DEVELOPMENT OF A FAMILY NURSE PRACTITIONER POSITION AT A COMMUNITY CLINIC FOR THE MEDICALLY UNDERSERVED

by

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ABSTRACT

The rising cost and limitations of health insurance, restrictions and reduced eligibility for Medicaid, and the lack of low-cost health care options have limited access to health care for many individuals. Many residents of Gallatin County (population 59,410) in southwestern Montana are among the ranks of the underinsured and "working poor" who cannot afford to purchase health insurance or pay for physician visits.

In 1996, grassroots concern about the medically underserved in Gallatin County evolved into a campaign that opened the Gallatin Community Clinic (GCC), a low-cost health clinic staffed by physicians, nurses, and other volunteers. Although only open on Saturday mornings, 1400 individuals received health care at the Clinic in its first 19 months. However, while low-cost primary care services are clearly needed in Gallatin County, it has become increasingly difficult to address the needs of the growing volume of patients within the Clinic's volunteer staffing and time constraints.

The purpose of this project was to: 1) Develop a nurse practitioner (NP) position at the GCC; 2) Identify potential sources of funding, and 3) Apply for funding. By creating a salaried NP position, the Clinic would be able to increase its hours of service and provide improved continuity of care and quality assurance. Ultimately, this new position would allow the Clinic's expansion to further address the health needs of low-income individuals and families.

Completing the project was a collaborative process with other GCC volunteers. It included a needs assessment, approval of the project proposal by the GCC Board of Directors, development of a job description and budget, and application for funding.

Results of this project have been the development of a NP or Physician Assistant position at the GCC. In June, 1998 a proposal submitted to the Bozeman Deaconess Hospital System was granted, thus providing funding for the half-time position. This project has demonstrated: the importance of community involvement in fundraising; the potential for successful collaboration among health professionals in addressing the community's unmet health needs, and; the proactive role that graduate nursing students can play in promoting the role of NPs and implementing change.

CHAPTER 1

INTRODUCTION

The Purpose

The purpose of this project was to identify and develop potential funding sources for a nurse practitioner position at a community clinic serving the medically underserved. A salaried nurse practitioner would enable this primarily volunteer-staffed organization to sustain its present services and to provide improved continuity of care and quality assurance. Ultimately, this new position would allow the clinic's expansion to further address the unmet health needs of low-income individuals and families in the community.

Background and Significance of the Project

I have conducted this project both as a graduate nursing student and as a nurse volunteer and member of the Professional Services Committee at the Gallatin Community Clinic. It was within these roles, and in discussions with colleagues and professors, that developing a paid nurse practitioner position at the clinic evolved. As an individual committed to both expanding the utilization of nurse practitioners and providing health care to the medically underserved, this project provided a "good fit" to pursue and intertwine my academic interests and community work.

The Medically Underserved

The rising cost and limitations of health insurance, restrictions and reduced eligibility for Medicaid, and the lack of low-cost health care options have severely limited access to health care for many individuals (Torrens & Williams, 1993). Lack of access is by no means a problem only of the unemployed. Full-time workers making minimum wage - sometimes referred to as the "working poor"- may be unable to afford health care or health insurance for themselves and their families. Even eligibility for Medicaid programs can be of little help in communities where many physicians refuse or strictly limit Medicaid patients due to its very low reimbursement rates (Millman, 1993).

Despite much discussion, the American people and government are far from one mind about what to do in regards to health care, health insurance reform, and the possibility of establishing a national health care system. While the subject is debated, overcrowding of existing low-cost clinics and local government health facilities occurs as well as the frequent use of hospital emergency rooms to treat non-emergent health problems. Most communities are faced with the reality of seeing many individuals, families, and children unable to access or afford health care at all (Brenner as cited in Cordes, Doeksen, & Shaffer, 1992).

Accessing Health Care

The Bureau of the Census (1994) estimated that 40 million Americans were uninsured (cited in Cleverley, 1997). Nationally, in 1996, nearly 13 million families (11.6 percent of all families) either did not get or experienced difficulty in getting

medical care. Most of these families reported they were unable to afford the care they needed. Other barriers to accessing health care included transportation problems, not being able to obtain child care, and insurance-related problems, such as not being able to obtain referrals. Not suprisingly, uninsured families were the most likely to experience problems obtaining needed health care (Medical Expenditure Panel Survey, 1996).

Furthermore, 46 million Americans had no usual source of health care in 1996. As stated in NEWsline for Nurse Practitioners, "Eighteen percent of the population had no particular doctor's office, clinic, health center or other place where they would usually go if they were sick or needed advice about their health" ("Millions Face Barriers", 1998, p. 12). In the same article, Administrator John Eisenberg, MD of the Agency for Health Care Policy and Research stated that "people without a usual source of care may be less likely to receive treatment in a timely manner and to receive preventative health care services" (p. 12).

The Medically Underserved in Gallatin County, Montana

In Montana, programs such as Women and Infant Children (WIC), and Healthy Babies, provide some preventive health care to young children from low-income families. Medicaid provides some help to very low-income and disabled individuals, while Medicare assists the elderly in meeting many of their health care needs. However, the majority of older children and adults under 65 are ineligible for medical assistance from state and federal programs. In fact, 74% of medically uninsured Montanans are between the ages of 18 and 64 years. Most of this uninsured group (86%) are employed at least part-time. Seventy percent of the uninsured live below 200% of poverty status (Montana

Health Care Authority [MHCA], 1994). At the time of the 1990 Census, poverty level was $6,280 for one person and $2,140 for each additional person (US Census, 1990). Two hundred percent, or twice poverty level, is considered the standard below which individuals and families cannot typically afford to purchase health insurance (Gallatin County Demographics, 1998).

Demographic data from Gallatin County in southwestern Montana indicate that many of its residents are among the ranks of the underinsured and working poor. While unemployment rates in the County are as low as 2.7 percent, wages are also low and many of the working poor cannot afford to purchase health insurance or pay for physician visits. Other low-income individuals have purchased catastrophic health insurance, but find the very high deductibles prohibitive for meeting their family's primary health care needs (Montana Department of Labor and Industry cited in Gallatin County Demographics [GCD], 1997). In 1990, 17.1 percent of residents in Gallatin County were living at or below poverty level. Especially at risk for poverty were families, with 30.5 percent of them living at the poverty level (U.S. Census, 1990).

Gallatin County (pop. 59,410) has a population density of 20.1 per square mile and is, therefore, considered a non-metropolitan county (US Census, 1990). Almost half of Gallatin County's residents live in the county seat and university town of Bozeman (population 25,067) nestled in the Rocky Mountains. Over 7,600 other residents live in the surrounding communities of Belgrade, Manhattan, Three Forks, and West Yellowstone. The remaining 25,000 of the County's residents reside outside any of these communities (Montana Department of Public Health & Human Services [MDPHHS], 1997). The area's economy is largely dependent on the university, service industries,

agriculture, and construction (Montana Department of Labor & Industry cited in GCD, 1997). Bozeman and the surrounding communities reflect the contradictions of many growing communities in the western United States, where economic growth does not always mean economic prosperity for all its residents.

The town of Bozeman itself is the center of the health care delivery system in Gallatin County. This is in part due to the presence of the 86 bed capacity Deaconess Hospital. Approximately 50 physicians, 18 nurse practitioners, and 5 physician assistants have made this area their home. As well, many nurses, physical therapists, mental health counselors, pharmacists, and other providers of health care are based in Gallatin County. There are also 8 Public Health Nurses who organize county immunization efforts, run the WIC program, and work as educators and statisticians in the county (Montana Department of Public Health & Human Services cited in GCD, 1997).

Despite the relatively high number of health care providers in Gallatin County, many residents do not have access to primary health care, in part, because many of the local physicians have specialty practices. It is also widely reported that very few physicians are accepting new enrollments of patients with Medicaid insurance (Montana Medicaid Managed Health Care, 1998). Within Gallatin County, the smaller rural towns of Three Forks, Manhattan, and West Yellowstone are still considered Federal Health Professional Shortage Areas (MDPHHS, 1997).

For generations people in need have counted on the generosity of the many physicians in Gallatin County who have provided sliding scale and free services to some of their patients. However, these donated services are often informal and spontaneous in nature, and especially difficult to obtain for individuals without a usual health provider.

Another important resource in meeting health needs of low-income individuals in Gallatin Valley is the non-profit Bridger Clinic; its services however are limited to family planning and reproductive health. Unfortunately, the only county mental health services closed in 1997 due to withdrawal of state funding. The nearest chemical dependency treatment center is 80 miles away in Butte, Montana.

A 1993 report assessing health care delivery systems in Gallatin County identified an urgent need for "additional Public Health space and resources to meet the growing needs of low income populations in Gallatin County." (Montana Department of Health and Environmental Sciences, 1993, p. 235) The panel recommended that "a planning group should be organized to consider the need for a federally funded Community Health Center in Bozeman" (p.235) to meet the needs of the medically underserved. However, by the time this report was circulated most health care providers and members of health service agencies in Gallatin County were already well aware and concerned that many of the working poor and uninsured had few viable options in meeting their basic health care needs. By 1995 an active grassroots effort had formed in Gallatin County to discuss how to address this issue as a community.

Community Response

Communities have responded in different ways to the lack of health care services available to low income and under-insured individuals and families. A common starting ground for many communities has been the founding of volunteer-provider health clinics. These clinics are often started on a very small budget, have limited hours of service, and depend on the goodwill and effort of the medical and nursing community to maintain

volunteer staffing. Among these clinics, those that survive and expand typically apply for private and/or public money to fund their maintenance and growth. In Montana, formerly volunteer clinics in Billings and Great Falls were both successful in applications for federal funding and are now federally-funded Community Health Centers (R. Flaherty, personal communication, January 16. 1998). Frequently, these federally-funded clinics provide much of their patient services through the utilization of nurse practitioners and physician assistants, both as clinicians and administrators (Edwards, Kaplan, Barnett, & Logan, 1997; Hatcher, Scarinzi, & Kreider, 1997; Lockhart, 1995).

