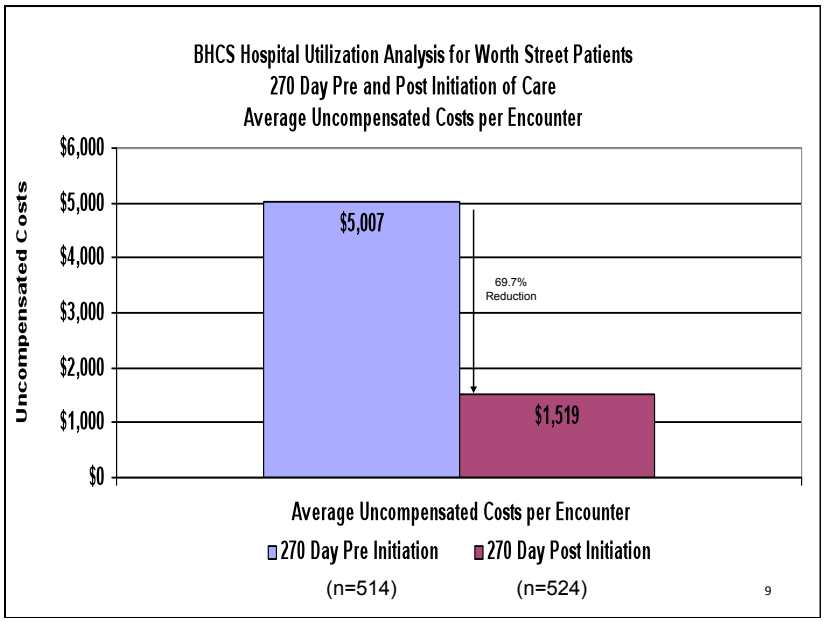

Patient A
Encounters Before 1st DOS
Encounters After 1st DOS
2/1/08
270 day Pre
10/28/08
1st Worth Street DOS
7/25/09
270 day Post
ED
IP
OP
7/31/09
Patient B
Encounters Before 1st DOS
No Encounters After 1st DOS
8/16/07
270 day Pre
5/12/08
1st Worth Street DOS
2/6/09
270 day Post
IP
7/31/09
Patient C
No Encounters Before 1st DOS
Encounters After 1st DOS
11/19/07
270 day Pre
8/15/08
1st Worth Street DOS
5/12/09
270 day Post
ED
7/31/09

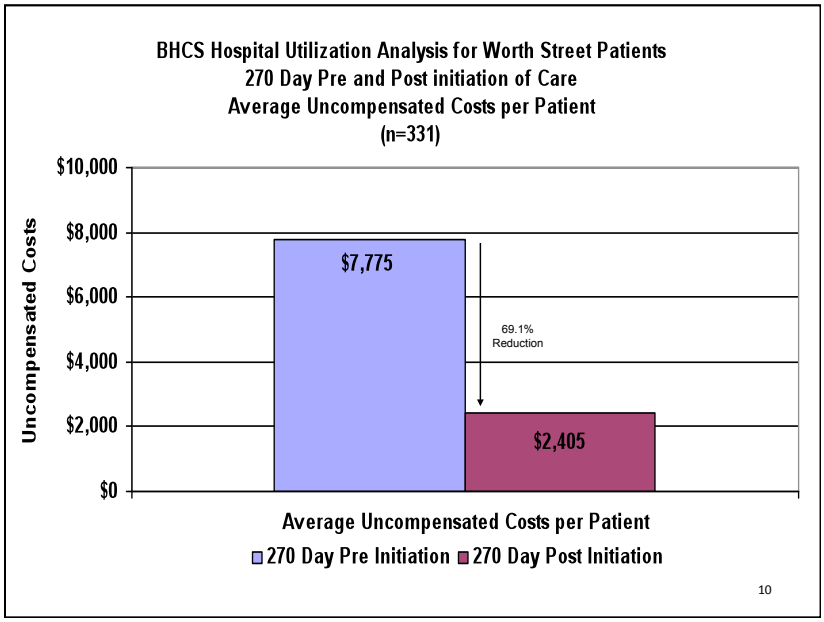

BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Number of Emergency, Inpatient, and Outpatient Services
(n=331 patients)
# of Encounters
600
500
400
300
200
100
0
291
234
19.6% Reduction
139
64
54.0% Reduction
84
226
169.0% Increase
514
524
1.9% Increase
ED
IP
OP
Total
270 Day Pre Initiation
270 Day Post Initiation

