IAFCC

ILLINOIS ASSOCIATION OF FREE & CHARITABLE CLINICS

Caring for Patients, Maximizing Resources and Responding to Changes in Health Care

2014 Statewide Survey of Free and Charitable Clinics

Report compiled and written by Leslie Ramyk, MA, Executive Director, and Emma Chung-Ming Tai, Researcher, with editorial and research guidance provided by Julie S. Darnell, PhD, MHSA

Design: Barbara Ciurej

The Illinois Association of Free & Charitable Clinics is grateful for support from:

THE CHICAGO COMMUNITY TRUST AND AFFILIATES

VNA Foundation

BlueCross BlueShield of Illinois

Community Memorial Foundation

BOARD OF DIRECTORS

EXECUTIVE DIRECTOR

EXECUTIVE SUMMARY

The healthcare landscape in Illinois is rapidly changing. The Affordable Care Act (ACA) has increased health insurance access to previously uninsured and underinsured populations through Medicaid expansion and private insurance premium subsidies. Concurrently, providers are under pressure to provide more cost-effective and outcome-oriented care.

The role of free and charitable clinics is unique and essential – a "front line responder" that rapidly identifies gaps in healthcare access as well as emerging health trends. While the ACA provides access to new health insurance options, many of the patients served by free and charitable clinics still need our services. There are several reasons why individuals may not be covered, including:

- **Immigration:** The ACA does not provide coverage for those who are undocumented. Lawfully present immigrants cannot apply for Medicaid during their first five years of residency.
- **Affordability:** There will be individuals whose income requires them to purchase insurance through the exchanges, but who still cannot afford it, even with subsidies.
- **Transition:** People who lose employer-provided health insurance due to job changes may need healthcare services until they are able to successfully navigate to new employer-sponsored coverage, the individual marketplace, or a state-supported policy (Medicaid).
- **Service Gaps:** The ACA does not universally cover dental care, health education, and other specialty services.
- **Provider Availability:** There may be insufficient numbers of Medicaid providers to serve the expanded patient rolls resulting from the extension of Medicaid eligibility.

The mission of the Illinois Association of Free and Charitable Clinics (IAFCC) is to enhance the ability of free and charitable clinics to provide high quality healthcare for low-income individuals who are uninsured and underinsured.

IAFCC conducted a survey of free and charitable clinics in Illinois to better understand how free and charitable clinics across Illinois do the vital work of caring for patients who might otherwise fall through the state's healthcare safety net. In May 2014, a 38-question survey was distributed to 42 free and charitable clinics across the state, encompassing Association members as well as nonmember clinics.

This report summarizes the findings from 23 responding clinics; the findings are divided into the three sections described below. In addition, we make several recommendations based on the survey results to further improve access to quality healthcare for low-income individuals across Illinois.

CARING FOR PATIENTS

KEY FINDING #1: In 2013, 21 free and charitable clinics in 18 counties across Illinois served 67,861 unduplicated patients and provided over 83,000 healthcare visits.

KEY FINDING #2: Free and charitable clinics provide comprehensive primary care and chronic disease treatment to uninsured and underinsured low-income patients including immigrants, homeless, formerly incarcerated, persons with substance abuse disorders and veterans.

MAXIMIZING RESOURCES

KEY FINDING #3: In 2013, free and charitable clinics sustained a vital healthcare safety net with charitable contributions from individuals, foundations and corporations, over 151,824 volunteer hours, and in-kind donations of medications as well as diagnostic and specialty services.

KEY FINDING #4: Free and charitable clinics are sites of continuous learning, clinical training, and medical education for students, residents and practitioners, as 78% of responding clinics provide valuable hands-on training for the healthcare professions.

RESPONDING TO CHANGES IN HEALTHCARE

KEY FINDING #5: During January, February and March 2014 – the first three months of the Affordable Care Act implementation – patients continued to seek out free and charitable clinics for services.

KEY FINDING #6: Free and charitable clinics are nimble and able to quickly adapt to rapid changes in healthcare delivery and local healthcare needs.

KEY FINDING #7: Free and charitable clinics are participating in healthcare innovations, with 83% of clinics utilizing data-driven quality improvement strategies and 52% using Electronic Health Records, though inadequate funding and lack of staff/volunteer time continue to be significant obstacles.

