A Parish-Based Free Health-Care Clinic

An Expression of Faith

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Pastoral ministry entails a responsibility to read the signs of one’s context in order to respond in an appropriate and life-giving manner. Access to health care is a growing concern that affects the daily living of our communities, and disproportionately affects our poorest and most vulnerable neighbors. This is one parish’s story to meet this need in a collaborative venture on the local level.

In 2005, after serving as priest at Saint Martin de Porres parish for several years, it became evident that the general lack of health-care resources was a major issue for our community. This was of concern especially in western Louisville, a predominantly lower-income area peppered with failed or failing industrial concerns and declining neighborhoods. Our parish is located in a historically underserved area of our city, and though we have several public health department clinics, they are heroically functioning well beyond the limits of their capacity. Our city and county merged several years ago. While that has provided an increase in public monies, the extension of city services into the county put more pressure on

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scarce resources. The waiting lists were getting much longer at the public health-care clinics, with less capacity to admit new clients to their programs.

Among my motivations to address the health-care needs in my community was the injunction of Jesus in Matthew’s gospel to announce the kingdom of heaven (10:7), an injunction that begins with the command to heal the sick (10:8) As one whose education and formation includes philosophy, theology, nursing, and medicine, this speaks to my vocation.

**Genesis of a Parish-based Clinic**

Health-care workers recognize that an increasing number of persons are using hospital emergency departments for their primary care needs. This is not just a local phenomenon; it is evident across the nation (Chin et al.; Falik et al.). Since my nursing background includes emergency department experience, I knew well that primary health-care needs could not be met by emergency services. I was aware of our continuing need to educate our community in primary care practices, especially in preventive care. One of my objectives was to obtain community support for primary care education outreach, while remembering that old habits are not easily changed. The parish leadership team was fully involved in this effort as several had experiences with those who had been hospitalized or who were facing health challenges that required major changes in habits. Our parish community is aging, and we were losing too many in our community who had unfortunate—and largely preventable—complications because of such factors as diabetes, heart disease, and cholesterol problems. As a parish with a treasured African American cultural heritage, attention to health matters also meant critical examination of dietary and cooking patterns.

**Our First Sunday: Identifying the Symptoms**

An intervention took place one Sunday after Mass with the assistance of several nurses, both actively employed and retired, who are part of our community. Stations were set up in the church vestibule to assess interested parishioners’ vital signs, especially blood pressure. Opportunities to obtain serum glucose (“blood sugar”) readings were available for those adults who wanted to know this information. Elevations in blood pressure (the “silent killer”) as well as serum glucose levels are symptoms commonly found in the African American community (Bowman). Pamphlets were distributed with additional health-care resources.

That Sunday, we saw almost two hundred people. In that number, we found many persons with seriously elevated blood pressure and quite a number with high blood sugar as well. Fortunately, we did not obtain any “critical values” that would
have required us to urge someone to go immediately to the hospital. We identified some persons with high blood pressure who already had medication prescribed. In some cases, they were unaware that their prescription was not lowering their blood pressure sufficiently. In other cases, people told us that they were supposed to take blood pressure medication but could not afford to fill the prescription. Working at the “Blood Sugar Table,” I was saddened to see what I already expected: most persons had borderline high serum glucose readings, and some had very high readings. Very few persons were aware that they had diabetes, and of those who did know, none tested their blood sugar levels on a daily basis because the test strips were so expensive. They dismissed the danger of these diseases because there were so few visible symptoms. Moreover, communal and familial activities and dietary habits made it possible to minimize the dangers and to continue the very practices and eating habits that allowed the diseases to worsen.

In our initial discussions of the parish leadership team, those of us with a health education background knew that we would find high blood pressure, diabetes, cholesterol problems, and obesity. However, our additional worry was that we would find these clustered in individuals, and thus would identify the metabolic syndrome (American Heart Association). This would make our work much more complex, requiring more resources over a longer time before we would see positive outcomes.

**Responding to the Needs**

Our clinic began modestly, after original plans to collaborate with a university fell through due to fiscal constraints. I met with the parish leadership team and asked for space in the old parish school. I would have a clinic outreach on Thursdays and see whoever came. It was free, supported by parishioners, colleagues, and friends. I had a large, black bag given to me by my little brother, who was a helicopter pilot in the Army. This bag has many little compartments, and holds just about anything I need for primary care: blood pressure cuffs, stethoscopes, ophthalmoscope and otoscope, reference books, tuning forks, glucometer, etc. I named the bag “Felix” in honor of the Felix the Cat cartoons—Felix’s magic bag of tricks always solved his problems, and I hoped mine would meet my needs.