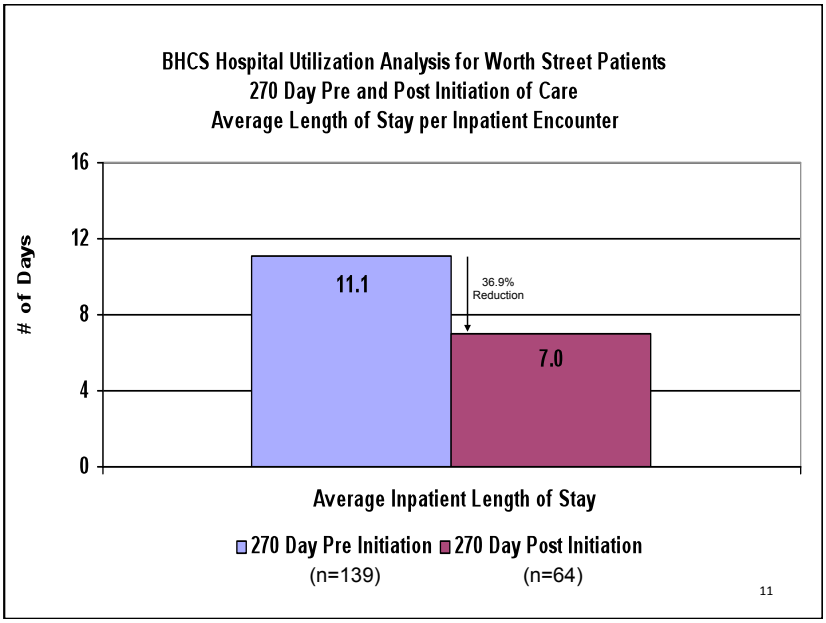
9/16/09


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Total Emergency, Inpatient, and Outpatient Uncompensated Costs
(n=331 patients)
Uncompensated Costs
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
$86,482
$82,488
$2,372,055
$406,576
82.9% Reduction
$115,019
$307,099
167.0% Increase
$2,573,556
$796,163
69.1% Reduction
ED
IP
OP
Total
270 Day Pre Initiation
270 Day Post Initiation
7


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Average Encounters per Patient
(n=331)
# of Encounters
2.0
1.5
1.0
0.5
0.0
1.6
1.6
Average Encounters per Patient
270 Day Pre Initiation
270 Day Post Initiation
8


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Average Uncompensated Costs per Encounter
Uncompensated Costs
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$5,007
69.7% Reduction
$1,519
Average Uncompensated Costs per Encounter
270 Day Pre Initiation
270 Day Post Initiation
(n=514)
(n=524)
9


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post initiation of Care
Average Uncompensated Costs per Patient
(n=331)
Uncompensated Costs
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$7,775
69.1% Reduction
$2,405
Average Uncompensated Costs per Patient
270 Day Pre Initiation
270 Day Post Initiation
10



Baylor Family Medicine @ Worth Street
9 Month Pre and Post Enrollment
Cost-Benefit Analysis

Projected # of Worth St. Patients Utilizing Hospital in 9-mo period: 81% of Worth pts experienced hospital utilization (matched in database) **1,722 pts seen at Worth St. in past 9 mo (Nov 08 – July 09)**	**1,395**
Average Savings per Pt from avoided hospital utilization (Uncompensated Costs): 9-mo Pre-Initiation: Avg. Uncompensated Costs per Pt = $7,775 9-mo Post-Initiation: Avg. Uncompensated Costs per Pt = $ 2,405	**$5,370**
Projected Savings for 1,395 Worth Street patients (Uncompensated costs): $5,370 savings x 1,395 pts	**$7,491,150**
Cost of Worth Street Operations (9 months):	**($867,195)**
Net Program Benefit (Loss):	**$6,623,955**

12

Worth Street Summary

270 Day Pre and Post Initiation of Care Analysis

- Uncompensated Costs
  - 69.1% Reduction in Total Emergency, Inpatient, and Outpatient Uncompensated Costs
    - Average ED, IP, and OP Total Uncompensated Costs per patient were reduced from $7,775 to $2,402, resulting in a **decrease of $5,370 in uncompensated costs per patient**

- Inpatient Length of Stay
  - 36.9% Reduction in Average Length of Stay per Inpatient Encounter
    - Average Inpatient Length of Stay was reduced from 11.1 days to 7 days, resulting in a average **decrease of 3.1 days per inpatient length of stay**.