I. Survey Background

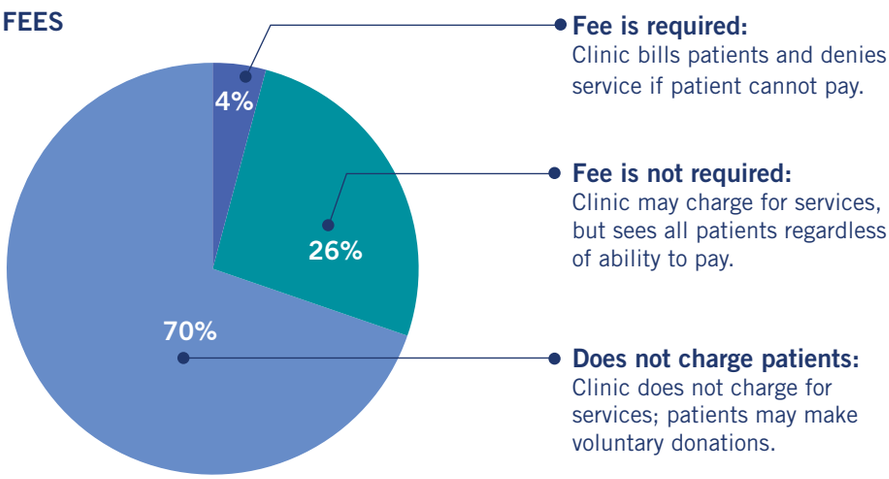
The 38-question survey contained eight sections: contact information, clinic information (location, target populations, patient eligibility, etc.), quality improvement, patient characteristics, services, electronic health records, staff and volunteers, and the Affordable Care Act. It was administered online and took an estimated 40 minutes to complete.

In the process of updating clinic contact information collected in the IAFCC 2011 Survey, staff discovered that 11 of the 53 clinics (20%) experienced significant changes in the past five years. Seven closed due to financial or staffing shortfalls (64%), three merged with Federally Qualified Health Centers (27%), and one was in the process of intentionally transferring patients to a new FQHC nearby (9%). Out of the remaining known and operating 42 clinics, 23 clinics completed the survey for a response rate of 56%.

II. Clinic Characteristics

A majority (70%) of 23 responding clinics identified as free clinics, providing all goods and services at no charge. About a quarter identified as charitable clinics, providing care in exchange for a small fee that can be waived. Only one clinic required a fee, and that was for dental services only. None of the clinics identified as hybrid clinics, rural health clinics, or Federally Qualified Health Clinics (FQHCs), although two organizations that selected "Charitable Clinic" also indicated that they currently bill Medicaid for dental services.

Figure 1. CLINIC FEES



Among the clinics that do charge patients, the most common price per medical visit was $10. Among the three clinics that provide and charge for dental services, the cost was higher, ranging from $20 to $60. Laboratory work fees range from $5 per visit to $20 per test. Only two respondents reported asking for payment for pharmaceutical services; one asks patients for $10 per visit while the other requests a $5 monthly fee.

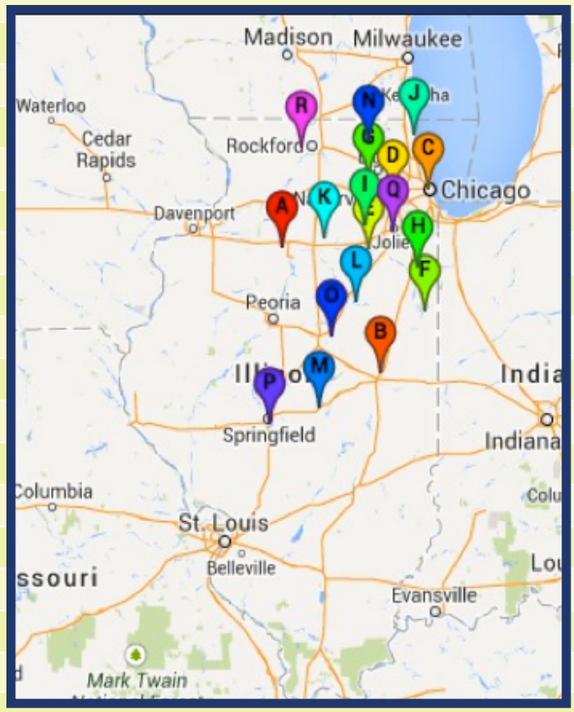
The vast majority of responding clinics (82%) do not bill for third-party reimbursement. No clinics bill private insurance, dental insurance, or Medicare, and two clinics (9%) currently bill Medicaid. Three clinics (13%) are planning to bill for third-party reimbursement but do not currently do so.

"We are considering the possibility that we may need to start seeing those with Medicaid insurance as well, but are not sure how to do that."

