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The Free Clinic Movement: America's Best-Kept Healthcare Secret

An Expert Interview With Nicole Lamoureux, Executive Director of the National Association of Free and Charitable Clinics

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Editor's Note:
When President Barack Obama signed the Affordable Care Act[1] in March 2010, it initiated major changes in how healthcare would be provided. All of the players in healthcare provision will be involved, with changes reaching far beyond hospitals and insurance companies. It is estimated that 32 million uninsured people will have healthcare coverage.

However, this is only the beginning of the story; many questions remain unanswered. This interview with Nicole D. Lamoureux, MA, Executive Director of the National Association of Free and Charitable Clinics (NAFC), offers insight into one of the most important questions: How will capacity be expanded to cover millions of patients? A significant answer to this question is the free clinic movement -- America's best-kept healthcare secret.

The purpose of this interview is to help readers understand and appreciate the value of free and charitable clinics in this era of dramatic change in how healthcare will be provided.

Dr. Jacobs: I want to thank you, Nicole, for taking the time to share on a subject that will be of growing interest to our readers over the upcoming years. First of all, could you tell us a little about yourself and your organization?

Ms. Lamoureux: I am the Executive Director of NAFC, a nonprofit 501(c)(3) organization whose mission focuses on the issues and needs of the more than 1200 free and charitable clinics and the people they serve in the United States.

I work daily with free and charitable clinics around the country, members of Congress, the media, and pharmaceutical companies, as well as volunteer, charitable, and faith-based organizations. Our mission is to provide research, education, and resources to promote, strengthen, and advocate for member organizations and the communities they serve.

I have been a guest on FOXNews, MSNBC, *Good Morning America*, and *The Dr. Oz Show,* discussing free and charitable clinics, the plight of the uninsured, and healthcare reform. I hold a Master's degree in American government and a Bachelor of Arts degree in politics from the Catholic University of America.

Before I joined the NAFC, I worked for 2 large trade organizations that represented the interests of the home building and the horse industries. Through these organizations, I received the Washington, DC, training that is critical to run a national organization. However, I knew deep in my heart that I was supposed to give back to this world in a tangible and impactful way. My current position at the NAFC is much more than a job; rather, it is my passion, my drive. In a small way, the work we do at the NAFC and in our member clinics is building a healthy America, 1 patient at a time.

What Are "Free and Charitable Clinics"?

Dr. Jacobs: I've posted for our readers the NAFC's definition of "free and charitable clinics," as found on the NAFC Website (Sidebar 1). Does this definition encompass the diverse network of free and charitable clinics across the United States?

Ms. Lamoureux: Absolutely. This is the definition that is accepted by our entire membership and is starting to get some traction on Capitol Hill as well.

Free or charitable clinics are 501(c)(3) organizations that use staff and volunteers to provide a range of medical services to economically disadvantaged individuals. Free and charitable clinics restrict eligibility for their services to individuals who are uninsured or underinsured, and/or have limited or no access to primary, specialty, or prescription healthcare.

Dr. Jacobs: How is the term "safety-net clinic" related to your definition of free and charitable clinics?

Ms. Lamoureux: "Safety net" is a label for all clinics providing care to the poor, uninsured, and underserved, including free and charitable clinics, federally qualified health centers (FQHC), and rural health centers. In some communities, urgent care centers, minute clinics, and healthcare providers' offices are serving these populations as well.

The difference between free and charitable clinics and other members of the safety net is that many times we catch those patients who fall through the cracks; we are the net under the safety net, if you will. It is important to note that many safety-net clinics, such as free and charitable clinics, are not FQHCs.

Dr. Jacobs: So is this a movement?

Ms. Lamoureux: Yes. We truly are a grassroots movement when it comes to healthcare and healthcare delivery. We are the community's response to the healthcare needs in a particular area. On a very basic level, we are neighbors helping neighbors.

