STARTING A FREE CLINIC IN A RURAL AREA

People in a small Kentucky town pool their talents to solve the access problem.

BY WILLIAM R. GRIMES, DMin

Today millions of Americans lack regular access to health care. Although we usually think of such people as city dwellers, the fact is that many can be found in our nation's rural areas.

What can be done to help the uninsured and disadvantaged? If people are truly made in the image of God, and, as his children, have a right to his gifts, including health care; and if we as Christians and ministers of the compassion of God really have the desire to care for those most in need—what should we do?

One set of answers is offered by the Christian Community Development Association (CCDA), a Chicago-based organization that specializes in training Christian community leaders for impoverished areas. Born in rural Mississippi in the 1960s, the organization now has members around the world.* The CCDA describes the plight of the uninsured as a "desperate condition" that calls "for a revolution in our attempts at a solution. . . . These desperate problems cannot be solved without strong commitment and risky actions on the part of ordinary Christians with heroic faith."

To its members the CCDA says: "Go to the people. Live among them. Learn from them. Love them. Start with what they know. Build on what they have. But of the best leaders, when their task is done, the people will remark, 'We have done it ourselves.'"

My own introduction to the plight of the uninsured came from one of my good friends, a nurse practitioner named Julia Maness. Julia was concerned about the fact that the hard-working poor of our area—rural eastern Kentucky—were not getting the health care they needed. Because of her concern, she had taken a job on a mobile clinic operated by St. Joseph Hospital in Lexington. The clinic, which travels around the area, specializes in treating the urban poor and uninsured in Lexington.

"We can do the same thing right here, in the hills of eastern Kentucky," she said to me one day. "Just imagine: We could have a mobile clinic and go from community to community with health care and spread the 'good news' at the same time."

From then on, each time we met (usually following services at St. Julie Catholic Church in Owingsville, KY), she brought up the idea. "When are we going to do this? It needs to be done now. Let's get it on the road."

Then, one day in December 1999, I was standing on the sidewalk in Owingsville, waiting to watch the town's annual Christmas parade, when my friend Dave Daniels happened to come by. Owingsville, a village of about 1,000 people, is in the mountains some 45 miles east of Lexington. Dave is a planner for the district's health department. I told him that I was concerned about the area's growing number of uninsured people. He

Mr. Grimes is a physician assistant/nurse practitioner at the Bath County Medical Clinic, sponsored by St. Claire Medical Center, Morehead, KY; assistant professor, College of Health Sciences, University of Kentucky, Lexington, KY; and chief executive officer, NewHope Ministries, Inc., operator of the NewHope Clinic, Owingsville, KY. He is also an ordained deacon of the Diocese of Lexington.

*For more information about the CCDA, go to www.ccda.org.

was concerned, too, and he had the demographics to back up his concern.

Not long after this, Julia, Dave, and I began meeting regularly in the church basement to discuss the problem. We knew from our reading that it is necessary, before tackling such problems, to analyze the community involved and see what assets are available. According to one source, community development must start from *within* the community. "Development of policies and activities [should be] based on the capacities, skills and assets of lower income people and their neighborhoods."[1] Every community needs its "movers and shakers." But in order for a community to mobilize, everyone involved must participate to one degree or another. "Community builders soon recognize that these groups [composed of people with low incomes] are indispensable tools for development, and that many of them can in fact be *stretched* beyond their original purposes and intentions to become full contributors to the development process" [Emphasis mine].[2]

Creating a Free Clinic

Here's how we went about "stretching" the Owingsville community to fulfill the promise of a free health care clinic.

Jeff, a carpenter who is himself uninsured, came first to our assistance and offered help with the planning. A local bank had given us the use of an empty store, but the building was in bad shape. The building had to be gutted and rebuilt. Jeff helped put up the new walls that would divide the structure into a waiting room, offices, a laboratory, and examination rooms. Charlie, a semiretired hardware store manager and electrician, put in new wiring. Danny, a contractor, directed the drywalling. Since Danny was uninsured as well, he became one of our first patients when the clinic finally opened.

Ron, who works at a local lumber company, got us discounts on building material. Scott, a journeyman plumber, put in all new plumbing, including five sinks and new water lines. Scott, who also has no insurance, has significant heart disease. We have been taking care of him for a year now.

Roy, who owns a heating and air-conditioning company, thinks I saved his life. Some years ago he came into the clinic where I worked complaining of chest pain. I started him on life support and sent him to the hospital in an ambulance. Now he is always eager to help and will get involved with me on any project. He installed a whole new heating and air-conditioning system in our building.

Money was sent to us by local people—some from "haves," but more from "have-nots."

John, who does carpeting and other flooring, came to show us how to use the nail gun to put down the subfloor. He wound up doing most of the job and also donated the flooring. Mike, a retired judge who has spent his retirement putting in computer systems, asked if he could help. "Sure," we told him. "We need a server and five work stations so that our medical records will all be computerized." It was done. And all the labor and equipment were donated.

Many other people volunteered hours of painting, plastering, cleaning, sweeping, nailing, drilling—and in general made themselves available for other duties as well.