The Gallatin Community Clinic

By 1996, grassroots concern about the medically underserved in Gallatin County had evolved into a campaign to open a low-cost health clinic staffed by physician and nurse volunteers. The founding Board of Directors of the Gallatin Community Clinic was formed amidst promises from numerous local physicians and nurses to volunteer at the Clinic when it opened. A grant of $32,000 from the United Way of Gallatin Valley, $10,000 from the Steel-Reese Foundation, $5,000 each from the State and County Health Departments, and $2,000 from Blue Jean Friday provided initial funding. The provision of free office space, donated medical equipment, and money from community fund-raisers, such as $500 raised by the Bozeman Fire Department Car Wash, enabled the Saturday clinic to open in August of 1996. This community effort became the Gallatin Community Clinic (GCC) which has been open and staffed by volunteers every Saturday morning since August, 1996. The stated mission is to "improve the health of Gallatin County's adults and children by providing access to low cost quality primary and

preventive health care to people with limited resources" (Gallatin Community Clinic, 1997).

Presently, the GCC uses office space donated by the Bozeman Physical Therapy Group. The GCC provides low cost primary care for acute and chronic conditions to low income individuals and families without insurance or with a very high-deductible insurance. The Clinic is staffed by volunteers and by a half-time Clinic Administrator and is held each Saturday morning. The Clinic is supported by patient fees and donations from local organizations and individuals. Patients are seen on a sliding scale of $5.00 to $30.00, although no one is turned away due to inability to pay at the time of visit. Fees are based upon the total household income, number in the family, and the complexity of the visit.

When referrals are necessary, patients are usually sent to specialists in the community who have agreed to see GCC clients at discounted rates. Bozeman Deaconess Hospital also provides a discounted fee for patients with illnesses/conditions who GCC providers have referred to the emergency room. Arrangements with pharmacies in Bozeman enable GCC patients to purchase medications at only $1.00 above pharmacy cost.

Although only open on Saturday mornings, 1400 individuals received health care at the Clinic in its first 19 months. The Clinic's one paid staff member, a half-time employed Clinic Administrator, is always present at Saturday Clinic. She is there to help set up the clinic and to coordinate and assist volunteers. The revolving volunteer staff include a receptionist to greet the patient and set up a chart, another individual trained to interview the client about his/her financial status and eligibility for clinic services, a nurse

to perform vital signs and gather pertinent history, and a physician to provide primary care. Often a nurse practitioner student, in consultation with her instructor from the Montana State University (MSU) College of Nursing, also provides patient care.

In the first few months of operation from 3 to 15 patients were seen each Saturday. However, as the GCC gained acceptance and recognition in the community, so have the number of clients seeking care. By October, 1997 as many as 27 patients were seen per clinic. The most common patient diagnoses and reasons for clinic visits are hypertension, bronchitis, sinusitis, upper respiratory infections, depression, and work physicals. Most patients were representative of Montana's least likely to be insured population, working individuals between the ages of 18 and 65 living at less than 200% poverty level. Some patients had health insurance, but were unable to take advantage of it with deductibles of $1,000 or greater (N. Cutler, personal communication, October 20. 1997).

The growing number of individuals seeking care at the GCC has been a strong indicator that low-cost primary care services were needed in Gallatin County. However, it has become difficult to address the needs of the growing volume of patients within the volunteer staffing and time constraints of the Saturday morning clinic. Patients have been overcrowding the reception room and waiting as much as two hours for an appointment. Physicians, nurses, and other volunteers have frequently remained beyond clinic hours to see patients. In response to this overcrowding, the Board is presently considering a temporary proposal to turn patients away from the Saturday clinic after a limit of 18 have signed up for appointments.

Needs Assessment

As the Clinic continues to grow and react to community needs, it is important that evaluation and assessment be utilized to help the Clinic expand in the best ways possible. As a participant in this evaluative process, I held discussions with volunteers, Board members, and the Professional Service Committee to identify current and future attributes essential to the survival and growth of the GCC. Out of these discussions, the following areas for improvement and/or unmet needs were identified: *Continuity*: Because the Clinic meets only once each week, and since different clinicians see patients each week, it can be difficult for volunteer clinicians to maintain continuity of care, such as follow-up on lab, medications, teaching, referrals, and return appointments. *Access*: Because the Clinic only operates on Saturdays, patients with acute conditions during the week must wait until Saturday or seek care in the Emergency Room. Even guaranteed access to the Saturday Clinic has become tenuous as patient load exceeds volunteer-staffing capabilities. Furthermore, patients requiring mid-week follow up must be seen elsewhere or wait a full week to have their condition reevaluated. *Coordination*: With different clinicians working each week, there is no single health professional to orient clinician volunteers to clinic activities and procedures and provide coordination of referrals, education, and clinic set-up.

Role of Nurse Practitioner

Concerns related to continuity, access, and coordination of care affect the credibility and effectiveness of the Clinic. To address these concerns I proposed hiring a

nurse practitioner (NP). The NP would facilitate the activities of the clinician volunteers and the provision of health care at the Clinic. The NP's role and duties would be specifically related to patient care. The position would be separate from, but complementary to, the Clinical Administrator, whose duties would continue to relate to the general administration of the Clinic.

The education and abilities of the NP, as well as the lower cost of employing an NP compared to a physician, make her/him uniquely capable and suited to practice in a community clinic. As the number of patients seeking care at the Clinic have grown, it has become clear that there is a need for the consistent presence of at least one health practitioner amidst the revolving group of physicians, NP's, and physician assistants who volunteer their time. Mundinger (1994) described collaborative practice between NP's and physicians as ideal for reducing costs while enhancing quality and comprehensiveness of care:

> In this structure, nurse practitioners bear the principal responsibility for the diagnosis and management of uncomplicated illness and provide the education, counseling, and management of disease prevention and health promotion, using primary care physicians as consultants and referral sources. Nurse practitioners have a good record of knowing when to call for help and when to refer a patient to a physician. (p. 213)

The effective utilization of a NP at the Gallatin Community Clinic has the potential to allow an expansion of clinic hours and services. A NP position would enable the Clinic to increase access to health care, improve the quality, continuity, and comprehensiveness of care that patients receive, facilitate improved communication among the volunteer medical and nursing staff, and be a liaison for medical and nursing students.

Objectives of Project

The objectives of the project were to: 1) attain support from the GCC Board to pursue funding for a NP position; 2). work with the GCC Professional Services Committee and others to define the NP position and related clinic objectives; 3) search for available funding and grant sources and select funding source(s) for application(s); 4) disseminate and discuss funding and grant information with the GCC Board of Directors prior to application; and 5) participate with GCC committee/board members in writing a draft of the grant application for the selected funding agency.

CHAPTER 2

LITERATURE REVIEW

> The Gallatin Community Clinic's mission is to improve the health of Gallatin County's adults and children. The clinic provides access to low cost quality primary and preventive health care to people with limited resources.
>
> Mission Statement
> Gallatin Community Clinic
> Revised February, 1998

The concepts *primary health care*, *access to health care*, and *community clinics* are embedded in the Gallatin Community Clinic's (GCC) mission statement. These concepts evolved as social scientists, consumer movements, politicians, community activists, and health care providers have described and addressed health needs in the population. In this chapter, these concepts are examined in the literature to better understand the context in which the GCC was founded and continues to evolve. Specifically, in light of this project's proposed development of a nurse practitioner position at the GCC, the historical successes of nurse practitioners in community clinics is explored - particularly in relationship to the nurse practitioner's ability to increase access to and provide quality primary health care to medically underserved populations.

Primary Health Care

Defining Primary Health Care

The most frequently cited interpretation of primary health care (PHC) was developed at the 1978 World Health Assembly in Alma-Ata, Russia, an international meeting of the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). It was at this conference that the phrase "primary health care" was coined to describe a global health strategy to decrease morbidity, improve life expectancy rates, and lessen the gap between living standards in the wealthiest and poorest nations of the world (Barnes, et al., 1995). In primary health care, health or well-being is viewed as a fundamental human right and the presence or absence of health is viewed as integrally related to broad social and economic issues.

As described by the WHO in their report, Global Strategy for Health for All by the Year 2000, (1981) primary health care is:

> . . . essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals . . . with the health system . . . bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO, 1981)

In practice, the above definition encompasses involvement of health providers in a multitude of arenas, including: education regarding existing health problems, equitable distribution of food and nutrition, adequate supply of potable water, basic sanitation,

maternal and child health care, prevention and control of locally endemic disease, treatment of common diseases and injuries, promotion of mental health and the provision of essential medications (WHO, 1978). Fundamental to the WHO definition of PHC is the acknowledgment that while many major communicable diseases have been eradicated through advances in science, there are still many more "dramatic decreases in morbidity and mortality [which could] be achieved by simple, local, inexpensive solutions to health problems, such as rehydration programs" (Barnes, et al., 1995, p. 7).

Defining Primary Care

Frequently PHC is confused with a system more accurately called primary care (PC). According to Barnes et al. (1995) PC refers to the individual's first-line contact with medical and health care providers and may include screening and maintenance care. PC also functions as a referral system and/or "gatekeeper" to other specialized services in the health care system. It may or may not include a fee for service or guaranteed equal access to health care regardless of ability to pay. Frequently, PC services are based out of community clinics or health department facilities. Primary care providers, while offering valuable services to the community, are generally reacting to the perceived health needs of individuals, rather than advocating changes in the broader community such as oppressive political structures, adverse environmental conditions, and economic inequalities.

Both *primary care* and *primary health care* are terms which have been appropriated by diverse groups with often divergent meanings. Wrestling with these two terms is much more than simply a semantic exercise: ultimately, the chasm between PC

and PHC is representative of the different approaches and solutions being advanced to meet health care needs worldwide. Richardson (1995) in explicating the differences between these similar sounding terms stated:

> Primary health care is an approach to health care that focuses on promotion of health and prevention of disease across the continuum of care. In contrast to *primary care*, in which the principal focus has been on the professional-client dyad and a client's first contact with medical providers, *primary health care* is concerned with the health of communities or populations. (p.15)

Access to Health Care

Access: A Multi-Dimensional Concept

Access is a term frequently used to express a wide array of concerns that "center on the degree to which individuals and groups are able to obtain needed services from the medical system" (Millman, 1993, p. 32). In describing needs of the rural elderly, Krout (cited in Richardson, 1995) described the six challenges of getting care as the availability, accessibility, affordability, appropriateness, adequacy, and acceptability of health care. Krout's description of barriers and facilitators to care is one of numerous models discussing the multi-dimensionality of the forces that determine accessibility of health care in relation to a specific population (Aday & Anderson, 1983; Blendon, Aiken, Freeman, & Corey, 1989; Bushby 1994; Robert Wood Foundation, 1983).

