Addressing Resource Gaps in the U.S. Health Care Safety Net:

An Assessment of the Free Clinic Network

April 2011

GE Foundation

AmeriCares is a nonprofit global health and disaster relief organization that delivers medications, medical supplies, and humanitarian aid to people in crisis around the world and across the United States. Since 1982, AmeriCares has delivered more than $10 billion in aid to 147 countries.

In the United States, AmeriCares provides medical assistance to free clinics, nonprofit pharmacies, and other health institutions that serve America's poor and uninsured. In 2010, our U.S. Medical Assistance Program delivered nearly $24 million in aid to health care partners and provided $215 million in free prescription medications through the AmeriCares Patient Assistance Program. A portion of our humanitarian aid each year is committed to disaster relief, which in the United States has included effective emergency responses to Hurricane Katrina and the Deepwater Horizon oil spill.

In addition, AmeriCares Free Clinics offer outpatient medical services to uninsured patients in resource-poor communities of Connecticut. In 2010, the three clinics conducted nearly 10,000 patient visits to 3,800 patients, for a total of $6 million worth of program services and aid. For more information, please visit www.AmeriCares.org.

This assessment was made possible by funding from the GE Foundation. The GE Foundation, the philanthropic organization of the General Electric Company, works to solve some of the world's most difficult problems. In coordination with its partners, it supports U.S. and international education, developing health globally, the environment, public policy, human rights, and disaster relief. In addition, the GE Foundation supports GE employee and retiree giving and involvement in GE communities around the world. In 2010, the entire GE family—including businesses, employees, retirees and the GE Foundation—contributed an estimated $250 million in cash, products, and services to charitable organizations around the world. For more information, visit www.gefoundation.com.

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April 2011

Tammy J. Allen
Project Director, U.S. Medical Assistance Program
Director, Global Partnerships – Asia & Eurasia

FOREWORD

AmeriCares is pleased to share our nationwide assessment of the free clinics that provide medical care to the growing population of low-income, uninsured patients across the United States.

We have long supported free clinics with medical aid deliveries on a consistent, ongoing basis and also immediately following disasters when patient visits surge and supply chains are disrupted. Our timely medical and humanitarian donations fill supply gaps in free clinic pharmacies and provide free, high-quality treatments to America's underserved patients.

In the wake of the recent financial crisis, AmeriCares made a commitment at the 2009 Clinton Global Initiative to double the number of U.S. safety-net institutions with which we partner. In large part due to generous funding from the GE Foundation, we are proud to have met and exceeded that goal. The number of free clinics and other partners receiving our assistance during a single calendar year has increased from 162 in 2009 to 357 in 2010.

We continue to enhance our U.S. Medical Assistance Program by establishing new partnerships, streamlining our gift-in-kind allocation model with new information technology, and disseminating our free clinic research to pharmaceutical manufacturers, medical practitioners, government representatives, and health care associations. Our outreach increasingly focuses on responsiveness, efficiency, and quality.

This report comes at a time when the U.S. and world economic forecasts remain uncertain, the costs of health care services and medications continue to rise, implementation of health care reform policy is under way, and immigration policy debates persist. Our analysis touches on each of these points in an effort to bring attention to the many factors that shape not only patient access to affordable health care but also free clinic access to consistent flows of resources.

Initially, the needs assessment was designed to inform AmeriCares own program expansion. However, recognizing the inherent value of the survey data, we realized that sharing our findings could raise awareness of the plight of the uninsured as well as increase free clinic visibility. We hope the report lends insight to the most effective ways that AmeriCares and other resource providers can increase support to the U.S. health care safety net and ease critical resource constraints in order to help people live longer, healthier lives.

Curtis R. Welling
President & CEO
AmeriCares
April 2011

ACKNOWLEDGMENTS

AmeriCares is grateful to the GE Foundation, whose funding made possible this valuable assessment and whose critical support continues to strengthen many other components of AmeriCares current and emerging U.S. Medical Assistance Program. During a time of significant economic and health care transformation, together we are saving lives and restoring health across the United States.

We also wish to thank the following donors, who have provided steadfast gift-in-kind donations essential to our U.S. Medical Assistance Program:

Alaven Pharmaceutical, LLC
Alcon Laboratories, Inc.
American Medical Association
Amneal Pharmaceuticals, LLC
AstraZeneca Pharmaceuticals, LP
BD
Boehringer Ingelheim Pharmaceuticals, Inc.
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Merck & Co., Inc.
Midmark Corporation
Ortho-McNeil-Janssen Pharmaceuticals, Inc.
Purdue Pharma
Shire Pharmaceuticals
Takeda Pharmaceuticals North America, Inc.

In addition, we are indebted to the staff of the free clinics who took the time to complete our online survey and to host site visits during our data collection phase. Particularly instrumental were the headquarters of Volunteers in Medicine, as well as the many state and regional associations that distributed the AmeriCares survey to their respective member clinics.

We thank the staff and board of the National Association of Free Clinics (NAFC) for providing to AmeriCares its list of member clinics and email addresses and for meeting with our staff during various stages of the research.

We thank Julie Darnell, PhD, Assistant Professor, School of Public Health, University of Illinois at Chicago, for sharing her clinic database and—more importantly—we recognize her for the pioneering research on free clinics that she has contributed to the public discourse.

We would like to express our appreciation to Executive Director Karen Gottlieb and staff of the AmeriCares Free Clinics, who provided insight into the many facets of patient care and clinic operational management.

Our dedicated team of volunteers and interns in the AmeriCares headquarters spent many months on telephone calls, research, and data analysis. Heartfelt thanks are offered to intern Cara Costich and volunteers Nancy DeFilippo, Nancy Nelle, Ryuzo Ogata, and Lauren Spatz.

We wish to recognize Rebecca McBride, PhD, for editing the report and ensuring that the final product was of high standard.

I am grateful to my colleagues in the U.S. program, Morgan White and Euthimios Theotokatos, for their enthusiastic participation in the survey distribution and site visits, which have brought AmeriCares to the field of research for the first time.

Finally, I would like to thank Dan, his parents, and my own parents for their incredible support of this project and many other endeavors.

Tammy J. Allen
AmeriCares

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EXECUTIVE SUMMARY

Objectives

The primary objective of this study was to identify the resource constraints limiting the incremental expansion of health care services by free clinics for low-income, uninsured individuals and families across the United States. The nationwide survey was designed to collect information that would enable AmeriCares to adopt a measured, evidence-based approach toward strategically addressing the most critical resource supply gaps and thereby expand our U.S. Medical Assistance Program.

Background

The number of uninsured has reached a historic high. Free clinics, which provide medical care to the underserved, have seen a rise in patient visits as resources decline. These opposing forces—inherent in a recession—are shaping primary and specialty care for the poor within today's health care reform and immigration policy contexts.

Methods

With generous funding from the GE Foundation, from May to October 2010 AmeriCares distributed an online survey to safety-net providers and collected additional information during site visits and telephone interviews with free clinic staff. From the target population of 1,200 free clinics, 332 questionnaires received from 49 states and the District of Columbia were analyzed; this reflects a response rate of 28 percent.

Results

Most (89%) free clinics have seen a rise in patient visits in the past one to three years. More than half (56%) have been forced to turn away eligible patients because of such resource constraints as lean medical and support staff; lack of electronic records; limited facility space; expensive labs, equipment and medications; and declines in financial support. The safety net is hamstrung.

Clinics are overwhelmed not only by the rise in number of individual patients but also by the increasing trend in number of visits per patient. Patients today present with multiple chronic conditions that require frequent visits and complex treatment. In addition to providing primary care, many free clinics now offer a suite of other patient-centered services such as specialty care, chronic disease management, pharmacy support, dental care, mental health care, and social services. However, without an adequate resource base, free clinics are unlikely to keep pace with the widening expanse of patient demand.

Conclusions

Each clinic brings to its community a unique set of services and strengths, as well as dedicated staff and volunteers who work diligently to address a daunting number of challenges. Yet free clinics, whether viewed individually (at the local level) or holistically (at the national level), are unlikely to fully address burgeoning patient needs—particularly the demand for chronic disease management—without increasing coordination and resource management at various organizational levels. For instance, increased clinic "buy-in" into state associations and the National Association of Free Clinics (NAFC) would enable associations to leverage a broader financial platform, expand capacity, and provide larger and more consistent resource flows across the free clinic network.

Implications

To reinforce and enhance their existing value as a niche component of the U.S. public health landscape, free clinics could invest in greater integration and information-sharing across state boundaries and among small, medium, and large clinics. Enhanced collaboration would serve to reduce fragmentation; centralize resource acquisition and distribution; build capacity in research, advocacy, and services; and strengthen national-level strategic planning in anticipation of future health care policy and immigration policy outcomes. Through such measures, free clinics would be more likely to gain sufficient momentum not only to meet the growing needs of their patients but also to move toward the center of health care reform debates and government budget discussions.

Viewed more broadly, such initiatives would serve to control chronic disease among the uninsured—which in turn would reduce public health costs and help raise U.S. economic productivity.

Research applications

AmeriCares is leveraging this evidence-based research to guide the expansion of our U.S. Medical Assistance Program. Today we are providing more U.S. free clinics with a greater quantity of medications—while at the same time striving to improve the quality of our domestic medical assistance. Thanks to the GE Foundation, the results of this nationwide assessment will enable AmeriCares to better align its pharmaceutical inventory and allocation with current and foreseeable trends among free clinic patients. For example, we are designing programmatic initiatives in response to the need for more diabetes medications and supplies, psychotherapeutic treatments, and dental products.