With two very important partners, St. Claire Medical Center, Morehead, KY, and the Gateway District Health Department (a consortium of four county health departments), we formed a coalition that we called NewHope Ministries, Inc. Our partners not only donated equipment to the clinic; as established not-for-profit health care entities, they also provided us with access to other equipment and materials.

Today St. Claire Medical Center renders us technical support and does our lab work at a reduced rate. The district health department assists us by providing specialty care such as mammograms and pap smears. Another local health care facility, Mary Chiles Hospital in nearby Mount Sterling, KY, does our x-rays at cost and one of its radiologists interprets them for us. St. Joseph Hospital, which is sponsored by the Sisters of Charity of Nazareth, Nazareth, KY, has given us equipment and supplies as well as financial and spiritual support.

Money was sent to us by local people—some from "haves," but more from "have-nots." In a few months, we collected $25,000 from such sources. Other funding was provided in the form of grants, mostly from local organizations: the Kiwanis Club, local churches, banks, and other businesses. Some congregations of women and men religious also provided grants to help us get under way. The renovations cost $4,500 (about a tenth of their estimated market worth); the equipment for the clinic was free except for transportation costs.

We began renovating the building in July 2000. On October 19 of that year, we opened the doors of the NewHope Clinic to the public. We were warmly greeted by, among others, the local ministerial association, whose members circled the building holding hands and praying for our success. A reporter from the *Lexington Herald Leader* attended the opening, later telling his readers: "The whole thing has been thrown

together over the last few months with a modest amount of donated money, a ton of volunteer labor, and more than a few prayers."[3]

But the best thing about the project was that we were able to get the community involved in—and excited about—the effort. The clinic is the child not of NewHope Ministries, Inc., but rather of the community of Owingsville, Bath County, KY.

Grace and Healing

As the Kentucky poet Wendell Berry so eloquently put it:

> The grace that is the health of creatures can only be held in common.
> In healing the scattered members come together.
> In health the flesh is graced, the holy enters the world.[4]

What have we created? We have created a tapestry (or perhaps, considering the region, a quilt) of individuals who have come together as a community to work toward a goal of helping others by creating a free clinic. We have taken a diverse group of people and formed them into a unified whole, one that represents all that is good and noble in this community. We have organized a group who, as disparate individuals, had a deep longing for unity and only needed a project under which to blossom.

Each time a needy person comes to the clinic for help and we are able to provide him or her with healing and caring, we do it in the name of the community. Each time someone longs to be of assistance to another, we give them a venue in which to do so. Each time a church group wants to answer the call to help those in need, we open a spot for them to share and care and give of themselves. NewHope Clinic is not the property of NewHope Ministries, Inc. It is the property of all the people of this area who have assisted us, or who need our help, or who have sent us donations, or who have helped us to create it.

In trying to organize my thoughts on "health care as ministry," I have found especially helpful the writings of Thomas Droege, associate director of the Interfaith Health Program at the Carter Center, Emory University, Atlanta. In an article about faith-based initiatives in health care, entitled "Congregations as Communities of Health and Healing," he urges "praxis, not theory."[5] Droege maintains that "we have a window of opportunity at this juncture of history to make a major contribution to health reform by recommitting ourselves to health ministry in congregations and communities and by giving priority to the needs of those who bear the greatest burden of suffering from preventable disease. We can meet the challenge with both vision and hope, confident of the presence and power of the One who said, 'I came that they may have life, and have it abundantly' (Jn 10:10)."[6]

We had decided that, as a group, we would serve others with the talents God has given us.

Sojourners

After three years of service to this community, we have accumulated more than 1,350 patients and responded to more than 7,000 patient visits. In the beginning, we saw patients from 9 am to 5 pm on Thursdays; recently we have held clinic hours on Monday as well. We generally see from 30 to 40 patients a day.

Two key staff members receive minimal pay for their work. Fortunately, the clinic also has many volunteers, both professional and nonprofessional, who provide everything from medical care and nursing to administration and cleaning.

Because there is so much poverty in the Owingsville area, we offer care at no charge to anyone in the range of 200 percent of poverty. Seldom have we had an uninsured patient who was not eligible for our clinic's care. We consider persons with Medicare or Medicaid coverage to be insured and do not accept them as patients; however, we do help many Medicare recipients get their prescription medications through indigent drug programs.

After the clinic's opening, an editorial about it appeared in the *Lexington Herald Leader*. "Various studies suggest that the uninsured receive less medical care and are in poorer health than those who have health insurance," the writer said. "The health care safety net is broad, though fraying, in this country. The volunteers who are trying to shore up the safety net in Bath County by operating the NewHope Clinic are heroes. So are countless health professionals who provide free care."[7]

But we who had launched the clinic knew we weren't really "heroes." We were only doing what, as Christians, health care providers, and concerned people, we *should* be doing. We had decided that, as a group, we would serve others with the talents God has given us. Service to others is thus an exercise in justice. And justice is the first step toward peace. I have seen a bumper sticker that summarizes it quite nicely: "If you want peace, work for justice" (Pope John Paul II).