Bushby (1994), for instance, examined access in relation to minority populations. Her study described access as dependent on financial resources, distance to service, available transportation, physical disability, literacy, socialization, and the health provider's willingness to provide uncompensated or partially compensated care. Regardless of the specific barriers and facilitators to care, all the authors described access

as the prerequisite without which primary care cannot take place.

In 1995, a panel of nurse leaders convened to assess the status of community-based health care in the United States (Richardson, 1995). In their report for the National Institute of Nursing Research the authors describe fundamental concerns which should be addressed in provision of successful community-based health care. Although they list accessibility as one of six concerns, Richardson implies that the interplay between these concerns ultimately shape an individual's ability and motivation to access health care. This panel described the six concerns as follows:

> *Availability* - the number, types, range, and frequency of health and social services offered.
>
> *Accessibility* - the ability of persons to make use of services, encompassing distance, effort, and cost for obtaining a service, as well as awareness of the services. Accessibility included attention to qualities such as the comfort level of persons entering the health care system
>
> *Affordability* - the ability of consumers to pay for services and the mechanisms to secure payment for programs (e.g., voluntary contributions or fees).
>
> *Appropriateness* - the ability of the health care program to provide the services that are needed, desired, and performed.
>
> *Adequacy* - the ability of a program to allow persons to enter at the levels they need, to not offer too little or too much, and related issues.
>
> *Acceptability* - the congruence between the service and the expectations, attitudes, values, culture, and beliefs of the target population. Acceptability is paramount, for if health care is not acceptable to the target population, the services provided will not be effective. (p. 19)

Measuring Access

Problems with access to the health care system are notoriously difficult to quantify. Nevertheless, personal stories about the difficult circumstances of individuals who cannot afford health care abound; these stories frequently include the uninsured, the

working poor, and individuals on Medicaid who are unable to find a participating provider. Ultimately, a lot of guesswork is involved in estimating how many medically underserved people are out there in America.

In 1993, a 17 member committee sponsored by the Institute of Medicine (IOM) was formed to develop a systematic approach to measuring access. The final report by the IOM committee recommended nation-wide utilization of a specific set of indicators for monitoring access and health outcomes. The committee chose five objectives around which to organize its indicators:

1. Successful birth outcomes
2. Reducing the incidence of preventable diseases
3. Early detection and diagnosis of treatable diseases
4. Reducing the effect of chronic diseases and prolonging life
5. Reducing morbidity and pain through timely and appropriate treatment.

(Millman, 1993, p. 2)

In each of their five chosen objectives the IOM committee discussed ways to measure access and its outcomes. For instance, one indicator of access to health care and its relationship to outcomes is the well-studied correlation between adequate prenatal care and fewer low-birthweight infants. In another example, the committee described utilization of mammography as a simple form of access data that might be collected through County Health Departments. However, they also pointed out the difficulty of measuring health outcomes (early detection of breast cancer and appropriate follow-up treatment) related to improved access to mammography. Specifically, they pointed out that data collection becomes more unwieldy as important questions related to access and outcomes by race, age and socioeconomic status are included.

Measuring access and health outcomes related to timely and appropriate use of

services is particularly difficult to measure. One approach to measuring levels of access related to socioeconomic status is the use of patients' zip code to make assumptions about their income level. This approach was used in a study that demonstrated under-utilization of primary care by low-income individuals. It is known that mild cases of diseases such as bacterial pneumonia, urinary tract infections, and cellulitis may often be successfully managed with antibiotics in an outpatient setting. When these diagnoses were used as indicators, admissions at hospitals from exacerbation's of these diseases were two to five times higher in admissions from low-income zip codes than from high-income zones. Based on these results, an assumption was made that the lower income individuals did not access the health care system until their illness developed into a critical problem (Ambulatory Care Access Project/United Hospital Fund of New York, 1991).

Overall the IOM committee commented on the enormous complexity inherent in collecting access and outcome indicators (Millman, 1993). Further, they discussed the strengths and weaknesses of different data bases, including vital statistics, surveys, hospital discharge data, tumor registries, reportable diseases, and claims data. The study report concluded by exploring the roles that federal agencies and state and local monitoring processes should play in collecting access indicator data and suggested directions for future health services research. Ultimately, while the committee was able to develop a set of national objectives and indicators to utilize in measuring access and outcomes, the authors stated that actual collection of these data will likely continue in a piecemeal fashion. Their hope was that by "cross walking" details from different data collection sources across the nation that they could at least "assemble a montage that will form a more coherent, more consistent picture" (Millman, 1993, p. 175) of access and

health outcomes in the United States.

Providing Access: A National Debate

Barriers to and inequalities in access are volatile subjects around which national political debate have occurred - debates in which accusations have flown in many directions. Over the last two decades, barriers to access have been increasingly blamed on the shift to profit-driven care in the United States with specific ire aimed towards managed care and private insurance companies. For instance, a Massachusetts group called the Committee to Defend Health Care laments that "Public resources of enormous worth - nonprofit hospitals, visiting nurse agencies, even hospices - built over decades by taxes, charity, and devoted volunteers are being taken over by companies responsive to Wall Street and indifferent to Main Street" ("For Our Patients", 1997, p. 1773).

Poor access to health care has also been blamed on low reimbursement rates for Medicaid, the closing of rural hospitals, callous physicians, and even a lazy and handout-hungry populace. Still others call it a crime that a wealthy nation of over 300 million people does not have a unified or comprehensive health care program for its citizens. To many such critics, it is the patchwork and non-centralized assortment of health care services in the United States - a system which does not guarantee universal access to health care as a right of citizenship - that is ultimately to blame for the many people who fall through the cracks.

Even individuals with health insurance are described as having to fight to get reimbursement for well care, procedures, and hospitalization. Health Maintenance Organizations (HMO's) in particular are often portrayed as major culprits in building

barriers to equitable access. In an editorial in The Nation ("For Patients, Not Profits", 1997) the authors painted a dark portrait of managed care as they discussed the "abuse of the insured":

> . . . HMOs, flush with investors' cash, rushed to enroll the healthy, to exclude the sick and unprofitable and to offer doctors bribes [the polite word is "incentives"] to collude in profit-making. Hospital takeovers soared, not because of efficiency [for-profits are actually 8 percent costlier per case] but because of fraudulently inflated billings, payoffs to nonprofits' executives and board members, kickbacks to physician-investors and investment bankers' accounting ploys. (p. 2)

The authors conclude that the for-profit system hurts the consumers they are supposed to be serving. Examples they give include mothers and newborns denied adequate length of postpartum care, patients routinely denied access to preventative care and screening tests, and exclusion of individuals with pre-existing health conditions.

Access: Populations at Risk

Across the nation, hospital emergency rooms have increasingly become the point of access to the health care system for individuals without a regular source of ambulatory care. Brenner (1992) argued that the increased utilization of emergency rooms by low-income individuals has evolved because they do not have a regular and affordable source of primary care and/or they have delayed treatment until their health condition has become severe. According to Hayward, Bernard, Freeman, & Corey (1991) those individuals without a regular place of care are less likely to be insured and more likely to be low-income. Millman (1993) calls having a regular source of ambulatory care the "sine qua non for access to medical care." Without it, he argued, individuals do not have the benefits of preventative care, periodic checkups, and providers knowledge about their medical and psycho/social history at times of illness.

Those individuals with chronic diseases are especially at risk for negative consequences when regular care is absent. Care may be fragmentary and lack continuity for the chronically ill when care is sought only for an acute health crisis. Access to regular care for the chronically ill enables periodic monitoring of the patient's health status, nutritional and other counseling, and the prescribing of appropriate medications and referrals. While life cannot always be extended, a regular provider can assist in minimizing discomfort, improving functioning, and helping the chronically ill individual to access social and economic resources.

Inability to pay is an enormous barrier to accessing health care and affects both the insured and uninsured. The costs of health care have risen faster than almost any other sector in the economy and have far outpaced growths in real incomes. Millman (1993) described it as "virtually unfeasible for most people to pay directly for any sizable portion of their medical bills when illness strikes" (p. 14).

A group sometimes dubbed the "underinsured" is also growing. The underinsured includes individuals who have insurance but still find it difficult, if not impossible, to meet required deductibles and co-payments in their policies. As well, the underinsured includes many people with catastrophic insurance that does not offer any coverage for primary care services. Even many elderly people who receive Medicare benefits could be called underinsured: Medicare benefits are not sufficiently comprehensive to meet the needs of the majority of elderly individuals, 80% of whom have purchased additional health coverage to supplement their Medicare plan (Millman, 1993).

Those individuals qualifying for government-subsidized Medicaid insurance may also have problems accessing health care. In fact, in some regions where few health care

providers accept this insurance, Medicaid may provide only the illusion of access. Even when living in areas with sufficient numbers of primary care physicians, many of today's poor cannot find a provider who will accept them as Medicaid patients, a trend largely blamed on Medicaid's low-reimbursement rates. Primary care providers across the nation have complained that Medicaid's reimbursement rates do not generate sufficient revenues to support their practices. Those providers willing to take patients with Medicaid insurance frequently set quotas for how many of these "charity patients" they will see ("For Our patients", 1997).

Nationwide there are three major surveys that have periodically monitored the size of the uninsured population in the United States (The National Medical Expenditure Survey; The National Health Interview Survey; The Current Population Survey of the Census Bureau). In each survey an "upward trend of about 25 percent" (Millman, 1993, p. 41) in the size of the uninsured population was found to have occurred during the 1980's. More recent data from the 1996 Medical Expenditure Panel Survey (MEPS) indicates that the proportion of the uninsured population continues to grow (Millman, 1993). And, as in previous studies, the MEPS report indicates that the poor and minorities are clearly the groups which continue to bear the heaviest share of the burden of being uninsured.