In addition, as a hallmark gift-in-kind donation to all U.S. free clinics, AmeriCares will publish for the first time a resource guide outlining case studies and best practices in effective resource acquisition and management. We sincerely hope that broad dissemination of our research and the expansion of our U.S. Medical Assistance Program will spur practitioners and other resource providers to increase their own support to the U.S. health care safety net.

INTRODUCTION

Survey Purpose

According to the U.S. Census Bureau's most recent population data, approximately 51 million people in the United States—or 17 percent of the population—lack health insurance today.[1] Another 25 million are underinsured because their insurance does not provide sufficient financial protection. Patients who lose insurance coverage are forced to spend down their savings and sometimes incur financial debt in order to pay for medical treatment. Lack of coverage exacerbates the financial burdens of the unemployed during an already difficult time of little or no income.

The U.S. health care safety net provides medical care to low-income individuals who are uninsured or underinsured. It is composed of community health centers (CHCs),[2] free clinics,[3] public hospitals, and nonprofit hospitals that treat low-income patients. By offering free or affordable health care services, these institutions eliminate or significantly reduce cost and other barriers to care. They also facilitate access to care by establishing themselves within underserved, economically depressed, often isolated rural and inner-city communities, and by providing patient outreach, case management, health education, and referrals. This report summarizes the findings of an AmeriCares study of the most critical resource constraints facing health care safety-net providers, with a focus on free clinics in the post-recession environment. The results of the comprehensive assessment are enabling AmeriCares to enhance its domestic medical outreach in line with evidence-based information about uninsured patient needs, free clinic capacity, and key supply gaps.

Methodology

From May through October 2010, AmeriCares distributed a *Survey of Free Clinic Resources* to solicit essential information never before asked of free clinics across the United States. The online questionnaire went beyond simply measuring any rise in patient demand to identify for the first time the resources that free clinics most need to expand capacity and serve more patients with greater efficiency.

AmeriCares collected surveys from 499 safety-net institutions, of which 417 questionnaires were judged as valid for inclusion in the study.[4] The primary target of the survey was the population of 1,200 free clinics in operation today, from which 332 valid questionnaires were analyzed. This 28 percent response rate indicates a confidence interval of 96 percent. Participating free clinics were located across 49 states and the District of Columbia (see Appendix A).[5] Using the most recent U.S. Census Bureau data, survey respondents were classified according to their zip codes (see Table 1).

Table 1:
Geographic and demographic composition of survey respondents

Region	Rural clinics (9%)	Urban clinics (91%)	Total	Percent of total respondents
Midwest	4	77	81	24%
Northeast	3	33	36	11%
South	20	146	166	50%
West	4	45	49	15%
Total	**31**	**301**	**332**	**100%**

To add context and a comparative aspect to the study, AmeriCares conducted a secondary survey of other providers that operate alongside free clinics within the U.S. public health landscape. Staff analyzed 85 valid questionnaires from community health centers, nonprofit pharmacies, and shelters.

AmeriCares staff also conducted field research through site visits and telephone interviews with medical and pharmacy staff of more than 60 safety-net institutions. We met with free clinic staff and patients as well as state association leadership across the four geographic regions. The generous support of the GE Foundation allowed AmeriCares to travel to: California, Connecticut, the District of Columbia, Florida, Illinois, Maryland, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, Texas, Washington, and West Virginia.

Limitations

Despite a high free clinic participation rate, the data have some limitations. Since free clinics that regularly receive—or are highly motivated to begin receiving—medical assistance from AmeriCares may have been more likely to complete the questionnaire, the data cannot be considered entirely random. Since the survey link was circulated by the National Association of Free Clinics and several state associations to their respective members, member clinics were more strongly represented in the data than those clinics that do not belong to any association. Survey participants self-reported their answers, which implies participant bias. It was not possible to measure changes over time using baseline survey data since many of the questions had never before been asked of clinics nationwide. As a result, inferences to the entire free clinic network should be made with some caution. However, the size, scope, and high participation rate appear to suggest that the AmeriCares assessment can be considered a valuable contribution to the current discourse about the state of the uninsured and the future of free clinics.

SURVEY RESULTS

The AmeriCares study indicates that free clinics and other safety-net providers are accommodating unprecedented numbers of new patients. Moreover, each individual patient is seen frequently, because chronic illness typically requires substantial time with clinicians and nurses for diagnosis, education, coaching, treatment, and medication regimens. Reflecting both the steady rise in the rate of the U.S. uninsured as well as the prevalence of chronic illness, nearly all (89%) free clinics have seen marked growth in patient visits in the past one to three years. Roughly one-half are absorbing increases of 20 percent or more, and slightly more than one-quarter are accommodating rises of 30 percent or more (see Figure 1).

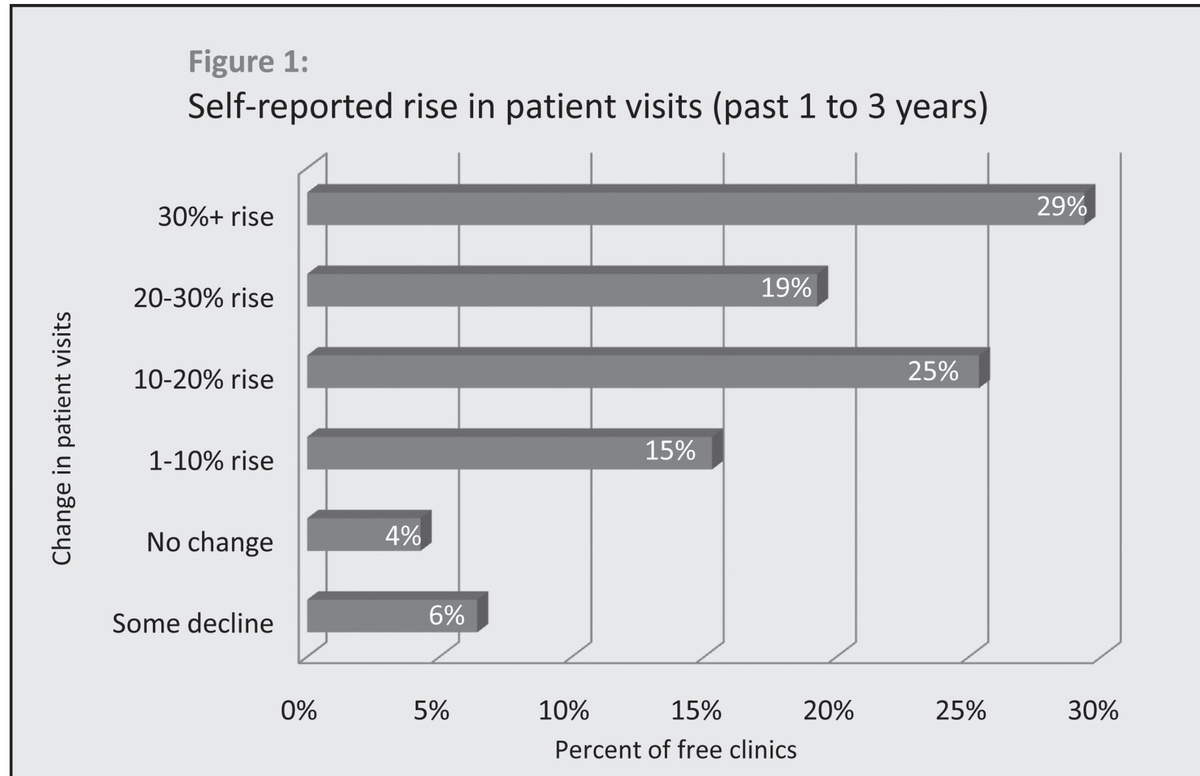


Figure 1:
Self-reported rise in patient visits (past 1 to 3 years)

Free clinics are logging an increase in referrals from hospitals and other facilities that are no longer able to accept patients without health insurance. At the same time, many clinics report protracted delays and obstacles when referring patients to specialists, state health departments, and other safety-net providers.[6]

Beneath this surge in patient demand lies a web of complex, interrelated causes. The rise in demand is heavily composed of newly uninsured individuals due to job loss. Many of these newly uninsured patients come from relatively well-off communities with higher incomes; previously they did not rely on safety-net providers. In fact, some clinics disclosed in interviews that some prior donors have now become patients.

A report by the Free Clinics of Michigan (FCOM) astutely surmised the following about the impact of the economic downturn on the state's clinics:

The newly uninsured represent a different class of patients with different needs from the traditionally uninsured. The number of patients in the 50 to 64 age range has increased drastically. The mental health aspect is also exploding, with many unmedicated patients presenting to free clinics. Many more patients require enrollment in [corporate] Patient Assistance Programs to receive medications. The number of patients seeking emergency and routine dental services also continues to rise.[7]

At the same time, clinics remain committed to steadfastly serving the chronically underserved—individuals who, even if insured, would still remain isolated from traditional medical facilities because of language or transportation barriers, challenges navigating the labyrinthine safety-net system, and the complexity of their health care needs. These patients are marginalized, vulnerable, often minority, and sometimes undocumented.