Jim Wallis, a social activist and editor of

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Sojourner magazine has written: "We don't have any blueprints for a new system. . . . At best, what we have are some spiritual guideposts and road maps. The process of change will feel more like a journey than a policy conference or board meeting. *And the sojourn itself is a part of the solution* [emphasis mine]."[8]

So those of us who seek health care reform are on a "sojourn" of faith and hope, love, and promise. Where will the sojourn lead us? How will we respond to the ever-growing need for health care? How can we overcome the obstacles that make modern-day health care such a bureaucratic quagmire? Seen this way, genuine reform looks almost Sisyphean.

The answer to this conundrum is to be found in faith. As one writer has said, "True faith—the only actually salvific faith—is faith informed by love, faith that becomes the practice of solidarity and liberation: orthopraxy."[9] Faith, in regard to service, is characterized by love in action. We who work in the NewHope Clinic are determined to help provide loving caring service to the marginalized of our society. We are on a mission to bring God's tender care and loving mercy to the working poor of Owingsville and the surrounding area. We are determined to be people for whom faith is more than a word, people who believe that faith is primarily a praxis.

How do we as health care providers look at our role in an ethical manner? I have come to believe that, ethically, we as providers of care are obligated to become the persons we were meant to be. But how do we become what we already are? How do we determine not only what God wants of us, but also what we are in actual fact in God's eyes? Thomas Merton wrote: "God utters me like a word containing a partial thought of Himself. A word will never be able to comprehend the voice that utters it. But if I am true to the concept that God utters in me. . . . I shall be full of His actuality and find Him everywhere in myself."[10] Merton, it seems to me, is saying that in order to be myself I must abandon any idea of who I am and seek my identity in God alone. Only in absence of self and presence of the Self, can I truly act, and only then will my actions be completely honest and true. When I serve others, I do so at the very center of my self, and God does the work, not in me or in spite of me, but through me.

So I've come to believe that in order to be the best possible health care provider, person, activist, missionary, Christian, and parent, I must become fully what God wants me to be; I must allow myself to be discovered by God. "Our discovery of God is, in a way, God's discovery of us," Merton wrote. "We cannot go to heaven to find Him because we have no way of knowing where heaven is or what it is. He looks at us . . . and His seeing us gives us a new being and a new mind, in which we also discover Him. We only know Him insofar as we are known by Him."[11] □

NOTES

1. John P. Kretzman and John L. McKnight, *Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets*, Northwestern University Press, Evanston, IL, 1993, p. 5.
2. Kretzman and McKnight, p. 6.
3. Jim Warren, "Free Clinic Opens in Owingsville," *Lexington Herald Leader*, October 29, 2000, p. B1.
4. Berry, Wendell, *What Are People For?* North Point Press, New York City, 1990, p. 9.
5. Thomas A. Droege, "Congregations as Communities of Health and Healing," *Interpretation*, April 1995, p. 119.
6. Droege, p. 128.
7. "Reality Check," *The Lexington Herald Leader*, October 21, 2000, section A.
8. Jim Wallis, *The Soul of Politics*, New Press, New York City, 1994, p. 147.
9. Leonardo Boff, *Cry of the Earth, Cry of the Poor*, Orbis Books, Maryknoll, NY, 1997, p. 5.
10. Thomas Merton, *New Seeds of Contemplation*, New Press, New York City, 1995, p. 37.
11. Merton, p. 39.

CRISIS IN THE COUNTRYSIDE

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RURAL CARE IS A KEY COMPONENT

Providing improved access to health care for rural Americans is a key component in improving the overall quality and reducing the cost of health care services in the United States.

We Americans have entered an era of health care networks, alliances, and service systems. A desire to reduce fragmentation, cut duplication, and maximize consumer value—these factors are making the isolated facility a thing of the past. Although true of all health care services, this is particularly true of rural facilities, where the threat of local competition is minimal and the ability to partner and network provides tremendous opportunities. As a result, rural hospitals increasingly have one or more organizational links. Networks, alliances, and service systems enable rural hospitals to meet more of the demands of today's health care environment.

Rural health care is the backbone of services for many Americans—and for many of the neediest: the elderly and the uninsured. The role of these hospitals in the U.S. health care "safety net" is critical. Meeting the challenges of service in today's rural environment is particularly difficult. Even so, many organizations are maximizing the opportunities. □

NOTES

1. See www.hospitalconnect.com/shsmd/resources/profilesofhealthcarerural.html.
2. Catholic Health Association, *Ministry Engaged*, September 2003, p. 2.
3. *AHA News*, November 17, 2003.
4. Office of the Auditor, State of Hawaii, *Follow-Up Study of the Hawaii Health Systems Corporation*, April 2002, p. 48, available at www.state.hi.us/auditor/reports/2002/02-09.pdf.
5. "Rural Docs Still in Short Supply," *Business Journal of the Greater Triad Area*, Greensboro, NC, March 26, 2003.
6. "Rural Docs Still in Short Supply."
7. Institute for the Future, *Health and Health Care 2010: The Forecast, the Challenge*, 2nd. ed., Jossey-Bass, San Francsico, 2003, Chapter 10.