Fortunately, the 16.6 percent of the uninsured population do not all go without care. Many institutional and individual providers provide some form of free or reduced-price services, frequently funded through federal, state, and local budgets. However, these "safety nets can be threatened by government budget cuts or the inability of programs to keep pace with increased demand when there are downturns in the economy"

(Millman, 1993, p. 42). Additionally, those individuals living in rural and less populated areas often have no access at all to the community clinics and programs more commonly available in urban settings.

Community Clinics

Historically community centers and clinics have played an important role in both local and national efforts to increase access to health care to economically, geographically, and otherwise disadvantaged Americans. In part, the modern community clinic is rooted in the events and social movement of the late 1800's, an era in which attention was focused on the social problems of the working class in the increasingly urban and industrialized society of the post Civil War United States. During this period the growth of "settlement houses," a type of neighborhood center that sought to establish contact between rich and poor in class-stratified neighborhoods, first blossomed in the United States. Among other things, settlement houses provided a space for social discourse, childcare services, clubs, and vocational classes. Individuals from the settlement houses were deeply involved in reform movements in the factory, the school, and in public health (Levine & Levine, 1970; Trolander, 1987).

Certainly nurses played a crucial role in the development of settlement houses and other community-based health initiatives. In 1898 Lillian Wald established the Nurse's Settlement (later known as the Henry Street Settlement) in New York City. As cited in Levine & Levine (1970): "Here the visiting nurse service, with their characteristic uniforms and arm bands, was established. Their nursing skills gave them entry and safe passage everywhere and also gave the women access to the problems of the

neighborhood" (p.85). Public school nursing and a vast variety of public health efforts developed from the Henry Street Settlement. Some of the first low-cost or free maternal, well child, medical, and dental clinics, as well as birth control services originated in settlement houses and their sister projects.

However, Trolander (1987) states that "the growth over the past fifty years in publicly funded health care services has meant that most of these settlement clinics have become a thing of the past" (p. 134). Certainly, various political eras, such as the 1930s New Deal and the 1960s Great Society have represented periods of increased energy and federal spending for public health initiatives, including community clinic development. Still other periods of federal withdrawal from publicly-funded programs have stimulated the emergence of volunteer-run and privately-funded health centers to meet the needs of the many people who are unable to attain or afford health care. Today, various types of neighborhood centers and clinics to assist those who face barriers to health care continue to blossom forth in various forms. Often started on shoestring budgets, many of these centers ultimately come to depend for funding on a potpourri of federal, state, community, and private sources.

In 1971 the National Association of Community Health Centers, Inc. (NACHC) was founded as a membership organization to advocate on behalf of "non-profit community-oriented primary health care programs and the millions of medically underserved and uninsured people they serve" (NACHC, p. 2). The NACHC, whose members collectively provide health care service to more than 10 million people, argue that community-based health care in both the public and private sectors can only be strengthened through the power of association between these organizations. Non-profit

health centers often sprout from quite humble beginnings and in isolation from other similar clinics; as these clinics grow the NACHC is available as a resource to provide technical assistance in areas of clinical operations, management, and governance (NACHC, 1997).

Role of Nurse Practitioners

Providers of Primary Care *and* Primary Health Care

Nurse practitioners (NPs) have been the focus of literally hundreds of studies evaluating their effectiveness as health providers. Specifically, their competency, cost effectiveness, and ability to provide quality primary care (PC) have been assessed in great detail (Saffriet, 1992). Perhaps the most comprehensive of all these studies was requested by the US Senate Committee and published in 1986 by the Office of Technology Assessment (OTA). This was an analysis of 268 previous studies and was published under the title: Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis (as cited in Saffriet, 1992).

Overall, OTA's meta-analysis clearly substantiated the appropriateness of family NPs as providers of quality and cost effective PC. Overwhelmingly, the studies indicated that patients were satisfied with the care that NPs provided and consistently rated them as superior to physicians in their ability to teach and convey information. The OTA study concluded that "within their areas of competence, NPs . . . provide care whose quality is equivalent to that of care provided by physicians" (Safriett, 1992, p. 159).

NPs also have specific training and experiences that prepare them to be effective as practitioners in the broader context of primary health care (PHC):

> Nurses are more likely to talk with patients and adapt medical regimens to a patient's preferences, family situation and environment. They are also more likely to provide disease-prevention counseling, health education, and health-promotion activities, as well as to know about and use community resources, such as nutrition programs, self-help or group therapy, and parenting and stress-reduction programs. (Mundinger, 1994, p. 211)

NPs are educated to be advocates for their patients *and* for the communities where they live. At his/her best, the NP strives to provide holistic care by demonstrating competency, caring, cultural awareness, effective case management, timely coordination of complex health care services, and active community involvement.

Increase Access

While medical schools in the United States are overflowing with students and new graduates, access to basic health services has remained out of reach for many Americans as the majority of physicians continue to pursue specialty education and practices (Safriett, 1992). To a significant extent, the NP role evolved in response to this need for more primary care providers in rural and inner-city America. Since the creation of the first NP program in Colorado, NPs have increased people's access to primary care services in a variety of settings. Frequently, the NP goes directly to the client, as witnessed in their practices in school-based clinics, migrant worker camps, nursing homes, correctional facilities, and hospice programs. They also provide care in nurse-managed community clinics, in collaborative practices with physicians, and in hospitals. A 1990 OTA study found that nurse practitioners "improve geographical access to primary care and are especially valuable in improving access in rural areas and in health programs for the poor, minorities, and people without health insurance (cited in Safriett, 1992, p. 164).

NPs also often cost the patient less than a visit to a physician-only practice. This cost-savings is not because their services cost less, but instead relates to the more economic plan of care typically chosen by the NP. Overall, NPs choose interventions for their patients that are less costly than, but as effective as, the interventions selected by physicians for the same diagnosis (American Nurses' Association, 1993).

It may be true that NPs are less productive than physicians if productivity is measured in patient visits per hour. As described in the 1986 OTA study, NPs generally spend more time per patient and see fewer patients per day than do physicians. However, during the patient visit the NP is "providing both services usually provided by physicians as well as services generally provided by nurses including preventative counseling and increased information about compliance with the prescribed course of treatment" (Safriett, p. 167). Ultimately, it can be argued that the extra time the NP spends with his/her patient is time well spent. Increased patient understanding and participation among patients treated by NPs has demonstrated improved patient outcomes that may save the patient and the system money (American Nurses' Association, 1993; Kaplan, Barnett, & Logan, 1998; Ramsay, McKenzie, & Fish, 1982).

Role in Community Clinics

The NP is prepared and motivated to go beyond a medically oriented PC model to help community health clinics grow into dynamic places that are responsive to multi-faceted community needs. Advanced Practice Nurses have demonstrated this innovation and commitment to community needs in over 260 nurse-managed clinics in every state in the Union. In a community clinic, the NP has important work to do as a clinician, but

also has the opportunity to prove herself as a fund-raiser and administrator - in fact his/her job may depend on it. Particularly in rural areas with few formal resources, the NP may take a leadership role not only in empowering his/her own patients, but also in facilitating local health and social issues. Ultimately, community clinics provide a rich environment for the NP to collaborate with a myriad of individuals and groups in the provision of health care and the creation of safe, healthy, and equitable communities (Edwards, Kaplan, Barnett, & Logan, 1997; Hatcher, Scarinzi, & Kreider, 1997).

Summary of Literature Review

Exploration of the literature focused on concepts embedded in the Gallatin Community Clinic's (GCC) mission statement, specifically *primary health care, access to health care,* and *community clinics.* These concepts were examined to better understand the context in which the GCC was founded and in which its volunteers strive to carry out its mission. The NP's ability to work in community clinics, increase access to care, and provide primary health care was also examined.

Based on the many definitions of *primary health care* and *primary care* reviewed, the GCC predominantly represents a *primary care* focus. In other words, "its principal focus has been on the professional-client dyad and a client's first contact with medical providers" (Richardson, p. 15). However, the Clinic's mission to improve the health of the community, to provide preventive services, and to lessen the health care gap between the rich and poor also fits well within the *primary health care* model. Krout's (cited in Richardson, 1996) six dimensions of access - availability, accessibility, affordability, appropriateness, adequacy, and acceptability - provide a framework for evaluation of

access to care. Yet, other studies point out the difficulties in measuring which individuals have barriers to accessing health care, as well as in measuring the outcomes for those who do receive it.

As reflected in the literature, the GCC is one of hundreds of community clinics across the United States. These clinics, which are funded by a mixture of federal, private, and community dollars, are providing health care to millions of medically underserved and uninsured people. Turn of the century historical accounts of nurses' role in establishing neighborhood-based health clinics set the stage for today's nurse-managed clinics. The successful marriage of community health clinics and nurse practitioners is well represented in the literature, with particular emphasis placed on the NP's competency and cost-effectiveness, as well as the ability to teach and to communicate effectively with the patient.

CHAPTER 3

PROJECT DEVELOPMENT

This chapter outlines the process I used to develop and fund a Clinician/Health-Coordinator (C-HC) position at the Gallatin Community Clinic (GCC). My interest in developing the C-HC position was stimulated by my volunteer involvement at the Clinic and was nurtured through my association with the Clinic's Professional Services Committee. The project development was a multi-stepped process which included securing support from the GCC Board of Directors, developing a job description and budget, and researching funding sources. The project culminated in the submission of a grant to the United Way of Gallatin County and a written proposal to the Bozeman Deaconess Hospital System.

Early Development of Project

Professional Services Committee

My interest in developing a paid nurse practitioner position at the Gallatin Community Clinic grew out of my experience as a nurse volunteer at the Saturday Clinic. At the end of a busy volunteer shift in November, 1997 I spoke to the Clinic Administrator and raised my concerns with clinic flow and lack of continuity of provider care and follow-up (as described in Chapter One). The Administrator asked me to attend

a meeting the following Monday so that I could discuss these concerns with members of the GCC's Professional Services Committee (PSC).

The PSC provides ongoing assessment and guidance of clinic function. The PSC is composed of clinicians, its members have included nurse practitioners, physicians, physician assistants, mental health counselors, and pharmacists. The Clinic Administrator attends the meetings when necessary. The physician assistant on the committee also provides chart review and lab follow-up for GCC volunteer clinicians following each Saturday clinic. Some of the committee members are also Board members.