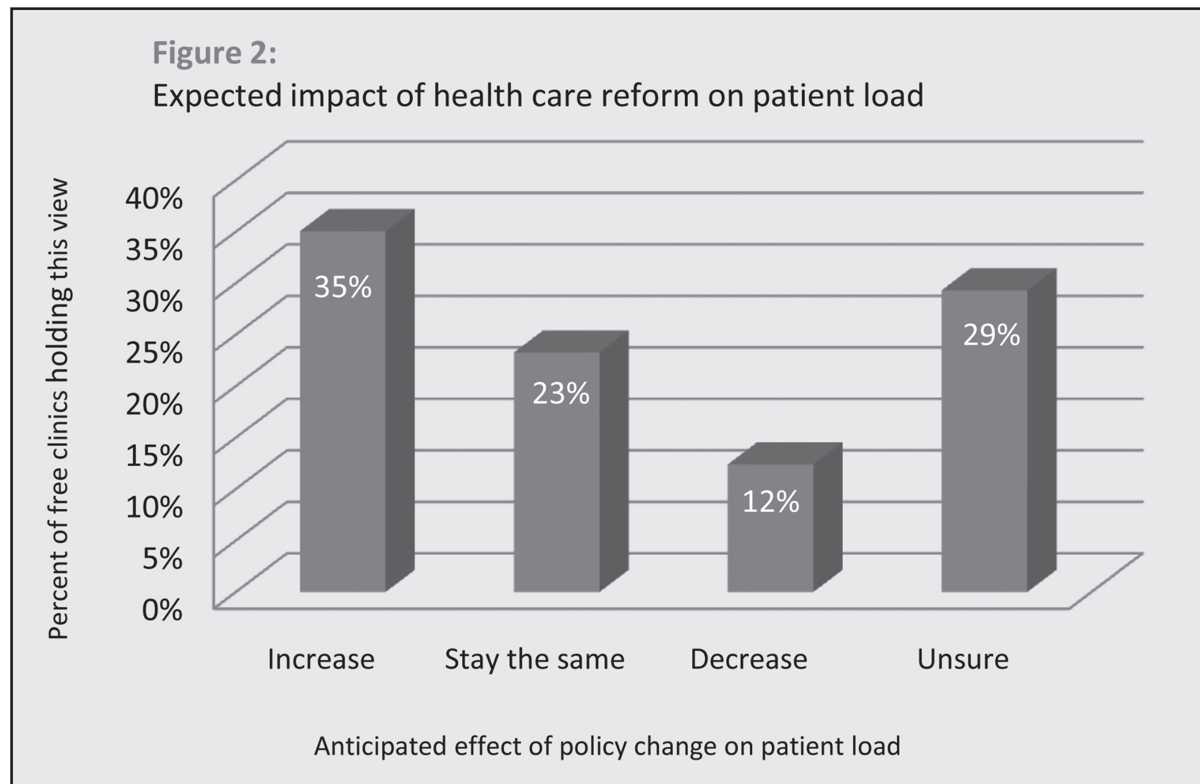
Whether traditionally or newly uninsured, safety-net patients today often present with multiple, chronic conditions, such as obesity, hypertension, hyperlipidemia, and diabetes. Largely due to lack of financial resources, many patients delay diagnosis or forego treatment, and such decisions result in worsening morbidity. Often these patients seek care at free clinics only after their illness has reached the point of urgency, which leads to more extensive, costly treatments and more frequent visits.

As a result, clinics are inundated. Some have stretched limited resources to operate slightly beyond capacity, whereas others have cut or reduced services in response to losses of funding and other resources. Up to 97 percent of clinics surveyed by AmeriCares confirm that if they were to increase operational capacity by 10 to 20 percent, they would have sufficient patient demand to use that capacity. Clearly, there is a documented need for clinics to expand and enhance services. However, it has become increasingly difficult to acquire adequate resources.

Coping with Limited Resources

As patient demand has risen, funding and other forms of institutional support have declined. The current recession has exacerbated situations that had been incubating even before the economic downturn while also ushering in other new challenges. As a result, we see decreases in tax revenues causing gaps in state and local government budgets; declines in state health department services such as screenings; and waning volunteer hours from medical providers.

Funding is consistently identified as the primary underlying issue. Many clinic directors attribute declines in donor funding levels not only to past and current economic conditions but also to the potential effects of health care reform. Some donors question the necessity for free clinics once health care policy is fully implemented in 2014 and insurance becomes more accessible. However, only 12 percent of survey respondents expect health care reform to cause their patient load to decrease (see Figure 2).



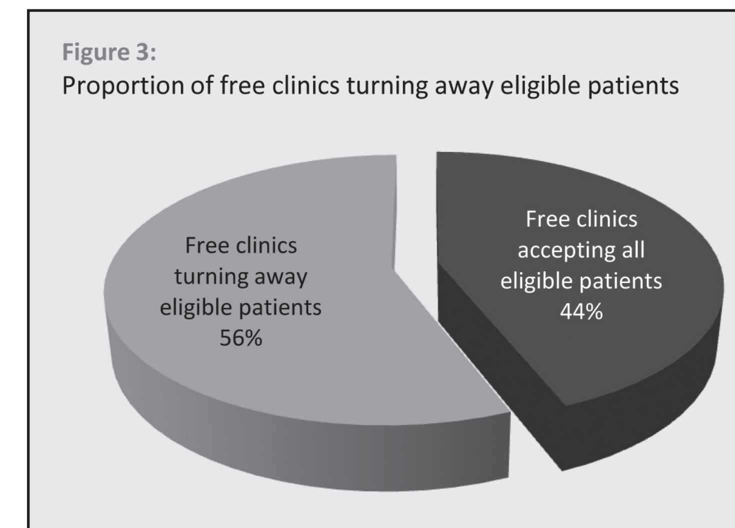
There is particular concern that as health care reform takes effect, free clinics will be known as service providers solely for undocumented patients, a population that certain donors consider outside of their core mission. In addition, clinics serving undocumented patients fear that debate surrounding immigration reform will result in reduced funding.

To stay viable, clinics have adapted to conditions, but it is conceivable that the full impact of the recession has not yet hit, and patient demand could continue to rise while funding and support continue to fall.[8] While employment rates have improved somewhat, the percentage of people covered by employer-sponsored health insurance is only 55.8 percent with a declining trend.[9] Many firms avoid providing employee benefits by hiring part-time employees or excluding coverage for new full-time hires.

Some individuals now face the reality that with their unemployment benefits winding down, it will be harder to cover medical costs. Furthermore, economic, employment, health, and other disparities persist across states and communities. Even as some parts of the U.S. economy begin to recover, others remain flat. Patients living in poor inner-city and rural areas continue to face formidable barriers to health care and look to free clinics for accessible care. Medicaid enrollment in some states is effectively "closed," with patients who may have been covered in pre-recession days now going without care or turning to emergency departments and free clinics.

Clinics are developing innovative strategies to operate under tighter budgets and maximize available resources. For example, many are opening new, or expanding current, evening or weekend clinics; doing this requires no additional facility space, rent, or equipment. This model allows medical providers who see private patients during the day to volunteer after-hours, and it offers access to services for the working poor. Other clinics focus on recruiting more volunteer clinicians to leverage office hours and nonmedical staff. Nearly all clinics and their practitioners are reaching out more assertively to build new, and strengthen existing, partnerships with hospitals, specialists, universities, government representatives, and donors.[10]

Some clinics are collaborating more closely to establish or bolster state associations or city-wide consortia that facilitate sharing of information and resources. Others are considering conversion from a free, independent clinic to a community health center (CHC), thereby launching task forces to evaluate medical needs in the community and eventually apply for federal designation as a "New Access Point." Still others are teaming up with neighboring community health centers to increase referral acceptance, initiate mobile outreach programs, serve the homeless, start dental services, or attract medical providers and donors.