In the first year of the clinic, I found that the presenting problems were exactly as we had thought—high blood pressure, diabetes, increased stroke risks, cholesterol problems, obesity. In addition to these, we discovered an even more pervasive problem: poverty and its effect on the body and soul (see Flores et al.). Some of the most heart-wrenching problems came not from the presenting symptoms themselves but from the stories that people told me. I heard from people who asked me to examine them, treat their illnesses, and write prescriptions for drugs they knew
they needed. They were aware of their own conditions because they had a primary care physician. However, they had an outstanding balance at the office, and the provider would not renew their prescriptions until they paid the balance! Too many of these people could not afford the copayment, so they were unable to even make an appointment to see their health-care provider.

I could diagnose and address high blood pressure and expect a very good success rate doing so. I could even do the same for high cholesterol and diabetes. However, “I” was just not enough. The problems that brought people to the clinic required a comprehensive approach. This meant we had to ask if clients had roofs over their heads, food, warm clothes, and even shoes. We needed to recognize not only a client’s symptoms but the signs of illiteracy and unemployment as well.

A comprehensive, holistic care response required an extensive support system, greater than our humble beginnings. Among the generous benefactors who responded graciously to our calls was a parishioner, George Merrifield, a former student of the parochial school. The clinic intersected with his vision for a vibrant parish, and he recognized an obligation to share his own personal resources with those in need. His organization funded a major part of the renovation of the old parish school. He also supports an outreach to the community in the form of a Life Skills Center. This apostolate aims to assist people in prioritizing and meeting the challenges of their daily lives. The center is just now starting its work. I hope as our clinic attempts to address the acute health-care needs in our community, the Life Skills Center can also empower clients to achieve a more holistic approach in managing their daily needs. The possibilities for collaboration are promising.

Continued Growth

In 2006 an opportunity arose to return to my alma mater, Bellarmine University. I was asked to join the faculty in building a family nurse practitioner program, as well as to help fashion a doctorate in nursing practice program. This position opened the door to new possibilities for collaboration about the clinic. The faculty and administration at Bellarmine supported the venture with donated supplies and faculty involvement. Because of this enthusiastic response, we suddenly saw that several other academic centers at the university—physical therapy, respiratory therapy, and clinical lab sciences—could augment the clinic’s outreach. Suddenly we grew from a small outreach to a comprehensive community endeavor. I must admit I was not prepared for this. We had made a few contacts with other clinics, yet no one was available to mentor us. Nevertheless, as we talked about how we wanted to develop the clinic, we realized that it was no longer going to focus exclusively on health care from a purely physical perspective. This shift to a comprehensive and organic response necessitated consideration of other issues and while we struggled with these questions, they were placed back on the shelf as graces in ever-greater measure overwhelmed us.
The Birth of Umoja

The celebration of Kwanzaa includes recognition of the Nguzo Saba, the “seven principles” (History, 2009). The first of these, *Umoja*, means unity. We strive for, and attempt to maintain, unity in our families, communities, nation, and race. We thought this principle illustrated well the work we wanted to achieve at our clinic, and thus we named it the Umoja Clinic. Only later did we discover that this name has been given to a number of community outreach ventures across the world. We chose well, and naming the clinic Umoja offers many opportunities to emphasize that what we do here has multiple expressions and necessarily involves a variety of persons with different skills. Our clinic is not only for those who need to receive but also for those in need to give. This is primarily demonstrated by the number of health-care providers who make certain to deliver supplies, who call to see how the effort is progressing, and who donate funds.

Comprehensive and Collaborative

The Roman Catholic Archdiocese of Louisville increased its existing support. The clinic received permanent space in the parish school, renamed the Catholic Enrichment Center and housing the aforementioned Life Skills Center. Our current space is wonderfully expansive. It includes a large central meeting and gathering room, a well-appointed examination room, and an office that can become a second exam room as we grow. The complex includes bathroom facilities as well as a small kitchen. Thanks to a major donation to the archdiocese, windows were replaced throughout the building, and the high ceilings allow for healing light to fill our space.