13

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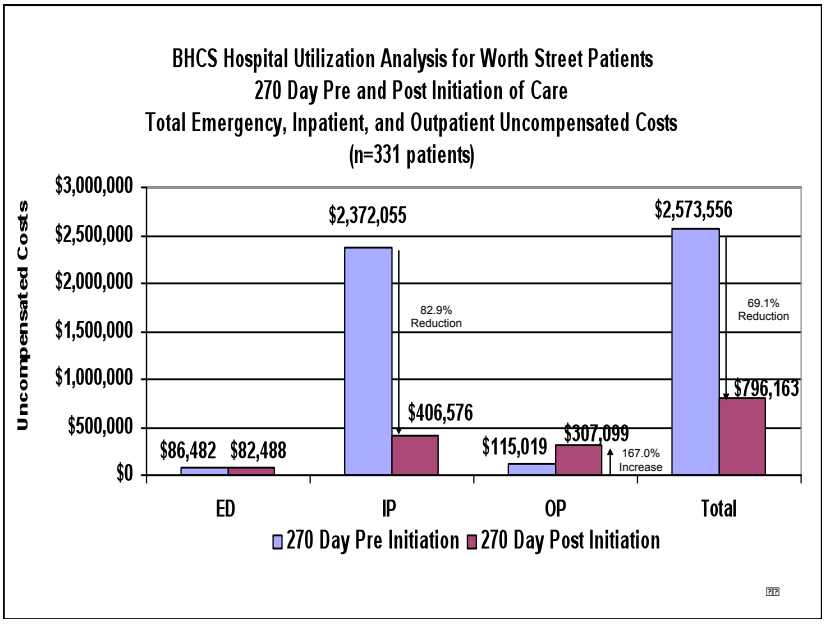
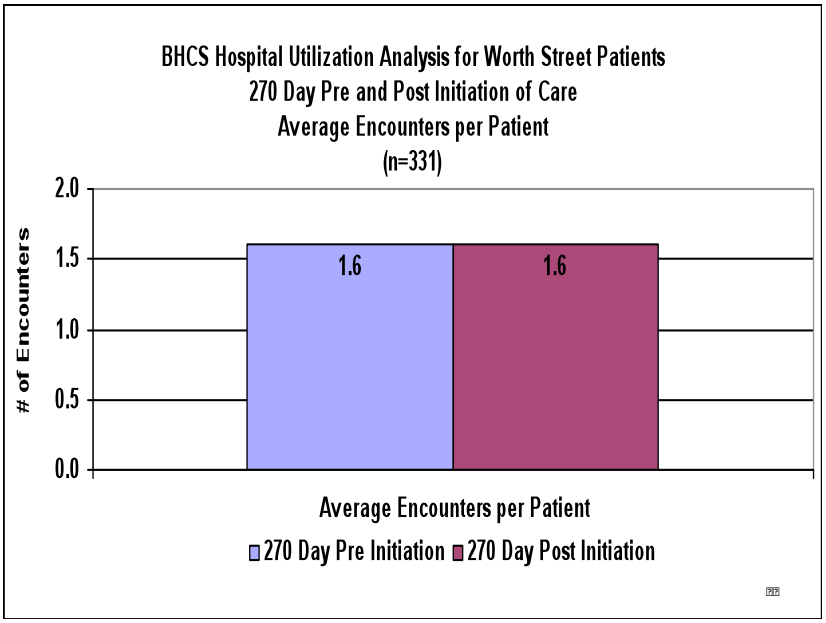

BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Total Emergency, Inpatient, and Outpatient Uncompensated Costs
(n=331 patients)
Uncompensated Costs
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
$86,482
$82,488
$2,372,055
$406,576
82.9% Reduction
$115,019
$307,099
167.0% Increase
$2,573,556
$796,163
69.1% Reduction
ED
IP
OP
Total
270 Day Pre Initiation
270 Day Post Initiation


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Average Encounters per Patient
(n=331)
# of Encounters
2.0
1.5
1.0
0.5
0.0
1.6
1.6
Average Encounters per Patient
270 Day Pre Initiation
270 Day Post Initiation