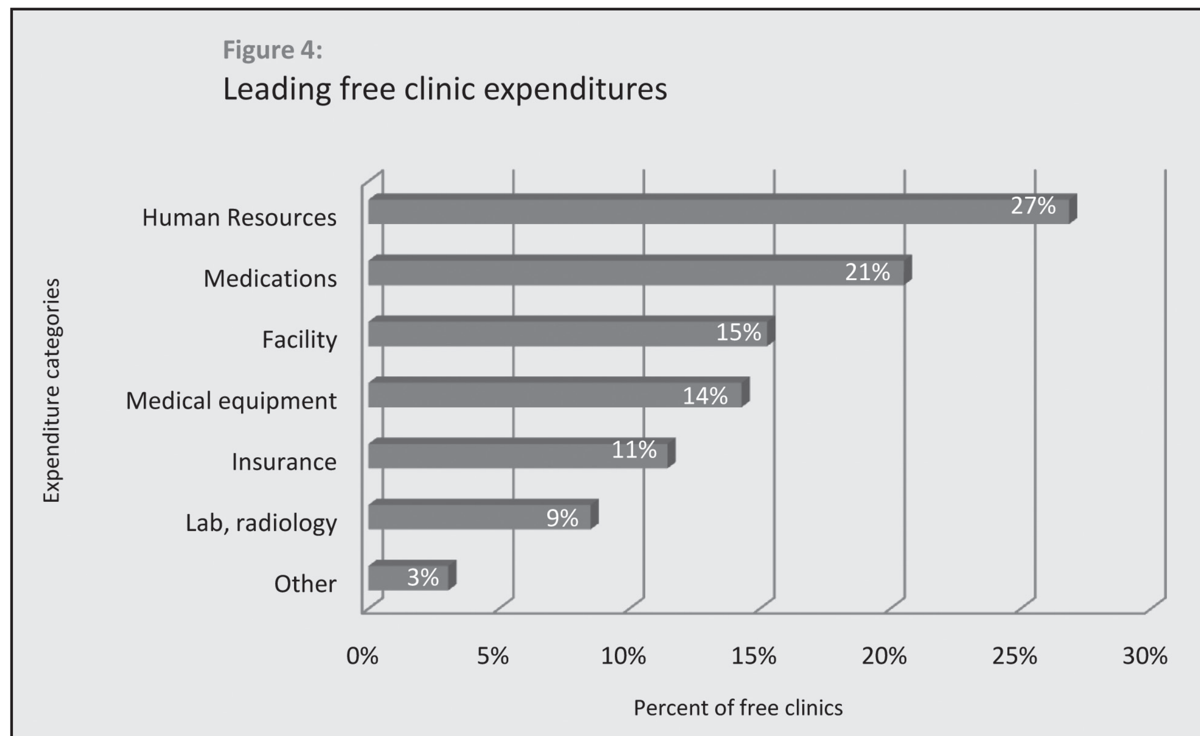


Despite these innovative approaches, some clinics have been forced to terminate services (such as dental, obstetrics, or nutrition) and turn away patients. In fact, more than half (56%) of clinics report that they are turning away eligible patients (see Figure 3). This rate is consistent across the United States, with 63 percent of clinics in the West, 60 percent in the Midwest, 55 percent in the South, and 44 percent in the Northeast turning away patients.

Key Resource Constraints Identified by Clinics

Looking ahead, 94 percent of surveyed clinics indicate they would like to serve more patients but lack the resources necessary to expand; only 6 percent do not want to expand. To obtain information on the specific resources needed for expansion, AmeriCares asked clinics to rank their annual expenses and leading resource needs.

Regarding expenses, approximately 27 percent of free clinics rank human resources (medical and non-medical salaries and benefits) as a cost burden, closely followed by medications (21%) (see Figure 4). These findings illuminate the important role AmeriCares donated medications play in providing budget relief to clinics so that scarce dollars can be reallocated toward other priorities.

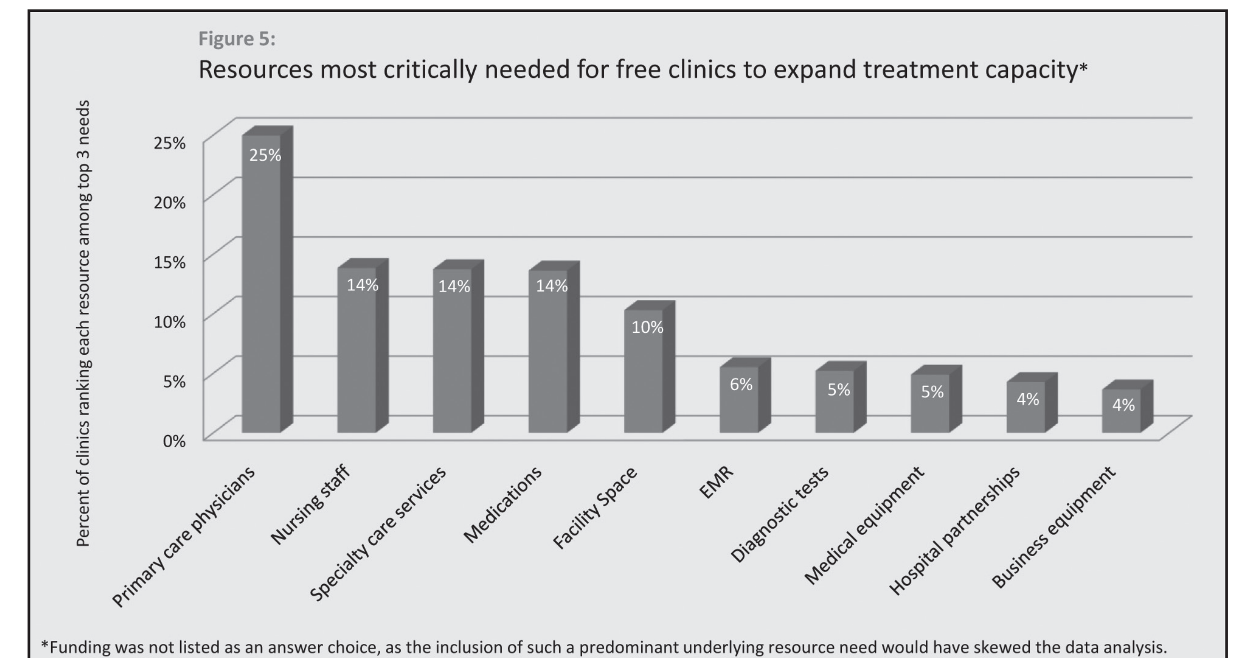


On average, clinics identify the following as among their top-three priority resource needs:[11]

1. Primary care physicians (25%)
2. Nursing staff (14%)
3. Specialty care services (14%)
4. Medications (14%)
5. Facility space (10%)
6. Electronic Medical Records (6%)
7. Diagnostic tests (5%)
8. Medical equipment (5%)
9. Hospital partnerships (4%)
10. Business equipment (4%)

1. Primary Care Physicians and Nursing Staff

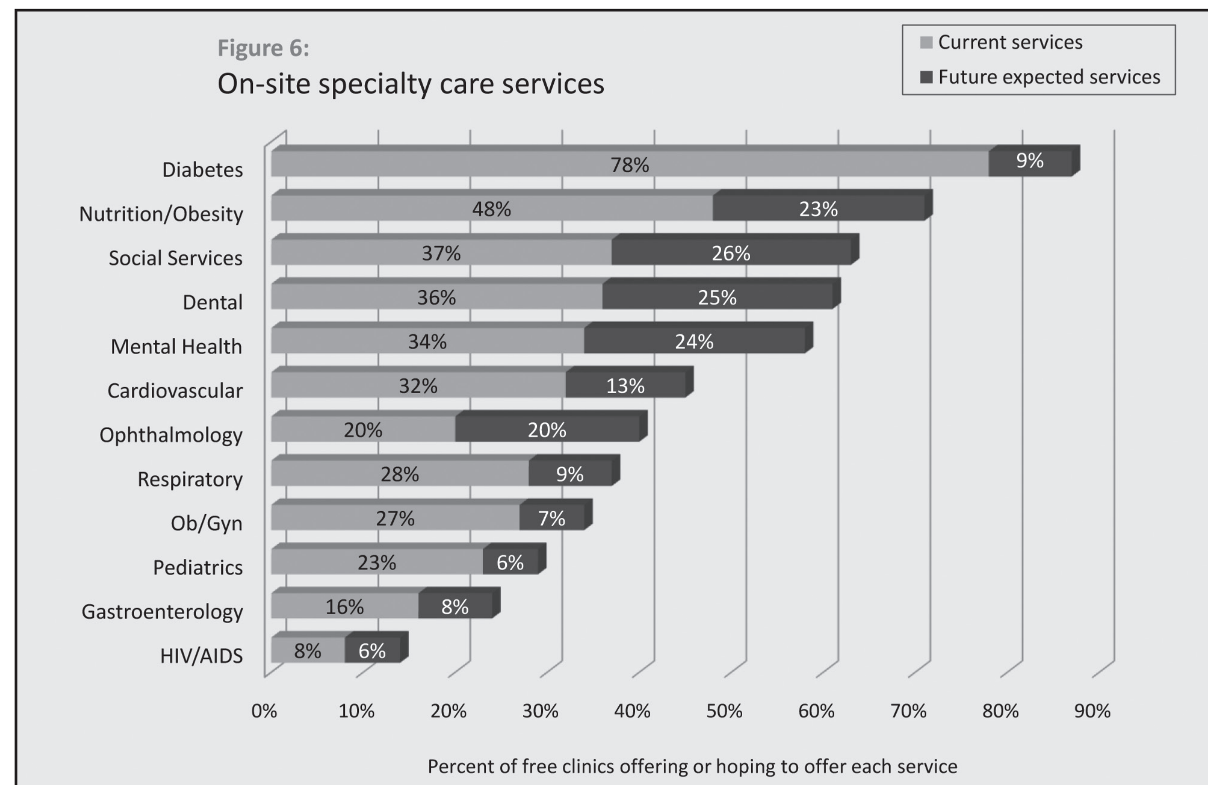
Not surprisingly, one-quarter of free clinics identify primary care physicians as a high-priority need, and another 14 percent point to nursing staff (see Figure 5). The common need for primary care physicians reflects not only a shortage of physicians available to clinic-based settings, but also a general propensity for medical students to select higher-paying specialties over primary care. In the United States, about 30 percent of all physicians choose to practice primary care (compared to 50 to 60 percent in other advanced countries); this is largely because U.S. insurers tend to pay specialists and sub-specialists more than primary care providers.[12] Nurses, especially nurse practitioners who hold advanced degrees and have clinical specialty training, currently fill a significant, cost-effective primary care role in many health care organizations, including free clinics.[13]



*Funding was not listed as an answer choice, as the inclusion of such a predominant underlying resource need would have skewed the data analysis.