While the survey was disseminated statewide, none of the responding clinics were south of Springfield. The 18 counties served by these free and charitable clinics represent 18% of the 102 counties in Illinois – and 77% of the state's population (US Census). The counties are listed and shown in the map below (Figure 2). Clinics serve patients in urban (56%), suburban (33%) and rural (11%) communities

Figure 2. COUNTIES SERVED BY RESPONDING CLINICS

County	Map	# Clinics
Bureau	A	1
Champaign	B	1
Cook	C	7
DuPage	D	2
Grundy	E	1
Iroquois	F	1
Kane	G	1
Kankakee	H	1
Kendall	I	1
Lake	J	2
LaSalle	K	1
Livingston	L	1
Macon	M	1
McHenry	N	1
McLean	O	1
Sangamon	P	1
Will	Q	2
Winnebago	R	1



One of the responding clinics was a mobile clinic; all others were 'bricks and mortar' though they may share a building with a partner church or community organization.

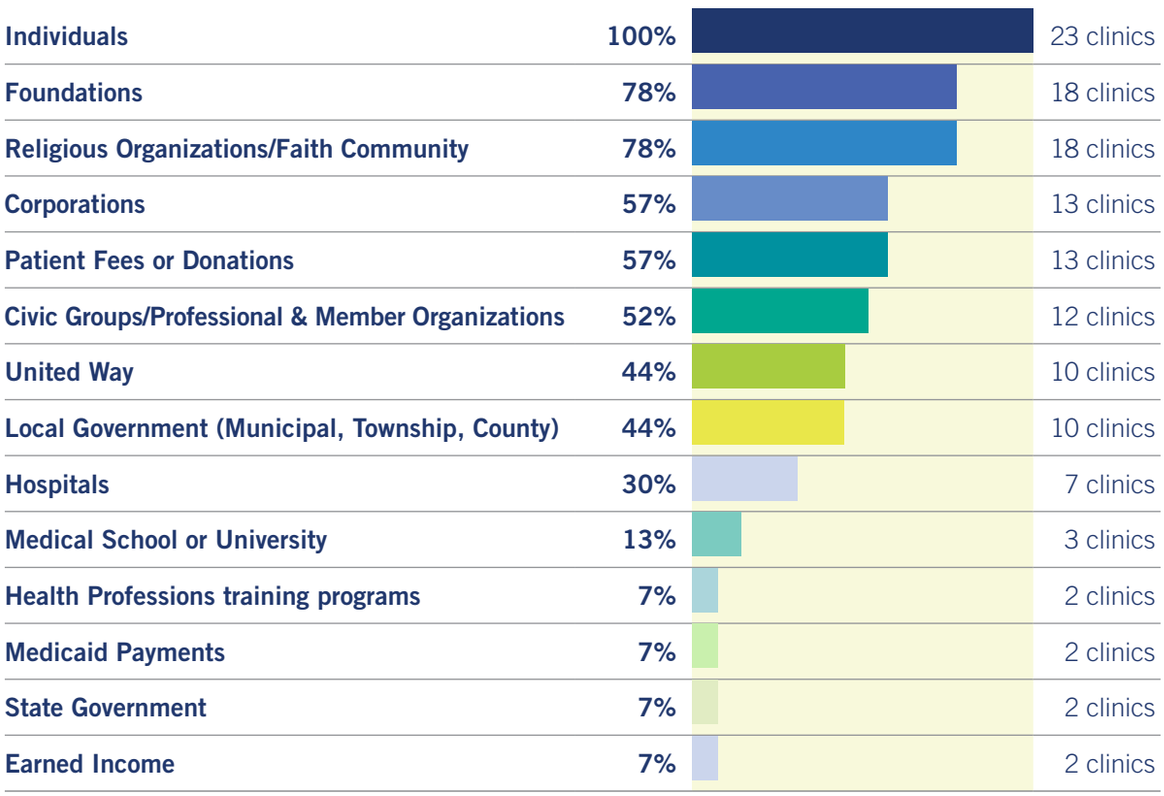
The 23 responding free and charitable clinics work with 2,788 **volunteers** on-site and an additional 213 volunteers off-site (mostly physicians that accept referred patients), for a total of 3,001 volunteers across the state. The majority of these volunteers are healthcare professionals, including 907 volunteer physicians, 723 volunteer medical students and residents, 199 volunteer nurses, and 53 volunteer nurse practitioners/medical assistants.

Sixteen clinics tracked and recorded volunteer hours in 2013. Their combined total amounted to 151,824 hours of care provided by volunteers.