At the meeting in November I discussed what I perceived as the growing need for a paid clinician who could insure increased continuity of care, provide communication with the volunteer health providers and enable us to expand Clinic hours. The PSC members were very interested in this idea and asked me to further develop the concept of a paid clinician at the GCC. I also accepted their invitation to join the committee.

Originally, as is reflected in the following sections and appendices, I envisioned the paid clinician to be a nurse practitioner (NP). Later in the development process the position was expanded to include physician assistants and the position title of "Clinician/Health Coordinator" (C-HC) was coined.

Developing Initial Position Description

In the two weeks following my first PSC meeting I worked - along with a physician who is a Board Member and a member of the PSC - to define the purpose and possible duties of a paid NP position at the Clinic. At our first meeting we brainstormed

on a number of issues related to the position, including defining a need for the position, describing the position and duties, getting Board approval to develop the position, and exploring sources to fund the position. Our meeting was productive and I immediately went home and organized and typed up notes from our session. Throughout the process of funding this position I have continued the habit of promptly typing and organizing notes after each meeting to clarify issues and identify tasks and goals. Appendix A includes the notes from this first meeting and reflect the initial stage in development of the C-HC position. These same notes were reviewed at the next meeting of the PSC and the committee asked me to type up a formal proposal to present at the next GCC Board meeting.

Proposal to Board of Directors

I presented my proposal to develop and fund a half-time NP position at the December 12, 1997 meeting of the GCC Board of Directors (Appendix B). The Board was receptive to the proposal, and while three Board members were absent, there were enough present for a quorum. I was given approval and encouragement to seek out funding sources for this position.

Clinician Survey

In conjunction with my work on the Professional Services Committee, and as a component of a needs assessment for the NP position, I also developed a questionnaire (Appendix C) to be sent to all volunteer clinicians. At their December 12 meeting, the Board of Directors reviewed and approved the questionnaire for mailing. I soon discovered, however, that there was no existing master list of volunteer addresses. In

January the Clinic Administrator and I located old lists and created a current volunteer directory. The survey was sent to 60 volunteers and had a 50% return rate. Results of this survey later were valuable in understanding levels of openness, cooperation, and reservations held by GCC volunteer clinicians towards hiring a mid-level practitioner. The needs assessment was also used by the Board to assist them in evaluating Clinic operations and the clinicians satisfaction with their volunteer experience at the GCC.

Exploring Sources of Funding

I began exploring funding sources in January 1998 at the Area Health Education Center (AHEC) office on the Montana State University campus. Initially I looked through AHEC binders containing information on federal grants for public health, nursing, and community education projects, but discovered that these were largely research-based grants. I also used the AHEC computer and browsed their extensive internet directory to grant-funding agencies in the health field. As I scrolled through the directory, I printed out information from those organizations that represented possible funding sources. Over the course of two days I had compiled data on 42 foundations and organizations which represented potential sources of funding.

In February, the GCC Clinic Administrator and I spent a morning reviewing the information collected from the AHEC internet directory. We particularly looked for those organizations with a demonstrated interest in funding health-related projects, with a record of funding projects for under-served populations, and with an interest in Montana or non-urban settings. We also sought out agencies that might provide funding amounts greater than $15,000. Together we determined which organizations' funding missions

were compatible with our goals and funding needs and later searched the directory for more in-depth information about those granting agencies.

On closer examination, the majority of the organizations we examined had limitations in their grants which excluded our project, such as geography (e.g. recipients must live in California or New York), type of population served (e.g. HIV positive or elderly), or type of project (e.g. education, research). We also developed a list of local businesses that were part of larger corporations and might have the resources to fund our project. When we pursued the philanthropic interests of these businesses we were frequently told that they fulfilled their mission to the community through allocation of money to the United Way Foundation.

Ultimately, as will be discussed in this chapter, we decided to pursue funding from three organizations: the Public Welfare Foundation, the United Way of Gallatin County, and the Jerry Metcalf Foundation. Later, as other opportunities presented themselves, we also targeted our funding efforts towards the Bozeman Deaconess Hospital Systems and exploration of federal funding.

Strategic Planning Meeting

On February 22, 1998 I attended a day-long strategy session with the GCC Board of Directors. The session was facilitated by a Board Member who used the SWOT (strengths, weaknesses, opportunities, threats) style of strategic assessment to help us examine our organization and plan for the future. In a SWOT analysis those attending the meeting participate in a brainstorming session which is used to identify the strengths, weaknesses, opportunities, and threats to an institution or endeavor. These identified

areas are then used as the foundation for the organization's strategic planning in the coming months and year(s). During the GCC's strategy session, the lack of a paid clinician was quickly identified as a weakness by the Board members. As well, many complimentary concerns such as an inadequate system for patient follow-up, limited hours that the Clinic is open, and increasing difficulty in finding volunteer providers for the Clinic were also described as weaknesses. My existing proposal to hire a nurse practitioner was identified as an opportunity.

However, while identified as an opportunity, discussion around hiring a nurse practitioner also created some tense moments at the strategy meeting. Board members who were absent at the December meeting when my proposal to develop a NP position was initially approved, denied any knowledge of this proposal. A new member who had joined the Board in January, was unaware of the plan to hire a NP and was concerned that increasing clinic hours would adversely affect the staff at the County Health Department where the GCC would be sharing Clinic space as of July, 1998. Other Board members, including the new President of the Board, questioned whether we should not be seeking a physician rather than a nurse practitioner for the position.

I spoke to the proven effectiveness of nurse practitioners in the community clinic setting and also argued that the total cost of hiring a physician, including their malpractice insurance, was prohibitive. As well, we discussed the possibility that other physicians might not want to continue in their volunteer capacity if they knew another physician at the Clinic was being paid. With strong advocacy from some Board members (including a physician), both the proposal to hire a NP and the decision to expand Clinic hours were retained. However, as described below, a decision was also made to expand

the job description to include Physician Assistants.

Position Expanded to Include Physician Assistants

The pros and cons of employing a nurse practitioner (NP) versus a physician assistant (PA) were also debated at the Strategic Planning Committee. A number of people pointed out the excellent volunteer work that PAs had already provided for the Clinic and felt they should not be excluded from the job search. The necessary physician oversight for PAs to practice was generally perceived by the Board as a small barrier to practice in the Clinic setting. Generally, it was felt that the "right person" rather than "right job title" was going to determine the effectiveness of their ability to juggle clinical, administrative, and community outreach duties. Ultimately, a decision was made by the Board to expand the job search to PAs, who would be grouped with NPs in Board discussion as the "Clinician/Health Coordinator"(C-HC) position.

Committee to Hire a Clinician/Health Coordinator Formed

By the end of the strategy planning session the Board had established nine major objectives to pursue in the coming year. One of these objectives was the establishing of a committee to hire a C-HC. The duties of the committee included: a) Develop a job description including clinical, administrative, and educational duties; b) Develop a budget for the position, including salary, benefits, malpractice insurance, and supporting expenses; c) Determine short term and long term funding sources for this position; d) Advertise and interview for the position and respond to Board with a recommendation of who to hire. I was nominated to this committee along with a physician and two NPs.

Developing a Budget

To develop a budget for the C-HC position I began by contacting the administrators at eight community clinics in Montana. Many of these clinics are federally-funded clinics that originated as volunteer-run organizations. Fortunately the clinic administrators were all willing to share information about the salary and benefits packages they offer their NPs and PAs. I also gathered salary and benefits information from the eight NPs who work in the Bozeman area. These practitioners all practice in the field of family planning and reproductive health and make a lower wage than practitioners in the community clinics which provide full primary care services. I chose not to contact mid-level practitioners who work for the Indian Health Service because their salaries are determined by federal wage scales.

The committee members and I discussed the disparity between Bozeman's lower wages for NPs and PAs who provide only family planning and reproductive health services, as compared to statewide norms for family nurse practitioners (FNP) and PAs who provide full primary care services. After some debate, and since the GCC provides a variety of primary care services, they concurred that we should use the higher pay scale to attract well-qualified candidates to the job. The budget and benefits package I developed approximated the median starting wage and benefits provided to the NPs and PAs in the eight community clinics contacted. Determining issues of malpractice insurance and licensing fees involved phone calls to different agencies to determine their fees and requirements (Appendix D).

Job Description

Developing a job description was an ongoing process that began at the inception of this project. From the beginning, this position was conceived as combining both clinical and administrative duties. I first described the possible duties of this position in my original proposal to the Board. Numerous discussions with the Clinic Administrator, volunteer clinicians, Board members, and meetings with the Professional Service Committee helped in refining and defining the C-HC's purpose and duties at the Clinic. On April 7, 1998, I met with the members of the C-HC committee to write a job description. The process was greatly facilitated by modeling the job description after those obtained from NP and PA job descriptions at both Bridger Clinic in Bozeman and Community Health Partners in Livingston, MT. Using these existing documents and the clinician's duties outlined in my proposal we were able to write the C-HC's job description at our two hour meeting. This document was later approved with slight amendments at the Professional Services Committee's April 22, 1998 meeting (Appendix E).

The decision to describe and advertise the C-HC as a 0.50 or "half-time" position was based on two main premises. First, Board members concluded that expanding the existing 0.50 Clinic Administrator position to a 0.75 position would allow her to perform some administrative duties previously anticipated for the C-HC. Secondly, the planned expansion of Clinic hours appeared to be somewhat limited by the anticipated move of the GCC from donated clinic space at Bozeman Physical Therapy to donated clinic space at the new County Health Department. Board Members worked with the County Health

Department personnel to negotiate use of clinical rooms and hours of operation for the GCC and office space for the Administrator and C-HC. Ultimately it was decided that the County Health Department could provide adequate facilities for a half-time C-HC.