2. Specialty Care

Following primary care clinicians, on- and off-site specialty care services are identified by 14 percent of clinics as a leading resource need. While nearly all free clinics provide primary care, many also offer a broad spectrum of on-site specialty care (see Figure 6), such as diabetes management, nutrition/obesity counseling, social services, dental care, and mental health care.



Clinic directors lament that referring patients to off-site specialists can be a complex and time-consuming task for both clinic staff and patients. Clinic staff or volunteers dedicate significant time to scheduling off-site referrals and encouraging patients to keep their appointments. In some cases, patients must wait a number of weeks or even months to see a specialist, and they may not be seen by the same specialist more than once. Patients are sometimes asked to travel to new places to see specialists, which can be intimidating and costly. All of these factors interrupt continuity of care and can even hinder access to care. In addition, the willingness of specialists to accept clinic referrals seems to be waning as they too experience budget constraints.

Many clinic directors are seeking to expand the breadth and depth of their on-site specialty care and to integrate it with their primary care services to offer patients a kind of "one-stop" medical home. On their own premises, clinic directors can manage specialty care first-hand to ensure continuity of care, oversee medication selections, and cultivate patient compliance with respect to not only appointment-keeping but also follow-up care and medication regimens.

Specialty Care – Diabetes Management

In the United States, 26 million children and adults—8.3 percent of the population—suffer from diabetes. Another 79 million people are estimated to have pre-diabetes, a condition that puts people at increased risk for diabetes. This chronic and destructive disease is the seventh-leading cause of death in the country, and it disproportionately afflicts Native Americans, Hispanics, and Blacks.[14]

A nationwide survey by Direct Relief International indicates that safety-net providers (free clinics and community health centers) saw a 13 percent increase in the number of uninsured diabetic patients seeking care during the first six months of 2009 compared to the same period in 2008. This rise is particularly concerning and untenable, as the costs for free clinics to treat this patient population are exorbitantly high.[15]

In response to the growing threat of diabetes, nearly all free clinics have integrated diabetes management into their core services. While 78 percent of institutions surveyed by AmeriCares already provide diabetes management, 9 percent of clinics would like to offer it.

Likewise, clinics indicate diabetic medications and supplies, such as insulin, syringes, glucose meters, and test strips, as the leading need among all medications. In an interview, one survey respondent provided eloquent testimony: "In our area [of the United States], individuals are 30 percent more likely to die from diabetes than other areas of the United States. Diabetic supplies and medications are a monumental need."

Complementing diabetic management, 48 percent of free clinics today provide nutrition and obesity management programs, with 23 percent hoping to offer these services in the future. Also, 20 percent provide ophthalmology, and another 20 percent hope to begin offering vision services. Some clinics also offer podiatry services.

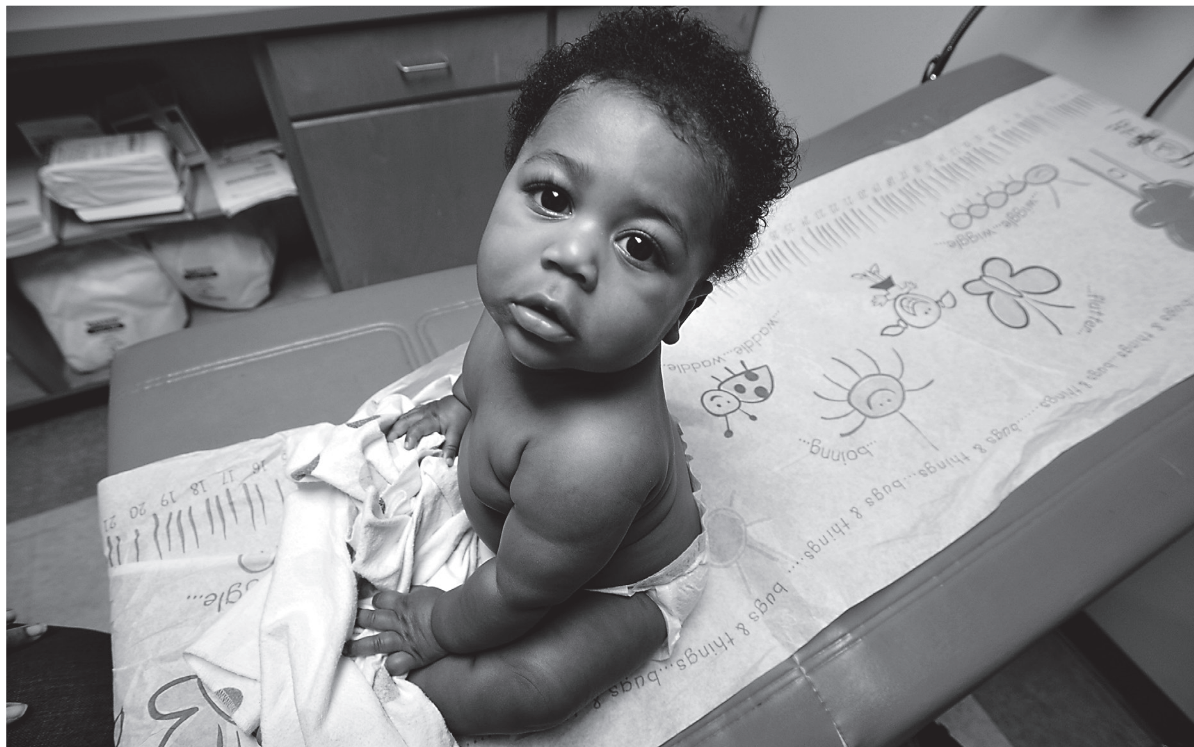
Specialty Care – Behavioral Health & Social Services

Free clinics are expanding services to address mental health and social needs. About one in four adults suffers from a diagnosable mental disorder, which translates to 58 million people. In addition, mental disorders are the leading cause of disability for individuals aged 15 to 44, and many patients suffer from more than one mental disorder at a given time.[16]

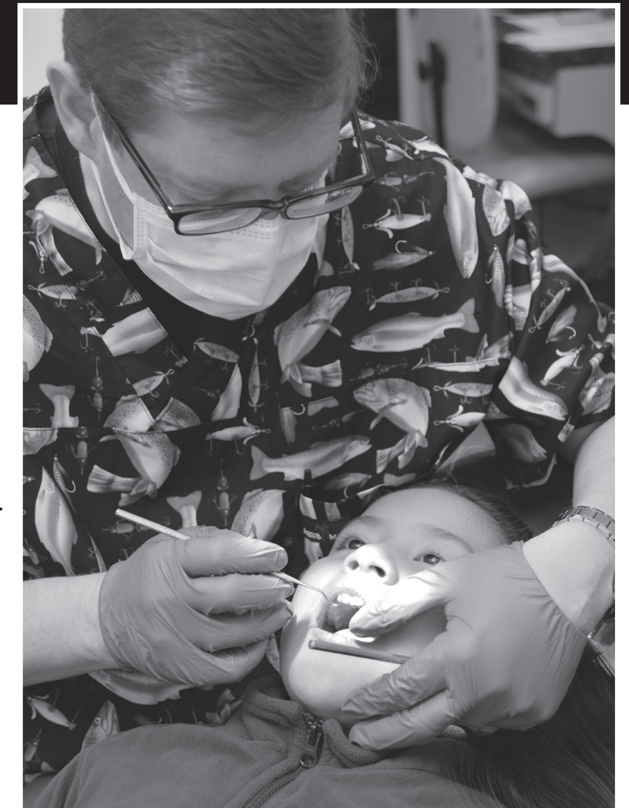
Clinic directors assert that behavioral disorders comprise a large and growing portion of patient visits, with depression and anxiety being the most common. To address these burgeoning needs, 34 percent of surveyed clinics currently provide mental health services, while an additional 24 percent intend to provide such services in the future. Thirty-seven percent already offer social services, while 26 percent would like to begin outreach in this area. Given these data, we could see up to 60 percent of free clinics providing mental health and social services in the future.

Remarkably, many clinic-based social workers not only offer high-quality counseling but also help patients navigate the overall safety net. A social worker might help patients identify organizations that assist with housing, employment, or child care; refer patients to local shelters or food pantries; or assist patients with enrollment in Medicaid and other programs. Still others operate mobile clinics that travel door-to-door to deliver health care outside of homeless shelters or directly within targeted, hard-to-reach populations, such as migrant farming communities.

While social workers are vital to clinic programs, some clinic directors report an additional need for paid or volunteer psychiatrists to address behavioral illnesses beyond anxiety and depression disorders and to prescribe and monitor more complex, appropriate medications.



Specialty Care – Dental Health



The gap in dental care for the underserved is enormous. Estimates by the U.S. Surgeon General's Office and the National Association of Dental Plans indicate that between 35 and 47 percent of the population lack dental insurance.[17] This rate is two to three times higher than the number lacking basic health care insurance. Poor oral health has the potential to cause or exacerbate infections, cardiovascular problems, and other life-threatening illnesses.

Historically—and to an even greater extent during a recession—uninsured patients view dental care as elective. Patients facing financial pressure postpone care, which delays diagnosis and increases health risks. Emergency departments tend to become inundated with urgent dental cases, but emergency practitioners typically provide only antibiotics and palliative care. Patients develop recurring problems, return time and again to the emergency room, and thereby add to the burden of public health costs. Eventually, when proper dental treatment is finally provided, it tends to be more extensive and costly.