Dr. Jacobs: Do you have any idea as to the number of clinics and the number of people who are provided care, or is it such a large, diverse network that it is difficult to get an accurate count?

Ms. Lamoureux: We know that 1200-1300 clinics in the country[2] fall under the NAFC definition (Sidebar 2). However, we expect this number to grow significantly as we continue to identify additional clinics.

It is more challenging to identify the number of people who are served by free clinics, and so our association has been working on processes to capture these numbers. It is very interesting how people define a patient visit, as well as how they define unduplicated visits. We anticipate that by the first quarter of next year. we will have good data to share.

With that said, the literature estimates 2-3.5 million medical and dental visits to free clinics annually.[2]

Dr. Jacobs: What can you tell us about the patients using the services of a free or charitable clinic?

Ms. Lamoureux: Here is a statistic that might surprise your readers: 83% of our patients come from a working household. Many people tell me, "Your patients are living on the dole," but that's just not true. Someone in the household is working. They just can't afford health coverage. These are people who have to make the hard choice between putting food on the table and buying health insurance.

At the Heart of the Free and Charitable Clinic Movement: Volunteerism

Dr. Jacobs: In your definition, you highlight the use of volunteers. Could you speak about the importance of volunteerism?

Ms. Lamoureux: The one message that I would like to stress is that volunteerism is alive and well in America. Many clinicians tell us that this is how they want to practice medicine, this is how they want to give back their time.

Our clinics are always looking for medical and nonmedical volunteers. With more volunteers, especially medical volunteers, we will be able to expand the care we provide to our patients.

In 2009, the NAFC started our CARE (Communities Are Responding Everyday) clinics, where we have engaged over 15,000 volunteers in large, 1-day clinics across the country. That's a lot of people giving up a day. People want to help -- and they want to help when it comes to healthcare -- because, as we know, if you don't have your health, you can't go to work or take care of your family. Through volunteering at our 1-day clinics or at our member clinics in various communities around the United States, individuals can help uninsured and underserved persons receive much-needed access to care.

Individuals who would like to volunteer at free or charitable clinics or make donations can visit the NAFC Website or call 703-647-7427.

Patient Satisfaction and Quality, Cost-Effective Care

Dr. Jacobs: Over the years, I have worked with safety-net clinics in Georgia to develop clinical approaches to optimize the use of resources. When funds are limited, obviously the focus of the clinics will be on utilizing interventions for which evidence for effectiveness is good.

Realizing that they operate with limited resources, could you comment on the service and care that free and charitable clinics provide -- an important discussion, as these clinics position themselves to play an important role in the era of healthcare reform?

Ms. Lamoureux: Finances are certainly a major challenge for free clinics: 44% of our clinics have operating budgets under $100,000. Patient demand in free and charitable clinics was up 40% in 2011, but donations were down 20%.

Although resources are low and free clinics are always asked to do more with less, we have learned that the one thing that remains constant is that the patients are happy.

Many patients truly look at the free or charitable clinic as their medical home. We hear story after story from patients about how pleased they are with the services that a free clinic provided them. Patients are getting the 1-on-1 care that they need at our clinics.

North Carolina just spearheaded a large outcomes study of their free clinic network. One area that they scored off the charts was patient satisfaction. Patients are saying, "This is where I need to go to get my healthcare." They believe that they are getting the time and the education they need.

Dr. Jacobs: And the quality of care?

Ms. Lamoureux: Virginia and North Carolina all have certification programs for their clinics through their state clinic associations.

Free and charitable clinics are eligible to earn National Committee for Quality Assurance medical home status. All of the clinics in West Virginia are applying for this status, and 1 is already recognized. We also have a clinic in Missouri

that is already recognized. In Connecticut, clinics must be licensed and recognized by the state as facilities to provide care. In North Carolina, all of the clinics are required to participate in an outcomes study that reports their findings to the state.