Pursuing Funding

United Way of Gallatin County

I agreed to write the United Way grant when I was informed that no application was planned by the Board of Directors for moneys from United Way in the 1998-1999 fiscal year. I accepted the task March 17, 1998 with the grant due on April 3, 1998. I was concerned that no formal meeting of the Board of Directors was held prior to submission of the grant and that a number of Board Members, including the President and Treasurer, would be on vacation and inaccessible for consultation while I wrote it. The Clinic Administrator attempted to talk in person or by phone with all the Board Members to get verbal approval to apply for funding from United Way. While those Members contacted were supportive, the Administrator was not able to reach other members who were away on business or vacation trips. Board support was especially important because acceptance of United Way funding carries the caveat that agencies who receive funding will also participate in fundraising activities for the United Way.

Prior to writing the grant application I had a 30 minute phone conversation with the Director of United Way of Gallatin County. She explained the process by which United Way grant applications are reviewed, which includes separate reviews by a citizens committee and by the United Way of Gallatin County Board of Directors. We also discussed such issues as appropriate length and style of answers to the eight narrative

questions, specificity of information required on financial statements, demonstrating non-profit tax exempt status, and maximum grant allocations given by the agency.

Over the next week the Clinic Administrator and I decided to seek partial funding for both the Clinic Administrator's salary and the C-HC position under a project called "Expanded Services." The Clinic Administrator assisted in collecting the necessary financial and clinic data to complete the grant. I finished the first draft of the grant prior to meeting on March 31, 1998 with the Secretary of the GCC Board who had agreed to review the grant application. He was enthusiastic about the grant as written and helped edit the narrative portion and complete the budgeting and financial information sections of the grant. Prior to meeting with the GCC Secretary I felt worried that so many decisions related to the grant had been left to myself and the Clinic Administrator while Board Members were either on vacation or busy elsewhere. The Secretary listened closely to my concerns and followed up by contacting additional Board Members to discuss and get informal approval of the grant request prior to its submission. The grant application was submitted to the United Way of Gallatin County's office on April 2nd, 1998 (Appendix G) and grant awards were announced on June 2nd, 1998.

Jerry Metcalf Foundation

After consulting with the Board of Directors, the Clinic Administrator and I wrote a two page letter of interest to the Jerry Metcalf Foundation in March (Appendix F). However, the agency responded that they were not interested in funding our project.

Public Welfare Foundation

The Public Welfare Foundation (PWF) was identified as a possible funding

source, in part, because it accepts grant applications on an ongoing basis throughout the year. However, since the C-HC position was funded through other agencies (as described in Chapter Four) it was not necessary to pursue PWF funding for this project. Nevertheless, the agency has been identified by the GCC Board as a potential source of funding for future projects.

Bozeman Deaconess Hospital System

In March, 1998 the Board Secretary showed the proposal written for the Jerry Metcalf Foundation to an administrator at Bozeman Deaconess Hospital Systems (BDHS) who responded that the BDHS foundation might be interested in funding the C-HC position. The administrator commented that a relationship with the GCC could be beneficial to the BDHS foundation from both a humanitarian and financial perspective. At the community level the BDHS perceives the GCC as filling an important niche in meeting the needs of medically underserved in Gallatin County. From a financial perspective, the hospital saves money if the GCC meets the primary care needs of patients of low-income who might otherwise end up in the BDHS emergency room and be unable to pay their medical expenses. In collaboration with the Board Secretary I developed a proposal requesting BDHS funding for the 0.50 half-time C-HC position (Appendix H). This proposal was presented by the Clinic Administrator and three GCC board members to the BDHS Board in May, 1998.

Federal Funding

Federal money, which is available to eligible community clinics, is another possible resource for both short and long-term funding. For instance, the newly opened

and federally funded Community Health Partners clinic in Livingston, MT serves a similar population base as the GCC. The Livingston clinic has a full-time staff, is open Monday through Friday, and is primarily designed to serve people from Park County. Informal negotiations are presently in progress to develop a collaborative relationship between the Livingston Community Health Partners and the GCC. Ultimately, Community Health Partners may be able to fund the proposed C-HC position at the GCC. In exchange, those patients seen by the C-HC at the GCC will be counted towards patient quotas necessary for Community Health Partner's clinic fulfillment of their federal grant requirement's.

However, in order to receive federal funding the GCC must first establish itself as being located in a Medically Underserved Area (MUA). Establishing MUA status increases the GCC's funding options, both enabling the previously described relationship with Community Health Partners and preparing the groundwork if the GCC Board of Directors decides to apply for federal money to fund the Clinic's expansion.

Summary

Developing and funding a Clinician/Health-Coordinator (C-HC) position at the Gallatin Community Clinic (GCC) was a multi-stepped process. The project development included securing support from the GCC Board of Directors, developing a job description and budget, and researching funding sources. The actual grant and proposal writing was an evolving process motivated by agency deadlines (the United Way), moving past rejection (Jerry Metcalf proposal), and recognizing opportunity when

it presented itself (Bozeman Deaconess Hospital Foundation). As a student and volunteer, I could not have developed and funded the C-HC position without a dynamic and supportive relationship with the GCC Professional Services Committee, Board of Directors, and Clinic Administrator. Their involvement was vital to defining the C-HC position and providing support for its funding and implementation.

CHAPTER 4

PROJECT OUTCOME

The purpose of this project was to identify and develop potential funding sources for a nurse practitioner position at a community clinic serving the medically underserved. I proposed that a salaried nurse practitioner would enable the Gallatin Community Clinic's primarily volunteer-staffed organization to sustain its present services and to provide improved continuity of care and quality assurance. Ultimately, I believed that this new position would allow the clinic's expansion to further address the unmet health needs of low-income individuals, families, and their children in the community.

Results

The resulting practical application of this project has been the successful development and funding of a half-time nurse practitioner or physician assistant position at the Gallatin Community Clinic (GCC). This position, which includes both clinical and administrative duties, has been titled Clinician-Health Coordinator (C-HC). In June the United Way Grant application was partially funded, giving the Clinic $10,000 to apply towards staffing needs. The GCC Board anticipates allocating this money to expanding the existing Clinic Administrator's position. In July - and specifically applicable to the aims of my professional project - the proposal submitted to the Bozeman Deaconess

Hospital System (BDHS) was fully funded. The BDHS's donation was deposited to the GCC this August, providing $29,363 to fund the GCC's 0.5 C-HC position. As of September, 1998, the position had been advertised, 13 applications were submitted, and interviews with three candidates were pending.

Long-term Vision

The long-term outlook for the clinic's expansion and role in Gallatin County is an issue that continues to be explored by the GCC Board of Director's. As of August, 1988, the GCC moved into a new space at the County Health Department's new facilities. Pending the hiring of a C-HC, plans are in place to open a midweek clinic to supplement the Saturday clinic. Prior to making long-term expansion plans for the GCC, its Board members will assess how well the Clinic functions in its new location with the addition of a mid-week clinic and a paid C-HC.

As described earlier in this paper, the possibility of applying for federal funding and/or partnering with Community Health Partners (CHP) in Livingston is still a long way from becoming a formal proposal. In June a special GCC Board Meeting was held in which federally-funded expansion options were discussed with the CHP Director and a Western Region Public Health Service Officer. I anticipate that the new C-HC will play an important role in determining not only the renewal of funding for his/her own job, but also in creating a long-term vision for the Clinic.

Limitations

The typical cycle for funding community agencies such as the GCC is based on an

annual reapplication process. The sources and terms of funding found for the C-HC position reflect this annual cycle, thus leaving the permanency of the funding for this position somewhat tenuous. Renewal or expansion of funding for the C-HC position will need to be addressed by the Board if the position is to become permanent.

Lessons Learned

Local Support

While searching for funding sources I found there are many institutions and foundations that allocate money to health-related projects for the medically-underserved. However, further inquiry proved that most of these organizations had highly specific application criterion which did not match our needs or population. Ultimately, we were successful by applying for funding from local agencies and institutions. The investment in the project by local institutions is particularly meaningful because it implies not only financial, but also moral and volunteer support for the GCC's mission in the community.

Physician Support

It is encouraging that the C-HC position was funded by an influential group in Gallatin County, the Bozeman Deaconess Hospital System (BDHS). Since the GCC is dependent on the volunteerism of local physicians, financial support from the BDHS implies a stamp of approval that may encourage continued physician volunteer participation. Additionally, the support by the BDHS gives pause to some of our assumptions as mid-level practitioners that the medical community is not supportive of our role in the health community. The BDHS board, which has many physician

members, was willing to "buy" the idea of a nurse practitioner or physician assistant as a primary provider of health services at the Clinic. Perhaps the creation of positions which are perceived by physicians as complementing, rather than competing with them, is one way mid-level providers will find a niche in communities that have been ambivalent or hostile to their presence.

Implications and Opportunities

Volunteerism and Paid Positions

Concern about those individuals who cannot afford health care has led many communities to develop volunteer provider health clinics. Similar to the Gallatin Community Clinic, these clinics are often started on a very small budget, have limited hours of service, and depend on the goodwill and effort of the medical and nursing community to maintain volunteer staffing. Individuals who volunteer at these clinics discover they provide a fertile environment to develop collaborative relationships across the spectrum of the health care community, including with nurse practitioners, physician assistants, therapists, nurses, physicians, and community health activists.

Ultimately, most volunteer clinics continue to expand, and as they do, the need for salaried health practitioners becomes inevitable. Midlevel practitioners, particularly NPs who are educated to be advocates for their patients *and* for the communities where they live - are ideal for these positions. By demonstrating competency, caring, cultural awareness, effective case management, and appropriately utilizing collaboration and consultation - the NP can find rewarding employment and fill an important niche in the community.

Change Agent

It was invigorating to take a seed of an idea and participate in the process by which it is nurtured and brought to life. This project was a small microcosm that represents our abilities as nurses and citizens to act as change agents in the community. Norton and Grady (1996) write that "change is a messy, emotional, disorganized business [even] when it is planned" (p. 250). At times, in attempting to accomplish this project, I found Norton and Grady's words to be all too accurate. Frequently I found myself "veering off " from my identified tasks to convince someone that the project was worthwhile or to explore a path or navigate a roadblock previously unidentified.