To relieve some of that cost burden—and to fill the gap seen in health care policy reform, which may not adequately address oral health[18]—many free clinics are considering opening new or augmenting current clinic-based dental services.

Likewise, AmeriCares is considering strategic horizontal expansion into the provision of dental aid, which is well aligned with the AmeriCares mission and its core expertise in the safe and effective delivery of basic medical aid. AmeriCares dental aid could provide the long-awaited resource access and momentum that many free clinics need in order to begin launching new or reopening temporarily closed dental services.

It is worth noting that the number of community health center dental care patients has doubled—from 1.4 million dental patients in 2001 to 2.8 million in 2007.[19] Despite this growth, the overall unmet demand for dental care prevention and treatment among uninsured patients is unlikely to be addressed without significant, deliberate expansion of capacity by the free clinics.

In certain communities, resource and funding shortfalls have been sufficiently steep to force some clinic directors to close their dental clinics. During site visits, AmeriCares staff saw vacant dental exam rooms—complete with first-rate equipment and supplies often donated

by local retired and practicing dentists. Overall, clinic directors report that for both paid and unpaid support, dentists and hygienists are relatively more difficult to recruit and retain than physicians. In addition, dental clinics are among the first services to be shut down by clinic directors who, not unlike patients, sometimes view dental health as ancillary to primary care and a drain on resources.

3. Medications

Fourteen percent of free clinics identify medications as one of the leading resource constraints on clinic expansion, a gap that AmeriCares strives to fill directly with donated prescription and over-the-counter medications (see Figure 7).

Through an open-ended question on the AmeriCares survey, clinic directors were asked to submit their high-incidence disease states. The following list summarizes (in alphabetical order) the most frequently diagnosed illnesses in the view of survey respondents:

1. Addiction
2. Anxiety and depression
3. Cardiovascular disease, hypertension
4. Chronic pain
5. Dental decay, periodontal disease
6. Diabetes Mellitus Type II
7. Gastroesophageal reflux disease (GERD)
8. Hyperlipidemia
9. Obesity
10. Respiratory illnesses, asthma, COPD
11. Viral infections and allergies

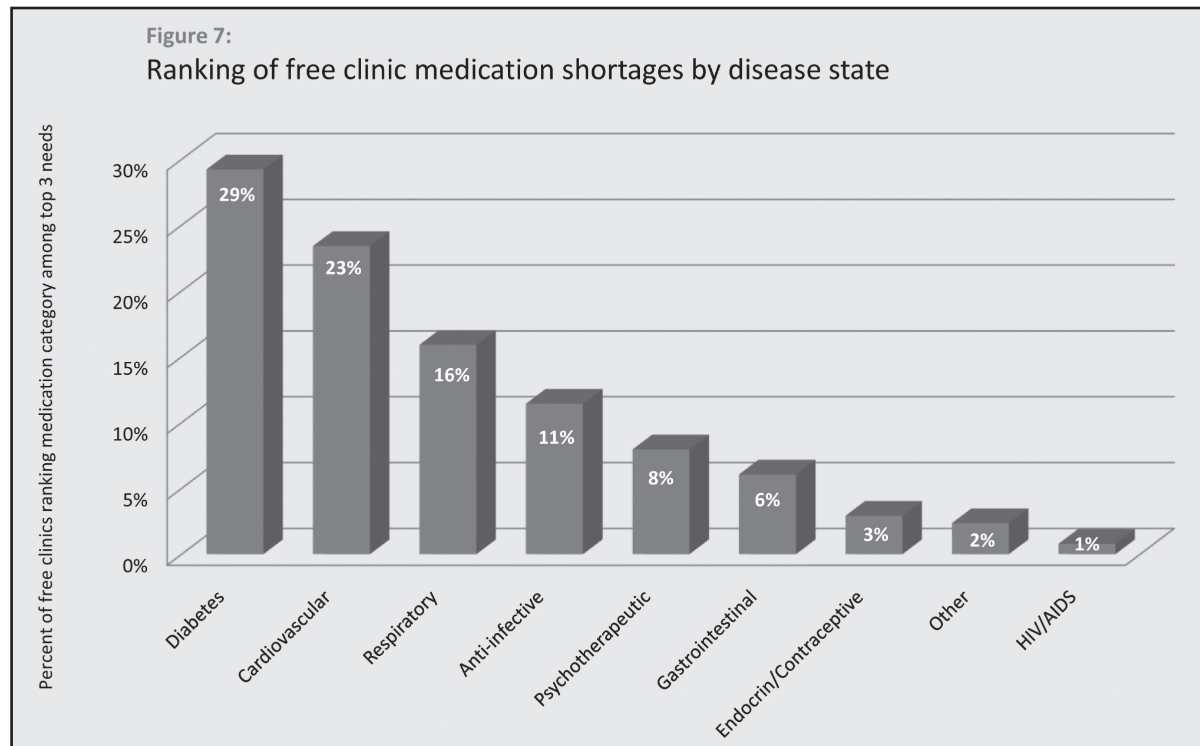


Figure 7:
Ranking of free clinic medication shortages by disease state

When asked to identify their leading three medication needs by disease category, clinic directors point to:

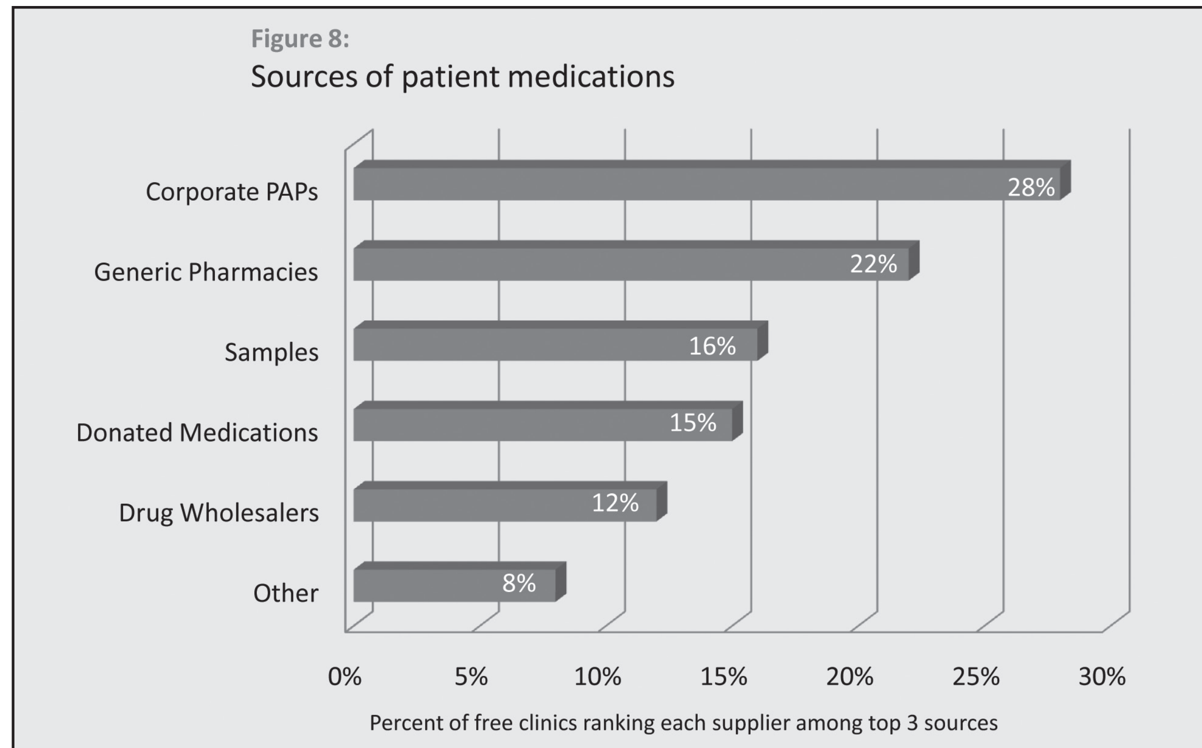
1. Diabetes (29%) – insulin, glucometers, test strips
2. Cardiovascular (23%) – cholesterol- and blood-pressuring lowering drugs
3. Respiratory (16%) – inhalers
4. Anti-infective (11%) – antibiotics
5. Psychotherapeutic (8%) – anti-anxiety, anti-depressants

However, if we sum the number of clinics identifying solely the single greatest medication need, we find that more than half of free clinics are facing a common deficit of diabetes medications:

1. Diabetes (55%)
2. Cardiovascular (14%)
3. Anti-infective (11%)
4. Respiratory (7%)
5. Psychotherapeutic (6%)

Sources of Medications
Field visits laid bare the various ways that free clinics knit together a patchwork of pharmacy support for their patients. Some facilities are fortunate enough to be located in a state or community that offers a central-fill pharmacy. Other clinics not only operate their own impressive on-site licensed pharmacies but also provide a training ground for graduate students of pharmacy, who in turn supply expertise to the clinic. Most others have smaller dispensaries overseen by pharmacy, administrative, and IT staff or volunteers, with cost-saving approaches to recycling empty bottles or labeling and tracking medications electronically. Still others provide only over-the-counter medications and ask patients to fill prescriptions at off-site pharmacies.