This past January, the NAFC, along with representatives from the National Association of Community Health Centers and the National Rural Health Association, worked on a report to Congress regarding quality of care and health information technology in our clinics. The Department of Health Policy at the School of Public Health and Health Services at The George Washington University prepared this report. This important report, which was delivered to Congress, discussed the importance and challenges of implementing health information technology and quality standards in safety-net clinics.[3]

Healthcare Reform and Free Clinics

Dr. Jacobs: Was the NAFC involved in the healthcare reform discussions?

Ms. Lamoureux: No. Leaders of the free clinic movement were not invited to join the deliberations. That was not for a lack of trying. Thousands of letters were written to the White House, the House of Representatives, and the Senate.

My feet are tired from walking the halls of Congress, but we'll continue to do that because when we talk about our clinics, it is important to remember that these are our patients. They are not just numbers. We are not talking about 45 million faceless people out there; they are people.

We will continue to knock on the doors. We remain hopeful that both Congress and the President will include us in the future conversations that affect so many Americans whom we see on a daily basis. As of yet, that has not happened.

Dr. Jacobs: If you had been involved in the healthcare reform discussions, what is the most important point that you would have emphasized?

Ms. Lamoureux: Our number-one challenge is to get policy-makers on both sides of the aisle to understand that an FQHC differs from a free or charitable clinic. As I mentioned earlier, FQHCs and free or charitable clinics are all considered safety-net clinics. However, major differences exist.

FQHCs were set up by the government and funded through Section 330 of the Public Health Service Act to serve uninsured persons and those on Medicaid.[4] Free or charitable clinics are different from these centers in that they receive little to no federal or state funding. I believe that the accompanying table from the NAFC Website delineates the differences (Table).

Table. Comparison of Federally Funded Clinics With Free and Charitable Clinics[a]

Critical Issues	Federally Funded Clinics	Free and Charitable Clinics
Regulatory agencies	Defined by Section 330 of the Public Health Service Act[4] as an FQHC or FQHC look-alike; oversight by the HRSA.	Varies by locale
Primary funding mechanisms	Federal government grant and Medicare; state government Medicaid	Private sector (eg, donations and grants)

	reimbursement; insurance payers; public and private gifts/grants; self-pay	
Population served	Insured/uninsured	Uninsured/underserved; usually up to 200% of the federal poverty level
Composition of board of directors	Federal rules require that at least 51% of board members be consumers	Per bylaws developed by each free clinic
Prescription assistance	Medications provided through private drug coverage benefits or at discounted pricing using the federal 340B drug pricing program[5]	Free or may include a processing fee; no 340B access
Primary care	Provided by clinic employees	Primarily and often exclusively provided by volunteers
Dental care	Provided by clinic employees	Primarily and often exclusively provided by volunteers
Vision care	Referrals on the basis of reimbursement	Referral to volunteers
Specialty care	Referrals on the basis of reimbursement	Provided on site by volunteers or through referrals at little or no cost to patients
Inpatient care	Referrals to hospitals; reimbursement or sliding fee scale	Referrals to hospitals; free or sliding fee scale
Fees for service	Third-party payers or sliding fee scales	Free orminimal fees may be charged only if fees are waived when necessary for essential services; patient donations may be accepted
Laboratory/radiology	Referral on the basis of reimbursement	Referrals, usually free
Economic impact	Unknown	Minimum 3:1

FQHC = federally qualified health center; HRSA = Health Resources and Services Administration

[a]Adapted from: Comparison of free and charitable clinics to federally funded clinics. Alexandria, Va: National Association of Free and Charitable Clinics; 2012. http://www.nafcclinics.org/sites/default/files/Comparison%20of%20Free%20clinics%20to%20FQHS%202012.pdf Accessed August 23, 2012.

The healthcare reform bill provided federal community health centers with a great deal of financial support that was unavailable to free and charitable clinics. We have to rely on volunteers and donations to serve our patient populations.