Altogether the clinics employ 153 full-time staff and 46 part-time staff. Given that physicians and other health care professionals are volunteers, a majority of the full-time employees are administrative staff or management. Other full-time and part-time staff includes health educators, medical assistants, pharmacists, laboratory technicians, social workers, and dentists. Free and charitable clinics have cash operating budgets to support staff and operating costs, from a reported high of $3,078,000 to a reported low of $1. The mean cash-operating budget (n=20) for 2013 was $457,906.

As shown in Figure 3, all of the 23 respondents reported receiving contributions from individual donors. The second most common source of support for clinics was from religious organizations and foundations. No clinics reported receiving funds from the federal government or from billing private insurance.

Figure 3. SOURCES OF FINANCIAL SUPPORT



III. Caring for Patients

KEY FINDING #1: In 2013, 21 free and charitable clinics in 18 counties across Illinois served 67,861 unduplicated patients and provided over 83,000 healthcare visits.

Survey responses provided detailed information about the size and characteristics of the patients who receive services from Illinois' free and charitable clinics. Two of the 23 responding clinics were new and opened in 2014; as a result, they did not report any 2013 patient numbers.

As Table 1 shows, clinics provided over 83,000 healthcare visits (including medical, dental, and behavioral health services) to these patients. Forty-eight percent of the clinics reported providing dental services; 52% reported providing behavioral health services.

Table 1. HEALTHCARE VISITS

2013 Patients Visits	Total
Total # Medical Visits (n=19)	**72,807**
Total # Dental Visits (n=11)	**5,260**
Total # Behavioral Health Visits (n=13)	**5,315**

NOTE: *"n" is the total number of clinics that provided this information*

As Table 2 shows, the patients served by free and charitable clinics represent a diverse cross-section of the state. At an average clinic, more than a third of patients are White (38%), 32% are Latino and 20% are African American. Most patients (93%) live on incomes 200% or less of the Federal Poverty Level. Only two clinics provided pediatric services as Medicaid covers virtually all low-income children in Illinois.

Table 2. PATIENT CHARACTERISTICS

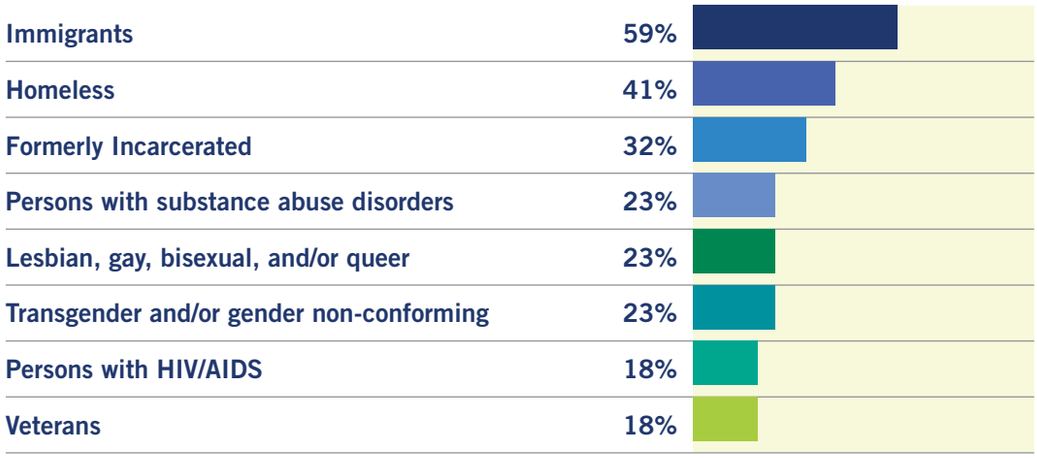
Patient Characteristics	%
Female	**59**
Male	**41**
Age Group	
Children Ages 0-17	**6**
Adults Ages 18-64	**83**
Adults Ages 65+	**11**
Race/Ethnicity	
White	**38**
Latino or Hispanic	**32**
Black or African-American	**20**
Asian	**6**
Multi-Race or Bi-Racial	**2**
American Indian or Alaska Native	**1**
Native Hawaiian or Pacific Islander	**0.1**
Income, % of Federal Poverty Level	
<100	**46**
100-200	**47**
>200	**6**

NOTE: *The data in the table are mean percentages. For example, at an average clinic, the percentage of patients who are reported to be female is 59%.*

KEY FINDING #2: Free and charitable clinics provide comprehensive primary care and chronic disease treatment to uninsured and underinsured low-income patients including immigrants, homeless, formerly incarcerated, persons with substance abuse disorders and veterans.