In the AmeriCares survey, clinics report that they rely most heavily on certain sources to fill pharmacy needs, such as Patient Assistance Programs (28%) and generic pharmacies (22%) (see Figure 8). Clinics avail themselves of corporate Patient Assistance Programs, but limitations include a deficiency of antibiotics, delays, and lack of accessibility for undocumented patients. In today's fiscal environment, some clinics that previously provided vouchers to subsidize co-payments at generic pharmacies are no longer able to do so. Clinics remain resourceful as they pursue affordable medications for their patients—for instance, devising creative ways to more efficiently collect free samples from private practices. To help fill this medication supply gap, AmeriCares is leveraging our own resources to expand our donation programs across the United States, particularly in those communities hardest hit by the recession, the 2010 Deep Water Horizon oil spill in the Gulf, the 2011 tornadoes in the South, and other local and nationwide shocks.

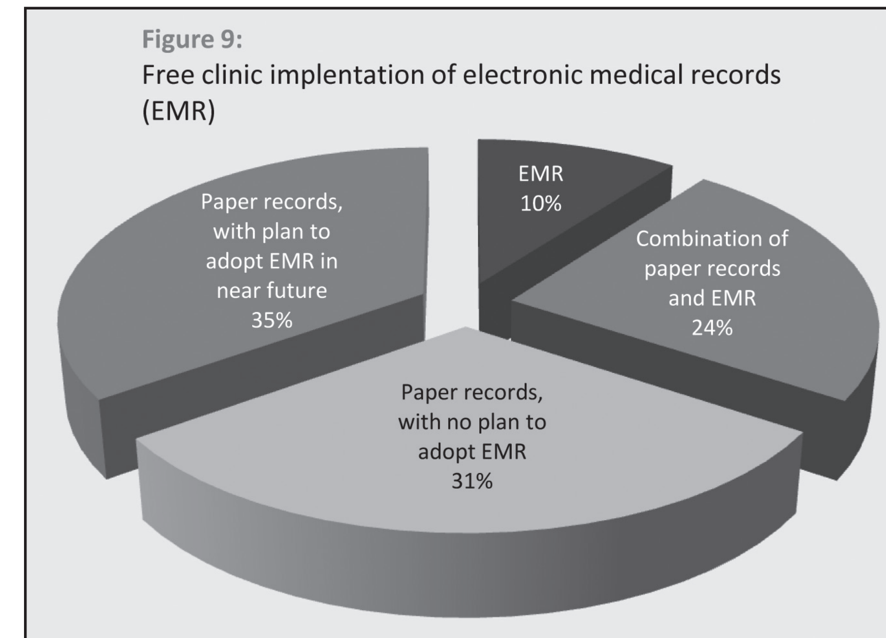


4. Facility Space

Free clinics confirmed in the AmeriCares questionnaire that facility space is a key capacity constraint. During site visits, AmeriCares staff visually confirmed the underlying need among clinics for more exam rooms and larger facility space overall to accommodate more patient visits, additional on-site specialty services, larger pharmacy and supply storage, greater point-of-care lab/diagnostic services, and enhanced work space for staff and volunteers.

5. Health Information Technology

Recent studies show that health care institutions with strong health information technology (HIT) demonstrate greater care coordination among providers as well as across settings of care, such as emergency departments and hospitals.[20] Yet according to the AmeriCares assessment, only 10 percent of free clinics are using electronic medical records (EMR) versus the 40 percent of community health centers surveyed by The Commonwealth Fund the previous year (see Figure 9).[21]



Beyond simply EMR, free clinics are seeking to build capacity to adopt the more advanced HIT, such as electronic prescriptions, patient tracking, and testing. As an initial step, some clinics have organized task forces to investigate HIT systems implemented by hospitals and other health care institutions in and around their communities. Impediments to early adoption include high costs, lack of coordination across partner institutions, and the time necessary to train clinicians and staff.

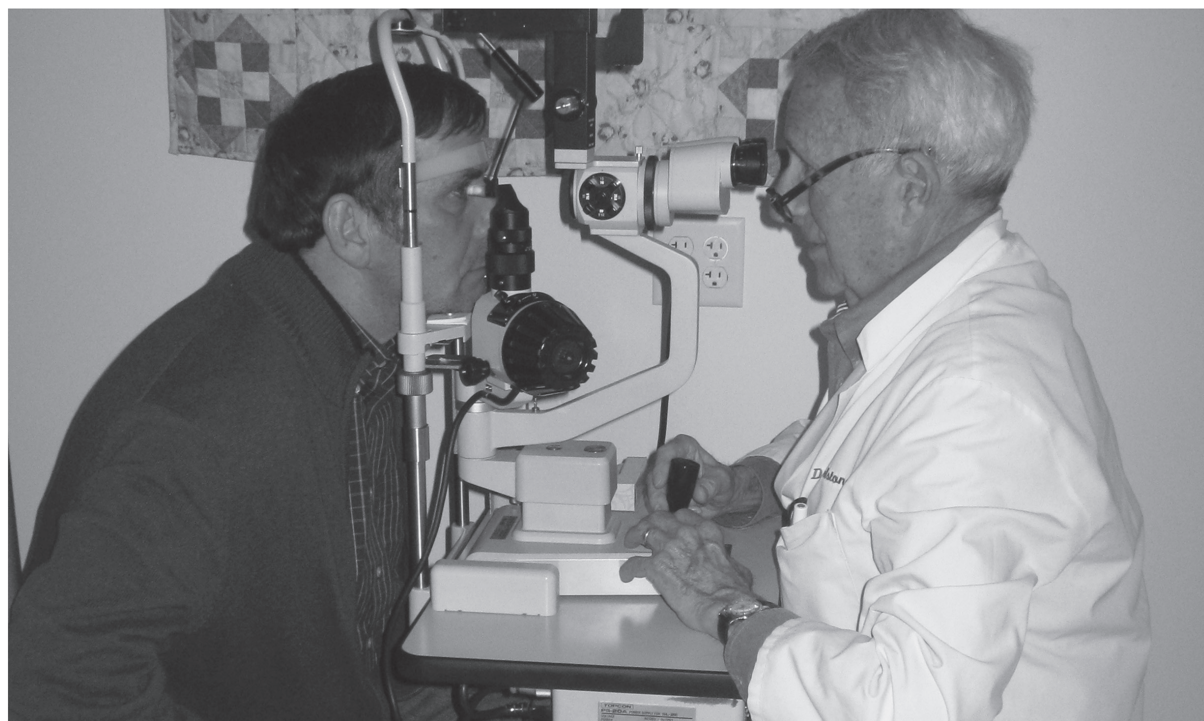
CONCLUSIONS

Historically, many free clinics were established as community-based, grass-roots organizations mainly focused on addressing acute illness, with some chronic care, women's health, and mental health services. Their role was "limited and reactive to specific critical needs of patients rather than responsive to an underserved 'population' as a whole." [22]

The roles of free clinics are ever-evolving, as they continually adapt their services, organizational structure, and use of resources to meet the changing needs of their immediate and surrounding communities. While some remain small with limited hours, others operate as full-time enterprises with paid staff and hundreds of volunteers working together to provide a comprehensive health care service delivery system. Some clinics provide a suite of services often not found even in private practice, including chronic disease management, HIV testing, gynecology, nutrition education, ophthalmology, dentistry, case management, and homeless outreach. Many strive to better integrate care in order to provide a singular, familiar medical home for patients.

Prior to the recession, free clinics were committed to offering efficient navigation through the safety-net system for marginalized, underserved individuals. Today, in the wake of the economic downturn, clinics are reinventing themselves even further—absorbing increasing numbers of uninsured patients and addressing increasingly complex medical, dental, and behavioral needs—all while facing sharp and significant declines in financial and other resource areas.

The AmeriCares assessment of the free clinic network illuminates the conflicting forces playing on clinics in today's environment. On the one hand, there exists a clear need for clinics to increase their size and scope; on the other hand, significant resource constraints impede such expansion.



RECOMMENDATIONS

Free clinics could benefit from increased investment in national- and state-level strategic planning, which would have the potential to ease some of the key resource constraints that clinics have in common regardless of location or size.

Today, free clinics are at a crossroads as they strive to respond to an array of challenges that are unlikely to be resolved in the near future. These include: rising chronic disease; escalating medication and other health care costs; declining employer-based health insurance plans; intensifying competition for scarce resources; and lingering post-recession economic problems. Such issues are couched within the context of health care reform, immigration policy, public election cycles, and other conditions that directly or indirectly affect free clinics and their patient populations.

In the face of these many challenges, there arises a clear need for increased free clinic collaboration to facilitate network-wide resource acquisition, planning, fundraising, advocacy, training, research, and dissemination of information. Currently, many clinics operate independently of their respective state associations and the NAFC; therefore, the network is fragmented. Resources tend to be acquired on an *ad hoc,* institution-specific basis, and best practices are shared sparingly. Greater information-sharing and more efficient, visible pathways to resources would increase clinic capacity at multiple levels.

Horizontally—Information and ideas could be integrated in order to develop national reporting and patient-level health outcome measurements. This capacity expansion would enable the free clinic network to conduct benchmarking, develop case studies, promote best practices, publish guidelines, and evaluate programs and models—all with the overarching aim of tracking progress and attracting more resources to the network.