Dr. Jacobs: Let's talk about the future role of free and charitable clinics as part of the healthcare reform solution. A recently published study of the Massachusetts' safety-net clinics concluded that "despite the significant reduction in uninsurance levels in Massachusetts that occurred with healthcare reform, the demand for care at safety-net facilities continues to rise."[6]

What do you think? Will free and charitable clinics across the country still be needed?

Ms. Lamoureux: Unequivocally yes, we will still be needed. And yes, free and charitable clinics will be a very

critical part of the healthcare solution in the future.

An estimated 23 million uninsured people will still need care. We also know that just because everyone will have a health insurance card in their pockets does not mean that they will be able to access care. The capacity of free and charitable clinics will be needed to close the gap in access to care.

We know that other issues need to be addressed. Medication assistance and dental and mental healthcare are areas that still have gaping holes in the present reform initiative, which free and charitable clinics will have to help fill. Julie S. Darnell, PhD, MHSA, Assistant Professor in Health Policy and Administration at the University of Illinois at Chicago, has called our clinics "gap-fillers,"[2] because in communities, free clinics find where their patients need the help and then develop the capacity to close the gap.

Unfortunately, at this point in time in our country, more than enough people need care from the various delivery models. We believe that free and charitable clinics are a very critical part of the solution.

Dr. Jacobs: If free and charitable clinics were to be part of the solution, decision-makers involved in reform will need to find ways to leverage and integrate this clinic model. With that in mind, what changes must free and charitable clinics undergo to respond to the changes that are coming in the future?

Ms. Lamoureux: As I have stated before in this interview, free and charitable clinics are the response of communities to the healthcare challenges in their particular areas; given this, they can be considered the "stethoscopes on the ground," if you will. During the implementation of healthcare reform, however, these clinics will provide critical community response and care.

I think that free clinics are going to be spending time with their boards and their communities to identify areas where service will be needed. We are not new to change. Free clinics have been around since the 1960s, and we have had to change to adapt to the needs in the country.

Free and charitable clinics are incubators for innovative ideas and partnerships to help provide quality healthcare to those who need it the most. In the coming years, some clinics will start to take Medicaid, some will continue to see only uninsured persons, and some will partner with their health departments and FQHCs to provide care.

More important, our clinics serve as advocates -- or navigators -- for many of our patients. Even if a patient is eligible for benefits, frequently they don't know how to access the care and need assistance navigating a confusing system. This advocacy role will most likely be a major function of free and charitable clinics in the future.

Patients who choose not to participate in the healthcare reform options because they cost too much, or those who do not qualify, such as undocumented immigrants, will still be an issue. In addition, the existing patients of these clinics may have insurance cards in the future, but because of limited capacity in a community, they may not be able to get into a healthcare provider's office. The question of access to healthcare is one that our clinics have been addressing for years with respect to the uninsured, and we are preparing to address this same question with respect to patients who may be newly insured.

When I started this job 5 years ago, many executive directors of clinics told me that they would be more than happy to go out of business tomorrow if they knew that their patients would get the healthcare they need. At this time, we understand that affordability, accessibility, and portability of healthcare are issues that remain critical to uninsured persons in this country.

I believe that this is an opportunity for free and charitable clinics to serve the patients who need care the most, in a unique way, using our unique delivery model.

Health Information Technology and Free Clinics

Dr. Jacobs: I noticed on the NAFC Website that one of the legislative priorities (Sidebar 3) is the expansion of health information technology to include free and charitable clinics. Tell us more about this priority.

Ms. Lamoureux: This is a perfect example of where free and charitable clinics, along with so many other safety-net providers, were not taken into consideration when it came to funding health information systems. We are not eligible for any of the incentive payments that were passed in the reform legislation.