At other times, the successful development of the C-HC position seemed inevitable, in large part because its purpose meshed so well with the Clinic's evolving needs. Kennedy (1984), in describing four "rules" which must be in place for organizational change to occur, could well be describing the GCC and the environment and variables which allowed the successful implementation of this project: 1) change occurs only when a *real need* for change exists; 2) change occurs only when a *clear plan* exists for at least the first few steps of the change; 3) change occurs only when an *actionable consensus* of people in the organization are behind the change; and 4) change occurs inevitably *at its own pace* (p. 330).

Developing and implementing the C-HC position was possible because, as Kennedy's four rules infer, the GCC was ripe for change. Since its inception, the GCC has attempted to respond to the unmet health *needs* of the medically underserved in Gallatin County. With its limited hours of service and sole dependence on volunteer

clinicians, the GCC fell far short of meeting this need. The development of a paid clinician position provided a *clear plan* that allowed the GCC to take steps towards expanding its services. The support of the Clinic Administrator, Board Members, and other volunteers, provided an *actionable consensus* for creating a C-HC position in response to a mutually recognized need to improve and expand its services.

The development of a paid clinician position - from the inception of the idea, to the actual interviewing of candidates for the job - took almost a year. This *pace* was in many ways determined by the cumbersome nature of work within a volunteer organization. Yet, ultimately, the process was also strengthened by the support and involvement of these same volunteers. Through their combined efforts to develop this project they are better prepared to envision and implement continued change and growth at the GCC.

Kotter (1996) states that the role that a "shared vision" plays in implementing organizational change, cannot be underestimated: "Vision helps align individuals, thus coordinating the actions of motivated people in a remarkably efficient way. The alternatives - a zillion detailed directives or endless meetings - are much slower and costlier" (p. 70). The ability of GCC volunteers to embrace the Clinician-Health Coordinator position as part of the Clinic's greater vision, provided a sense of purpose, urgency, and even joy, to the work necessary to implement it.

Collaboration

Respect and careful nurturing of working relationships enabled the successful development of the C-HC position at the GCC. This collaborative process is the grease

which oils the wheels of community organizations. Hanson and Spross (1986) write that "shared values, commitment, and goals allow for differences in opinions and approaches (that enable) successful collaboration" (p. 242). Certainly, development of the C-HC position was made easier by the shared commitment of every GCC volunteer to improving access to health care for the medically underserved.

The development and funding of the C-HC position at the GCC began by voicing an idea, finding allies to help articulate and promote it, and then persevering with the work necessary to accomplish it. As a graduate nursing student, I found that my clinical foundation, as well as graduate course work in research, epidemiology, finance, administration, and rural health issues, provided me with the tools and impetus to undertake this project. However, I also found it particularly helpful that my primary collaborators on this project were a physician and an administrator, both of whom frequently represented different viewpoints from mine. As Hanson and Spross (1996) describe it, effective collaboration occurs when "each member brings a particular set of skills and unique expertise to the table for a combined strength that cannot be matched by individuals working alone" (p. 234). Together, through the creation of the C-HC position, we were able to implement a practical solution to address some of the health care needs of the medically underserved in our community.

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APPENDICES

APPENDIX A

Outline: Major Tasks in Developing a Nurse Practitioner Position at the Gallatin Community Clinic

Major tasks in developing a Nurse Practitioner position at the Gallatin Community Clinic

1. Needs assessment

-Mail a survey to physician, nurse, NP, and PA volunteers
-Focus group with Board Members
-Focus group/brainstorm with members of Procedures Committee (specially with Holly H. re. chart review)
-Survey of client satisfaction, perceptions of services provided, patient education needs: "Marketing survey"
-Outreach/phone interviews with directors or NPs at similar clinics in Montana and surrounding states (use to forecast needs as clinic grows)
-Profile of practice: demographics, disease prevalence, referrals made.
-Assess clinic functioning- the flow of direct patient care (Ask Bob what he intended here - possibly Procedures Comm. will address this?)
-Examine existing needs assessment data, e.g. from original GCC grant, from United Way data, from County and State Health Dept. statistics
-Specifically assess need for mid-week clinic
-Literature search based source of economic and primary care benefits of a Nurse Practitioner in this position

2. Define the nurse practitioner job position and its merits

-Continuity of care
-Increased clinic credibility with clients and medical/nursing community
-Coordinator of medical/nursing volunteers
-Enable mid-week clinic and increased access to clients
-Lab follow-up
-Equipment and supply maintenance
-Chair the Professional Services Committee
-Develop patient education materials and activities
-Create bridges to Public Health Department, Mental Health Services, MSU Health and Human Services Dept.
-Ongoing communication to referral services such as Bridger Clinic
-Patient follow-up
-Chart review (of volunteer providers)
-Potential for 1/2 time job share with MSU College of Nursing FNP program
-Quality Assurance

Note* A 1/2 time Clinic Administrator will still have many duties re. reporting to the Board, coordinating services and office volunteer staff, financial and clerical duties, facilitating outreach to the community, fundraising, etc.

3. **Present Proposal to Board members**
   -Problem statement
   -Objectives
   -Define NP position: job description
   -Steps/tasks: more formal needs assessment, explore funding sources, prepare grant(s).
   -Timeline

4. **Identify funding sources**
   People (in the know) to consult:
      -Bob Flaherty, MD (file drawer!)
      -Clarann Weinert, College of Nursing Faculty
      -Audrey Thurlow, Adm. Assist Research, 2nd floor Montana Hall, Rm 207
      -Karen Wojtanowicz, Director, Bridger Clinic
   -Public funding
   -Private funding
   -Fund office space also?

5. **Grant writing**

APPENDIX B

Proposal to Create a Clinical Coordinator Position at the Gallatin Community Clinic

A proposal to create a Clinical Coordinator position at the Gallatin Community Clinic

Presented by: Alison Marcus, BSN, RN and Robert Flaherty, MD

Problem Statement

The Gallatin Community Clinic (GCC) provides low cost primary care for acute and chronic conditions to low income individuals and families without insurance or with a very high-deductible insurance. The Clinic is staffed by volunteers and by a half-time Clinic Administrator and is held each Saturday morning. The Clinic is supported by patient fees and by donations from local organizations and individuals. With strong support from community volunteers, eight to eighteen patients have been seen in the Clinic each Saturday since it opened in August 1996. Identified areas for improvement and/or unmet needs include the following:

Continuity: Since the Clinic meets only once each week, and since different clinicians see patients each week, it can be difficult for volunteer clinicians to maintain continuity of care, such as follow-up on lab, medications, teaching, referrals and follow-up appointments.

Access: Since the Clinic only meets on Saturdays, patients with acute conditions during the week must wait until Saturday or seek care in the Emergency Room. Furthermore, patients requiring mid-week follow up cannot be seen until the next Saturday.

Coordination: With different clinicians working each week, there is no single health professional to orient clinician volunteers to clinic activities and procedures and provide coordination of referrals, education and daily clinic set-up.

Objective

These concerns related to continuity, access, and coordination of care affect the credibility and effectiveness of the Clinic. To address these concerns we propose investigating the possibility of hiring a part-time Clinical Coordinator. This Clinical Coordinator would facilitate the activities of the clinician volunteers and the provision of health care at the Clinic. The Clinical Coordinator's role and duties would be specifically related to patient care. The position would be

separate from, but complementary to, the part-time Clinical Administrator, whose duties would continue to relate to the general administration of the Clinic.

Possible duties of the Clinical Coordinator

We recommend that the Clinical Coordinator be a Nurse Practitioner (NP) who would have the following duties:

-Provide patient care at a mid-week evening clinic

-Coordinate and orient volunteer clinicians

-Provide patient and lab follow-up

-Maintain medical equipment and supplies

-Chair the Professional Services Committee

-Develop patient education materials

-Serve as a liaison to Gallatin City/County Health Department, local mental health services, Montana State University (MSU) College of Nursing, and other clinical organizations

-Provide ongoing communication with referral services such as Bridger Clinic

-Oversee quality assurance, including chart review of volunteer providers

Needs assessment

A detailed assessment of specific clinic needs will be performed. The assessment will include input from board members, the Clinic Administrator, clients, and a survey of volunteer staff. Demographic data from our own clinic as well as information from the county and state Public Health Departments will be compiled. Since the employment of a NP Clinical Coordinator might allow the development of a mid-week evening clinic, we intend to study that possibility.

Identify funding sources

Potential sources of private, public, and community funding for a NP Clinical Coordinator position will be researched pending approval of this proposal's objectives by the Gallatin Community Clinic Board of Directors. This study will be performed by Alison Marcus RN, and Robert Flaherty, MD.

APPENDIX C

Volunteer Clinician Survey

Volunteer Clinician Survey

1) Are you a: (please circle)

Physician	Specialty_____
NP/PA	" _____
Nurse	" _____
EMT	" _____
Student	" _____
Other_____	

2) How many times have you volunteered at the Clinic?_____

3) How satisfied are you with your experience volunteering at the Clinic?

Not		Somewhat		Very
1	2	3	4	5

4) Are your skills well utilized at the Clinic? Yes_____No_____

If yes, why_____
If no, why_____

5) What do you like about the functioning of the Clinic?

_____
_____

6) What do you dislike about the functioning of the Clinic?

_____
_____

7) How could we improve the functioning of the Clinic?

_____
_____

8) When you volunteer at the Clinic, how well do you understand: (please circle)

	Don't		Somewhat		Well
How to make referrals to specialists	1	2	3	4	5
How to order lab tests and x-rays	1	2	3	4	5
How patients pay for their visit	1	2	3	4	5
Which pharmacies give discounts to our clients	1	2	3	4	5
How patients are followed up for lab results, phone calls, appointments	1	2	3	4	5

9) If the Clinic were to employ a Nurse Practitioner or Physician Assistant as a Clinical Coordinator, what activities do you think that Clinical Coordinator might perform? (Check all that apply)

_____Provide direct patient care
_____Staff a weeknight clinic
_____Coordinate and schedule volunteer clinicians
_____Follow-up on lab between Clinic days
_____Follow-up with patients on their progress
_____Maintain medical equipment and supplies
_____Develop patient education materials
_____Oversee quality assurance / improvement

Other (please write in comments)_____
_____
_____

10) How willing would you be to volunteer at the Clinic on:

	Unwilling		Somewhat		Very
Saturday morning (this is the current schedule)	1	2	3	4	5
Saturday afternoon	1	2	3	4	5
Saturday morning AND afternoon	1	2	3	4	5
Weeknight evening	1	2	3	4	5

11) How often do you hope to volunteer at the Clinic in 1998?
(please write in number)_____

APPENDIX D

Job Description for Clinician/Health Coordinator
Gallatin Community Clinic

JOB DESCRIPTION

GALLATIN COMMUNITY CLINIC

TITLE: Clinician/Health Coordinator
STATUS: 0.50 FTE or greater

DEFINITION

The Clinician/Health Coordinator (C/HC) will be a Family Nurse Practitioner or Family Practice Physician Assistant and will have both administrative and clinical duties. The C/HC will assume responsibility for the administration of the Gallatin Community Clinic (the "Clinic") in the absence of the Clinic Administrator.