During the past year, we have networked with organizations that help free clinics obtain the resources they need. One of the most helpful has been the National Association of Free Clinics. As our contacts with other community organizations develop, we have discovered that we are not alone and a number of other free health-care clinics operate in our area. When our clinic initiative was in its earliest stages, we received wonderful press coverage from the local newspaper. People who read of our efforts called to donate time, talent, money, and equipment. We grew quickly from one rather empty room to a suite of rooms with medical equipment and resources. The Kentucky Coalition of Nurse Practitioners and Nurse Midwives now provides a venue to share information. I continue to receive calls from professionals in the area and from around the state who supply materials and resources as well as offers from other nurse practitioners and physicians to share surplus equipment, and to volunteer their time.

The collaboration with the university moves forward as the School of Physical Therapy set up equipment in the clinic, and prepares to expand their services. Respiratory Therapy and Clinical Lab Sciences will also join the effort, for we are
now finding that the increasing incidence of asthma in the community is placing both children and adults at greater danger for illness.

One of our major hospital systems has recently begun an outreach to the African American community aimed at addressing high blood pressure and stroke. This is a massive effort, involving dedicated staff, funding, and resources, and it surpasses anything that our small clinic could offer. However, the hospital strives to work with the community and does not seek to duplicate or replace successful local efforts. The result has been an augmentation of existing programs and an increase in overall resources available to the community. The positive dimensions of this hospital initiative are evident by the willingness of the administrators and nursing leaders to meet with community leaders in an effort to maximize cooperation.

On a larger basis, the clinic participates in city-wide health care fairs. These well-publicized and equally well-attended events bring together many community organizations in a coordinated health-oriented outreach. Local hospitals provide staffing, materials, and funding. These fairs underscore the sad reality that significant numbers of persons have serious health-care needs even as they go about their daily lives. Often, they lack insurance or are underinsured. They obtain their health care at local hospitals, using emergency departments for primary care. They use these resources only as a last resort and at an incredibly higher cost than would be incurred were preventive health care a priority.

We expected to find clusters of uninsured and underinsured persons in our region and indeed, we did find this. However, these clusters were not just in the so-called poorer sections of town. Populations in need and at risk included persons who avoided using their health insurance for fear of an unexpected financial burden. Additionally, it became vividly evident that the public health-care system did not have the resources to cover sufficiently the needs of the greater community. For example, when we discovered an individual with seriously high blood pressure, and we recognized that there was a danger of stroke, if that person did not have health-care insurance it was often impossible to add the client into the existing public health-care systems. The only option available was to inform the individual of the condition yet offer no means of assistance beyond counseling therapeutic lifestyle changes such as diet and exercise. While these health fairs perform a valuable community service and remain expressions of care, they are inadequate to meet the overwhelming needs present across the socioeconomic spectrum in our community. These fairs highlight what we already know are serious challenges and demonstrate the inadequacy of our responses.
especially in the presence of growing and even prohibitive costs. Unfortunately, the toll on communities and individuals will be manifest by increases in acute illnesses, some of which could have been addressed by preventive measures and reasonable health-care coverage. As the story of our modest parish clinic shows, comprehensive pastoral care includes attention to matters of health and quality of life. However, the sheer magnitude of these problems requires coordinated and collaborative responses.

An Abruptly Changing National Scene

Our national health-care systems are broken. Using the latest available data, the Centers for Disease Control (CDC) released the “National Health Interview Survey 2006” that contained some disturbing statistics:

- 18.6 percent of Americans are uninsured (54.5 million persons)
- 19.8 percent of adults are uninsured (36.5 million persons)
- 9.3 percent of children are uninsured (6.8 million persons)
- Almost a third (32.1 percent) of Hispanic persons were uninsured
- 15.9 percent of non-Hispanic black persons were uninsured
- The South has the highest level of lack of health insurance, at 18.4 percent
- Educational attainment was a good predictor of lack of health-care insurance: 30.3 percent of those with less than high school diploma were uninsured; this dropped to 19.8 percent if a person had a GED or high school diploma, and to 10.6 percent if more than high school education was present.