If you are on an operating budget of less than $100,000, or even $1 million, it is a major challenge to transform your entire practice to an electronic medical record (EMR) system. This is especially true for nonprofit clinics that use a large number of volunteers as the delivery model. They need to find an EMR system that is affordable, practical, easy to use, and easy to train, and that makes sense administratively and clinically.

Healthcare information technology is one of the areas in which we would like a level playing field for our clinics. At this time, we don't have it. More grants are needed for free and charitable clinics to have the opportunity to purchase EMRs that meet meaningful use guidelines and that will enable information to flow from the clinic to the hospital, and even more important, to enable information to flow from the emergency department to the clinic.

Because our clinics rely on volunteers, staff, donations for medications, laboratory tests, services, and equipment, the NAFC is looking for opportunities to help clinics acquire EMRs. This is why this area is such a major legislative priority for us.

Dr. Jacobs: Is the NAFC working on any other legislative issues that affect free clinics?

Ms. Lamoureux: As your readers know, medical malpractice is a very important issue for everyone. We are excited to say that the Federal Tort Claims Act[7] now covers malpractice for both our staff and our volunteers. That was a legislative victory for the many partnerships across the country that worked together to get this passed.

The continued expansion of the Federal Tort Claims Act to include the free clinic entity and to incorporate charitable clinics remains a priority for us.

Closing Comments

Dr. Jacobs: As we close, I would again like to refer our readers to the NAFC's Website for further information on free and charitable clinics, including an extensive bibliography.

One final question, Nicole. You suggested the title for this interview: "America's Best-Kept Healthcare Secret." What led you to make that recommendation?

Ms. Lamoureux: No matter how many speeches I deliver around the country, no matter how many television interviews I do, I still hear people say, "I didn't know these clinics existed; how do I get involved?"

People are generally not aware of the tremendous value of this major movement. Free and charitable clinics truly are America's best kept healthcare secret, and yet we continue to play a critical role in the healthcare delivery system in this country by building a healthy America, 1 patient at a time.

Dr. Jacobs: Thank you so much for sharing this extensive information on a very important topic that our readers might not find elsewhere.

Sidebar 1. NAFC Definition of a Free or Charitable Clinic

Free and charitable clinics are safety-net healthcare organizations that use a volunteer/staff model to provide a range of medical, dental, pharmacy, vision, or behavioral health services to economically disadvantaged individuals. Such clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization.

Entities that otherwise meet the above definition, but charge a nominal or sliding fee scale to patients, may still be considered free or charitable clinics, provided that essential services are delivered regardless of the patient's ability to pay. Free or charitable clinics restrict eligibility for their services to individuals who are uninsured or underinsured, or have limited or no access to primary, specialty, or prescription healthcare.

Sidebar 2. Telling the Story With Numbers[2]

Free Clinics

- 1200-1300 in the United States
- Percentage of patients from a working household: 83
- Percentage of clinics with operating budgets under $100,000: 44
- Patient demand was up 40% in 2011, but donations were down 20%

Healthcare Coverage in the United States

- Number of uninsured Americans today: 50.7 million
- The Affordable Care Act promises to expand health insurance to 34 million persons by 2019[1]

Sidebar 3. An NAFC Legislative Priority: Health Information Technology

Expansion of health information technology programs will include free and charitable clinics.

Health information technology is a priority of this Congress and the Administration. The NAFC would like to be an active participant in this arena; however, the cost of health information technology is prohibitive for many free and charitable clinics that rely on donations, grants, and volunteers to provide services to uninsured persons.

The NAFC urges Congress to expand the funding and programs for health information technology and their adoption and use by free and charitable clinics. Currently, the incentive programs through the American Recovery and Reinvestment Act of 2009 are not available for free and charitable clinics, given that the majority of these entities do not bill.

The NAFC encourages Congress to introduce legislation that will provide grant programs that will place free and charitable clinics on a level playing field with other safety-net providers by encouraging incentives for adoption, similar to those offered in the American Recovery and Reinvestment Act.

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