Vertically—Greater clinic integration would facilitate the downward and upward stream of information from the largest and most well-established free clinics at the top, to the medium-sized, and eventually down to the smallest and newest institutions. Valuable trickle-down effects could permeate the network and usher in incremental change.

A locally-informed but nationally-oriented roadmap would articulate where the free clinics have been positioned in the past, and where they hope to stand in the long term, with a comprehensive analysis of emerging obstacles and the resources necessary to overcome them. Finally, an action plan could outline and sequence new strategic initiatives and partnerships that would increase the flow of resources to the free clinic network.

To conclude, AmeriCares looks forward to further developing our own U.S. Medical Assistance Program with a strategic plan to address evolving free clinic resource needs. Our abiding focus remains on the safe and effective delivery of medical and humanitarian aid in order to continue improving and saving lives.

NOTES

1 U.S. Census Bureau population data, released September 16, 2010, http://wwwcensus.gov.

2 Health center is an all-encompassing term used by the federal government for a diverse range of public and private nonprofit organizations and programs. Four types of health centers are funded under Section 330 of the Public Health Service Act: community health centers (CHCs), migrant health centers, homeless health centers, and public housing health centers. Federally-funded FQHCs meet federal health center grant requirements and are required to report administrative, clinical, and other information to the federal bureau of primary health care, Health Resources and Services Administration (HRSA). Across the United States, 1,200 FQHCs with 7,500 delivery sites provide a total of 67 million patient visits annually. Of the 17 million patients, approximately 38 percent (6.5 million) have no health insurance, 36 percent have Medicaid, and 8 percent have Medicare. FQHCs provide service to all persons regardless of ability to pay, and charge for services according to a board-approved sliding-fee scale that is based on each patient's family income and size. (National Association of Community Health Centers (NACHC), "America's Health Centers," Fact Sheet #0309, October 2009, http://www.nachc.com/research; The Commonwealth Fund, Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers, May 2010, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/May/Enhancing-the-Capacity-of-Community-Health-Centers-to-Achieve-High-Performance.aspx.)

3 The most recent nationwide census identified 1007 free clinics operating in 49 states and the District of Columbia and providing annually 3.5 million medical and dental care visits to 1.8 million patients. Since the time of that survey, our research indicates the number of free clinics in operation has grown to 1,200. When calculating the response rate of the AmeriCares survey, we chose 1,200 as the denominator, which yields a more conservative rate of 28 percent. (A denominator of 1007 would yield a response rate of 33 percent.) Free clinics generally do not receive federal funds nor charge patient fees. These nonprofit, charity organizations rely on funding from state and local governments, private grants, individuals, hospitals, and in some cases churches and other faith-based organizations. Free clinics generally provide services for low-income, uninsured, and medically underserved people; they tend not to accept patients who have government-sponsored health insurance such as Medicaid or Medicare. (Julie S. Darnell, "Free Clinics in the United States: A Nationwide Survey," Archives of Internal Medicine, 170(11), June 14, 2010, http://archinte.ama-assn.org/cgi/content/short/170/11/946.)

4 AmeriCares received 499 total surveys, and after careful review considered 417 questionnaires to be valid within the parameters of this study. Of those, 332 questionnaires were coded as free clinic respondents and another 85 as community health centers, nonprofit pharmacies, and shelters. A questionnaire was considered valid if: the institution submitted no more than one questionnaire, and the staff person who completed the survey entered responses that were judged to be sufficiently complete and reliable in line with the expectations of the survey.

5 There are no known free clinics operating in Alaska.

6 AmeriCares research found that clinics across the U.S. reflected this trend, noted in Free Clinics of Michigan, Survey of Michigan Free Clinics: A Report Prepared in Response to Michigan's Health Care Safety Net Meeting Discussion Questions, 2009, http://www.fcomi.org/reports-and-statistics.html.

7 See note 6.

8 Laurie E. Felland et. al., "The Economic Recession: Early Impacts on Health Care Safety Net Providers," Center for Studying Health System Change, Research Brief No. 15, January 2010.

9 U.S. Census Bureau population data, released September 16, 2010, http://wwwcensus.gov.

10 See note 6.

11 Beyond the 10 resources listed in the AmeriCares survey, many clinics reported a need for support staff to oversee referrals, patient in-take, and lab reports, and to provide other support and administrative functions.

12 John D. Goodman, "Patient Protection and Affordable Care Act: Promise and Peril for Primary Care," Annals of Internal Medicine, April 19, 2010.

13 Barbara Redman, "Primary Care Vital for Patients: Health Reform Bill A Chance to Give Nurses More Responsibility," The Detroit News, July 27, 2010.

14 National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, National Diabetes Fact Sheet, 2011, http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

15 Direct Relief International, The Economic Recession and Nonprofit Safety-Net Health Centers and Clinics in the United States: Nationwide Survey of Patient Volume, January-June 2009 compared to 2008: Overall Patients and Patients with Diabetes, 2009, http://www.directrelief.org/uploadedFiles/Survey%20Findings%20Release%20FINALtt.pdf.

16 Kessler R.C. et. al., "Prevalence, Severity, and Comorbidity of Twelve-Month DMS-IV Disorders in the National Comorbidity Survey Replication (NCS-R)," Archives of General Psychiatry 63 (June 2005): 617-27, cited in The Numbers Count: Mental Disorders in America, National Institute of Mental Health, http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml.

17 U.S. Department of Health and Human Services, National Call to Action to Promote Oral Health, NIH Publication No. 03-5303, Spring 2003, http://www.surgeongeneral.gov/topics/oralhealth/nationalcalltoaction.html.

18 The American Dental Association provides an overview of dental-related health care reform provisions and a synopsis of their position at: http://www.ada.org/sections/advocacy/pdfs/HCR_QA.pdf.

19 National Association of Community Health Centers, A Sketchbook of Community Health Centers, 2009, www.nachc.org.

20 Michelle M. Doty, et. al., Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers, May 2010, The Commonwealth Fund, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/May/Enhancing-the-Capacity-of-Community-Health-Centers-to-Achieve-High-Performance.aspx.

21 See note 20.

22 Peak Performance Consulting, Strategic Planning Session and Management Report, on behalf of West Virginia Health Right, Inc., April 10, 2010.

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APPENDIX A

Free Clinic Survey Responses by State

State	Abbreviation	Number of valid questionnaires from free clinics
Alabama	AL	4
Alaska	AK	0
Arizona	AZ	2
Arkansas	AR	14
California	CA	13
Colorado	CO	4
Connecticut	CT	9
Delaware	DE	3
District of Columbia	DC	1
Florida	FL	13
Georgia	GA	15
Hawaii	HI	1
Idaho	ID	2
Illinois	IL	6
Indiana	IN	4
Iowa	IA	11
Kansas	KS	2
Kentucky	KY	2
Louisiana	LA	4
Maine	ME	2
Maryland	MD	3
Massachusetts	MA	3
Michigan	MI	23
Minnesota	MN	1
Mississippi	MS	3
Missouri	MO	10
Montana	MT	1
Nebraska	NE	3
Nevada	NV	4
New Hampshire	NH	1

State	Abbreviation	Number of valid questionnaires from free clinics
New Jersey	NJ	3
New Mexico	NM	1
New York	NY	2
North Carolina	NC	24
North Dakota	ND	1
Ohio	OH	13
Oklahoma	OK	10
Oregon	OR	6
Pennsylvania	PA	14
Rhode Island	RI	1
South Carolina	SC	13
South Dakota	SD	1
Tennessee	TN	5
Texas	TX	32
Utah	UT	3
Vermont	VT	1
Virginia	VA	10
Washington	WA	11
West Virginia	WV	10
Wisconsin	WI	6
Wyoming	WY	1
Sample size	--	**332**
Target population	--	**1,200**
Response rate	--	**28%**
Confidence interval	--	**96%**
Minimum	**	**1**
Maximum	**TX**	**32**
Average number of responses per state	--	**6.64**

**Each of the following states is represented by one valid survey response: District of Columbia, Minnesota, Montana, New Hampshire, New Mexico, Rhode Island, South Dakota, Vermont, and Wyoming. In several of these states, only one free clinic is known to be in operation.

About the Author

From April 2010 to 2011, Tammy Allen served as Project Director of AmeriCares survey research in the U.S. Medical Assistance Program. Previously, Tammy was Head of Foreign Government Relations at the Population Council, an international nonprofit research institute that designs innovative solutions to address health care and population issues in developing countries. She holds a Master of International Economic Policy from Columbia University's School of International and Public Affairs, where she was the recipient of a Foreign Language & Area Studies Fellowship for the region of Asia. She earned her B.A. in Foreign Affairs from the University of Virginia.

Tammy is also Director of Asia and Eurasia Partnerships at AmeriCares. In 2010, AmeriCares provided program services and relief aid valued at $850 million to 97 countries, of which $67 million supported initiatives in Asia and $64 million supported Eurasia. She oversees regional program development with government and non-government partners in Afghanistan, Armenia, Bangladesh, Cambodia, Kosovo, Mongolia, North Korea, Philippines, Romania, Uzbekistan, and Vietnam, while also helping to coordinate AmeriCares disaster relief for victims of the March 2011 earthquake and tsunami in Japan.

In times of epic disaster, daily struggle or civil conflict, AmeriCares restores health and saves lives by delivering medicines, medical supplies, and humanitarian aid to people in need around the world and across the United States.

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