How do these figures reflect our experience so far? From my own conversations with people who come to our clinic, almost 100 percent lack comprehensive health insurance. Most, but not all, are African American. Mental illnesses, including chronic depression and anxiety, often accompany and complicate physical illness, sometimes precipitating the latter and preventing effective address. Substance abuse is a serious issue that continues to destroy individuals, families, and communities. Violence, both at home and in public places, remains a grave problem—especially for the homeless, who often suffer at the hands of others. Homelessness makes comprehensive care unattainable. Additionally, it becomes exceedingly difficult to pursue educational opportunities in the midst of physical or mental illness.

In our clinic experiences, we discovered that children often needed assessment and care. However, an adult who could legally give permission for treatment rarely accompanied these children. This made primary care impossible and meant that
these children, if their illness progressed, would most likely need acute intervention by the emergency department of our children’s hospital. We have thus been unsuccessful in addressing the needs of children in our clinic.

**Lessons Learned and Shared**

In many ways, we have been fortunate, especially considering the fact that we began our parish clinic initiative in a naïve manner. In hindsight, among the lessons we have learned, one is most clear: mentorship is necessary in considering an undertaking of this magnitude. As a parish leadership team, we were not aware of the complexities involved in the creation and sustenance of a health-care clinic. We perceived a need in our community and drawing on our shared personal and professional experiences, we sought to respond. We did not fully appreciate the multi-layered implications of addressing health care, or the coordinated effort it would entail to provide access in a comprehensive way.

I share with all of my students the insight that our role as nurse practitioners is not only to address current health concerns; we must meet the entire person. In a similar manner to the story of Emmaus in the Gospel of Luke, we accompany our clients on part of their journey. Their story becomes part of our lives, and in the exchange of our stories we have an opportunity to break bread together. However, this sort of relationship must be a positive therapeutic relationship. Our relationships, as health-care providers, are not only with individuals who stop by the clinic but with entire communities as well. Louisville has had free health clinics that have opened with great fanfare but then closed quietly not long afterward. What sets us apart from those clinics?

I believe the most important thing is ownership by the community, in our case the parish community. As I reflect on that, and what we have learned in the past two years, I have come to the following conclusions:

1. This work requires a coalition of supporters who share a clearly articulated common agenda. Competing agendas have the capacity to undermine the best of intentions. Some of these competing agendas are not constructive ones, and mature discernment is necessary. This has a spiritual dimension as well, because not all those who want to provide care for others are themselves healthy, especially psychologically. The phrase “wounded healers” is often heard when describing ministers; yet the vineyard also contains “wounded wounders” and this can prove to be detrimental in a mission guided by a mandate to do no harm.

2. This work requires a network of committed partners and benefactors. Coalition building and network maintenance require a special set of skills and ongoing dedication. The best persons to do this may not necessarily be the health-care
professionals themselves or even the clinicians who work in the clinic. A degree of political and practical understanding is necessary to maintain communal outreach.

3. Communities have similar central needs, but each community has particular needs that may not be clearly visible. This requires a deeper level of investigation and analysis in order to identify specific needs and design appropriate responses. For example, community-wide epidemiological trends in high blood pressure, cholesterol disorders, and diabetes may certainly be present. But in some circumstances, a holistic and appropriate response will require recognizing the roles of literacy levels, domestic violence prevalence, unemployment patterns, and unreasonable levels of daily stress in exacerbating these health matters.

4. Health-care clinics constitute a long-term investment in the well-being of communities. The formation and nourishment of community-wide positive therapeutic relationships must be among the primary objectives. Out of this may arise more effective approaches to preventing and even treating health-care challenges like hypertension, high cholesterol, and diabetes, but if that community embrace and engagement is not present the efforts will be minimally effective, and limited to one person, one at a time.

Ultimately, our parish commitment to respond to the health crisis we experienced daily was an act of faith. The outcomes are not easily identifiable or even always visible. For example, we see many persons, particularly the homeless, whom we never see again. Have we made a difference? I do not know, but on a basic level our parish initiative attempts to provide access to minimal levels of health care and the resources to encourage preventive measures among those who have few if any options. As part of our ministry we recognize that care must also attend to matters of physical health, and toward that end, we have helped to educate our people regarding good habits of self-care. Occasionally, I even see someone who has made major lifestyle changes thanks to our efforts. This is just the story of one parish that discerned a local need, and responded to a gospel invitation to announce the reign of God by healing the sick in their midst.

References