QUALIFICATIONS

The C/HC must:

- Be a graduate of an accredited master's degree Family Nurse Practitioner program or a Family Practice Physician Assistant program
- Have a current license to practice as an Advanced Practice Registered Nurse or Physician Assistant in Montana
- Have prescriptive authority, including Drug Enforcement Administration registration
- Must be able to be insured for medical malpractice liability
- Have the ability to plan, direct, coordinate and evaluate the relevant clinical and administration components of the Clinic
- Be able to effectively communicate with the Clinic Administrator, Clinic Board of Directors, colleagues, and patients and their families.

SUPERVISION

The C/HC will be supervised and evaluated by the Clinic Administrator who shall seek input from Clinic volunteers, the Professional Services Committee and the Medical Director. The C/HC will collaborate and be advised by the Clinic's Medical Director. The C/HC will have a probation period of six months, and will be evaluated quarterly during the first year of employment, then annually thereafter.

DUTIES AND RESPONSIBILITIES

Administrative

- Assist the Clinic Administrator with the general day-to-day Clinic administration.
- Serve as a liaison between the Clinic and the community, health care providers, and other community resources.
- Maintain the medical equipment and supplies inventory.
- Serve as liaison between the clinical volunteers and administrative staff and volunteers, and between the clinical volunteers and the Board of Directors.
- Serve as the Chair of the Professional Services Committee and report its activities to the Board of Directors.
- Serve as liaison between the Clinic and the Gallatin City/County Health Department

Human Services Director or designee.
- Serve as liaison with student training programs.
- Conduct internal chart audits directly and via peer evaluation.

Medical
- Monitor clinical components of the Clinic and clinical volunteers, including quality assurance.
- Write, or acquire, and update practice protocols, instructions sheets, patient education materials and consent forms as necessary.
- Conduct clinician meetings as necessary.
- Facilitate orientation of new clinical volunteers and health professions students.
- Provide patient care at the Clinic on Saturday mornings and at weeknight clinics, in cooperation with volunteer clinicians.
- Perform physical and psycho-social assessment, diagnosis, treatment and patient education based on established protocols.
- Determine which clinical problems must be evaluated by a physician.
- Recognize and triage to the emergency Room life-threatening conditions or those conditions beyond the scope of the Clinic or the C/HC.
- Perform, as appropriate to the C/HC's training and experience, routine diagnostic and therapeutic procedures including but not limited to obtaining vital signs, injections, minor surgical procedures and office laboratory tests.
- Write prescriptions for indicated medications in accordance with Montana Board of Pharmacy regulations and in consultation with physicians or per standing orders or protocols.
- Make and follow-up on medical, social services and other community referrals of Clinic patients, and provide liaison as needed.
- Request, evaluate and follow-up diagnostic studies on all Clinic patients as indicated.
- Document findings, plan of care and follow-up in a clear, concise manner in patients' charts, complying with clinical protocols.
- Serve as a community and patient resource for health education, wellness and disease prevention.
- Maintain professional expertise in primary care and prescriptive authority through continuing education.
- Perform other Clinic duties as determined by the Board of Directors.

-END-

APPENDIX E

Clinician/Health-Coordinator Salary and Benefits

NURSE PRACTITIONER / PHYSICIAN ASSISTANT
SALARY AND PRO-RATED BENEFITS

SALARY (base level with 2 years experience minimum req.)

(1.0 FTE)	$50,000
(0.75 FTE)	$37,500
(0.5 FTE)	$25,000
(0.25 FTE)	$12,500

Employer-paid benefits:

1. Social Security and Medicare (7.65%)
2. Unemployment Insurance (approx. 1.5%)
3. Montana Old Fund Liability (0.2%)
4. Workers Compensation ($50 per $10,000)

(1.0 FTE)	$4924
(0.75 FTE)	$3693
(0.5 FTE)	$2462
(0.25 FTE)	$1231

Health Insurance "Coupon"

(1.0 FTE)	$1,200
(0.75 FTE)	$900
(0.5 FTE)	$600
(0.25 FTE)	$300

Educational Leave

(1.0 FTE)	$1,000 and 5 paid days EL
(0.75 FTE)	$750 and 3.75 paid days EL
(0.5 FTE)	$500 and 2.5 paid days EL
(0.25 FTE)	$250 and 1.25 paid days EL

Annual Leave: Begin with 3 week AL for FTE
Sick Leave: Accumulate 1 day per month SL
Holidays: For discussion; usually 6-8 days HL
Retirement: None at this time

TOTAL COST SALARY AND BENEFITS PACKAGE:

(1.0 FTE)	$50,000 +	4,924 +	1,200 +	1,000 =	**$57,124**
(0.75 FTE)	$37,500 +	3,693 +	900 +	750 =	**$42,483**
(0.5 FTE)	$25,000 +	2,462 +	600 +	500 =	**$28,562**
(0.25 FTE)	$12,500 +	1,231 +	300 +	250 =	**$14,281**

OPTIONS:

1) **Malpractice Insurance** (usually provided by employer)

Nurse Practitioner: $662 (1.0 FTE); **$331 (0.5 FTE)**
Nursing Services Organization 1-800-982-9491
Professional Liability: 1 million each. 5 million aggregate.

Physician Assistant: $1,251 (1.0 FTE); **$625 (0.5 FTE)**
National Professional Group 1-800-503-2272
Professional Liability: 1 million each. 5 million aggregate.

2) **Licensing Fees** (sometimes paid by employer)

Nurse Practitioner:	**Initial MT**	**Renew MT**
1) RN	$70	$40
2) NP	$50	$25
3) Prescriptive Privilege	$75	$50
4) DEA (fee every 3 yrs.)	$210	same

Physician Assistant:

1) Re-registration NCCPA (fee every 2 years)		$80
2) Continual Medical Education Review/NCCPA (fee every 2 years)		$85
3) National Certification Exam (test and fee every 6 years)		$200
4) Montana Board of Medical Examiners:	(Initial MT license fee)	$150
	(Renewal every year)	$50
5) "Utilization Plan" Change in supervising physician cost		$25
6) DEA (fee every 3 yrs.)		$210

APPENDIX F

Jerry Metcalf Foundation Proposal

Jerry Metcalf Foundation Proposal

Project Description: Expanding Services to the Medically Underserved

The Gallatin Community Clinic (GCC) is seeking funding to develop a nurse practitioner (NP) or physician assistant (PA) position; a position which will expand the clinic's ability to provide quality health services to the medically underserved in Gallatin County, Montana. In August of 1996, through grassroots efforts, the GCC was opened in Bozeman to meet the needs of Gallatin County's many residents with limited access to primary and preventive health care services. This rural county (population 59,410) has seen a steady and remarkable population growth in the past 15 years. Yet this growth has not meant economic prosperity for all its residents. Although unemployment rates are low, so are wages. For many of the "working poor" health insurance is only a dream. Of particular concern are the 30.5% of Gallatin County families living at or below poverty level (Montana Department of Public Health & Human Services, 1997).

Presently the Clinic provides very low cost services to those low-income individuals and families without health insurance or who have policies with a very high deductible. The Clinic's services include health care for acute and chronic conditions, health care education and disease prevention, and referral services to appropriate medical practitioners and social welfare agencies. Successful collaboration with area mental health workers enable our patients to get affordable counseling. Local pharmacists offer our patients excellent discounts on medications.

Our clinic is open only on Saturday mornings and staffed almost entirely by volunteers, yet after only sixteen months we have already seen over 1500 patients. Because of limited resources, the GCC has not attempted to reach or advertise to all of those in need, yet the clinic is growing at a rate of 60% new patients each week. In fact, patients are now being turned away because the demand is exceeding the capabilities of our volunteer staff. Clearly the Clinic's limited hours are insufficient for meeting the health needs of this population. Of special concern are those patients who require follow-up evaluations within a few days of their GCC visit. These people have only two choices; either seek high cost emergency room care at a local hospital or wait a full week to be seen again at the GCC.

The lack of continuity of care is an urgent issue which must be addressed. The Clinic is currently staffed by eager volunteers from the community and includes office and professional personnel. But this dynamic flow of volunteers has resulted in some problems in the continuity of health care delivery. For instance, clinicians may be unaware of patients needing follow-up assessments, teaching, medication adjustments, referrals, and/or analysis of lab reports.

Immediate Goals and Outcomes

The immediate goal of the GCC is to increase the number of hours and days per week that services are available. The most pressing need for accomplishing this goal is the hiring of a three quarter-time NP or PA as a medical coordinator. This NP or PA would work both as a clinician and coordinator of services, increasing the Clinic's hours of service and greatly improving continuity of patient care. S/he would enable the opening of a mid-week clinic, provide patient care at the Saturday clinic in conjunction with a volunteer physician, provide patient lab follow-up, coordinate appointment follow-up, provide ongoing quality assurance of clinic activities, and expand community health education and outreach. Ultimately, the Clinic plans to make this practitioner position self-sustaining through partnerships with other community entities.

How Money Will Be Spent and Preliminary Budget

Nurse Practitioner/Physician Assistant (.75 FTE)	
$50,000 base annual salary	37,500
Fringe benefits (figured at 25% of salary)	9,375
Total:	$46,875

APPENDIX G

United Way Grant

Due to its length, this grant is on file with the office of the United Way of Gallatin County.

APPENDIX H

Proposal to the Bozeman Deaconess Hospital System

Due to its length, this grant is on file with the office of the Gallatin Community Clinic.