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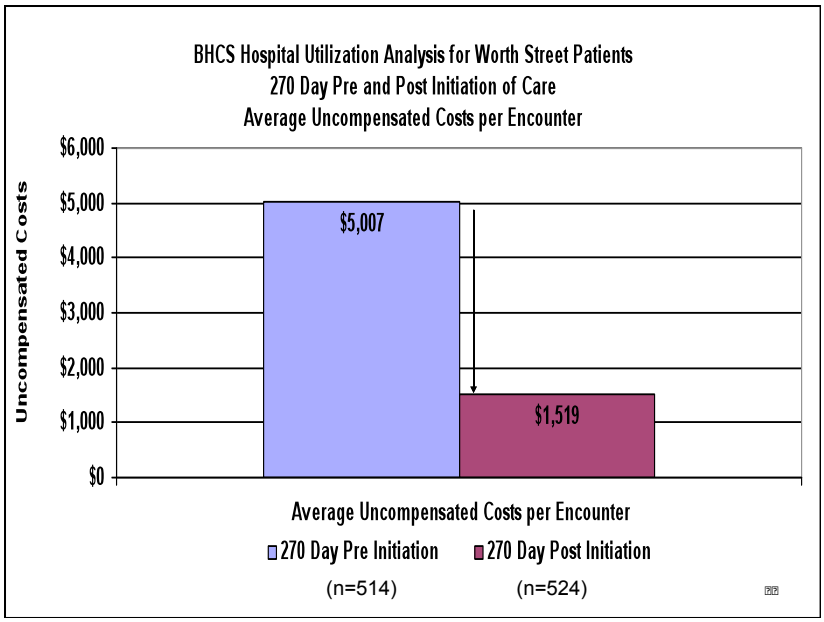
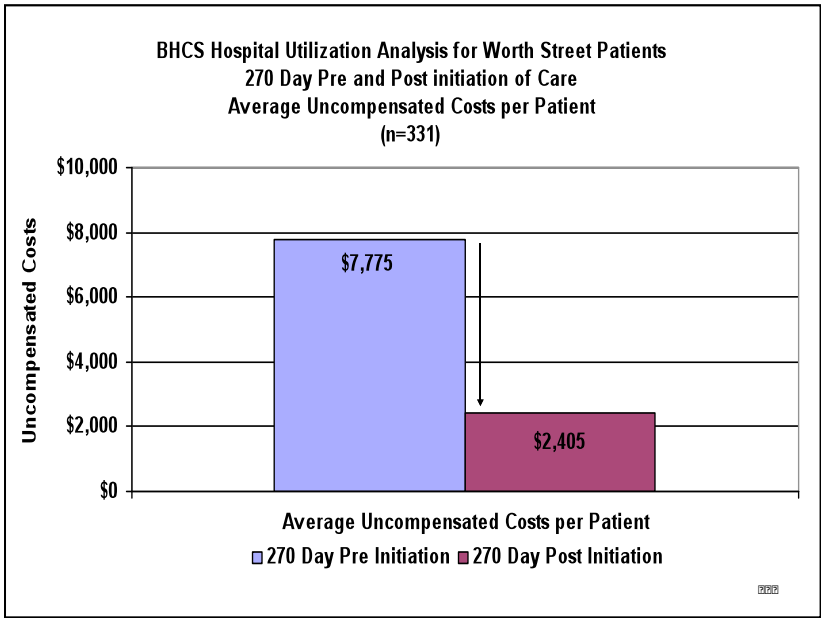
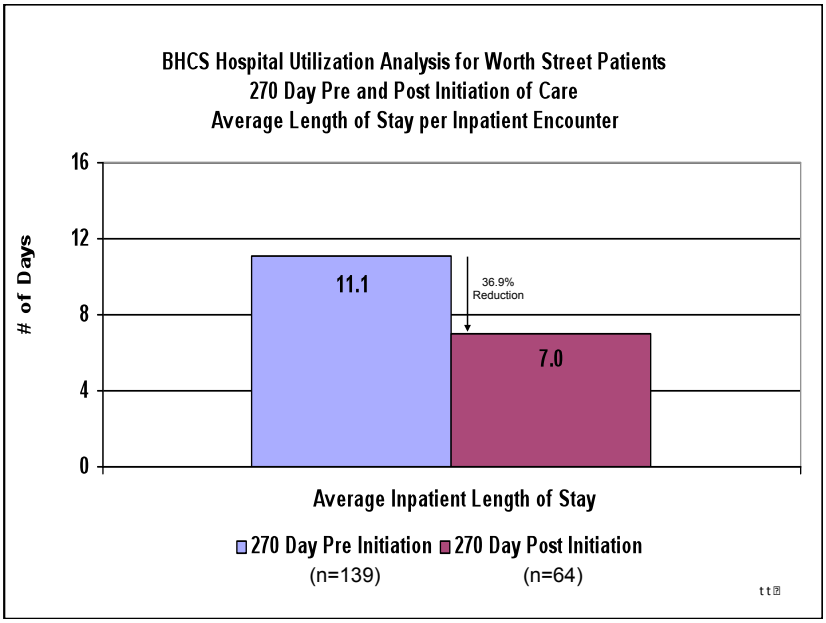

BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Average Uncompensated Costs per Encounter
Uncompensated Costs
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$5,007
$1,519
Average Uncompensated Costs per Encounter
270 Day Pre Initiation
270 Day Post Initiation
(n=514)
(n=524)


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post initiation of Care
Average Uncompensated Costs per Patient
(n=331)
Uncompensated Costs
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$7,775
$2,405
Average Uncompensated Costs per Patient
270 Day Pre Initiation
270 Day Post Initiation


BHCS Hospital Utilization Analysis for Worth Street Patients
270 Day Pre and Post Initiation of Care
Average Length of Stay per Inpatient Encounter
# of Days
16
12
8
4
0
11.1
7.0
36.9%
Reduction
Average Inpatient Length of Stay
270 Day Pre Initiation
270 Day Post Initiation
(n=139)
(n=64)