As shown in Figure 4, responding clinics reported that they regularly seek to serve Illinois' most vulnerable patient populations.

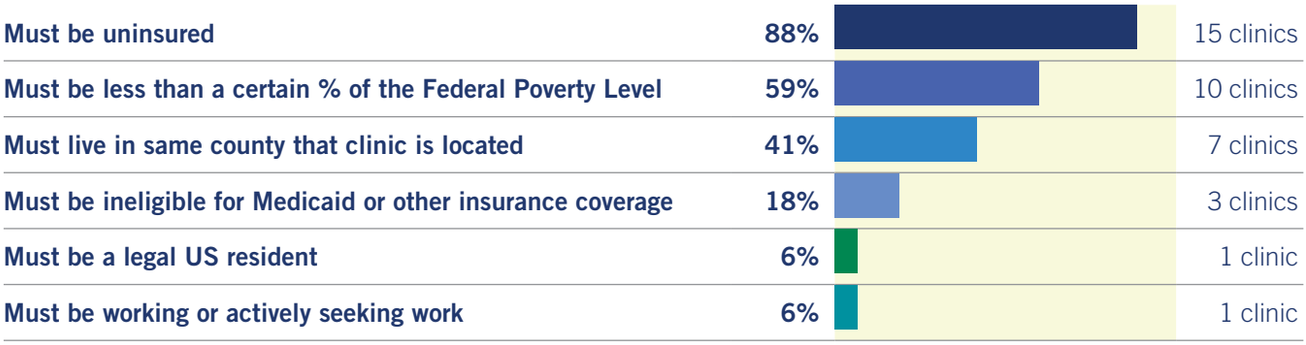
Figure 4. TARGET POPULATIONS SERVED BY RESPONDING CLINICS (n=22)



Most clinics (74%) screen patients for eligibility. As shown in Figure 5, common criteria include patient health insurance status, family income level, and local residency. Of the clinics that do screen, 88% reported that patients must be uninsured to receive care, while nearly 60% of clinics require patients to be below an established percentage of the Federal Poverty Level (FPL). The highest reported FPL threshold was 250% and the lowest reported threshold was 150%.

In addition, some clinics had other patient eligibility requirements, including that the patient must live in the same county as the clinic (7 clinics), must be working or actively seeking work (1 clinic), or that the patient must be a legal resident of the U.S. (1 clinic).

Figure 5. ELIGIBILITY CRITERIA



The two most commonly reported diagnoses were diabetes and hypertension. This correlates to the target populations and proportions of low-income patients served by free and charitable clinics, as the Centers for Disease Control and Prevention has found diabetes and hypertension to be common chronic diseases among populations living in poverty.[1]

[1]Fact Sheet – CDC Health Disparities and Inequalities Report – U.S., 2011 www.cdc.gov/minorityhealth/CHDIR/2011/FactSheet.pdf

Clinics were asked to write in the top five most common diagnoses at their clinics. Table 3 shows both the overall frequency of the most common conditions as well as the median ranking score of these conditions. Diabetes and hypertension were the most common diagnoses across clinics as well as within clinics. In an average clinic, diabetes is seen more frequently than other conditions.

Table 3. FREQUENCY AND RANKING OF COMMON DIAGNOSES

Diagnosis	Frequency (n=20)		Median Ranking Across Clinics
Diabetes	17	85%	1
Hypertension	15	75%	2
Asthma, COPD, Respiratory	11	55%	4
Obesity	11	55%	3
Depression, Anxiety, Mental Health	9	45%	4
Hyperlipidemia	8	40%	3

NOTE: *Asthma and chronic obstructive pulmonary disease (COPD) were grouped together by some clinics. The majority of clinics reported "Depression" as a common diagnosis, while some categorized it as "Depression/Anxiety" or "mental health diagnosis."*

To address these conditions, **clinics provide a range of free or low-cost services.** Patient treatment includes primary medical care, access to prescription medications, health education, and chronic disease management. Clinics also reported a variety of services made available by external providers who accept clinic patients by referral.

As shown in Table 4, patients receive preventative care, chronic disease management, and health education services at free and charitable clinics. Substance abuse treatment and non-dental x-ray are not provided on site but can be made available by referral.

Table 4. PATIENT SERVICES

Service	% On-Site	% Refer Out	% Not Available
Health Education (n=22)	100%	5%	0%
Physical Exam (n=22)	86%	5%	14%
Chronic Disease Management (n=21)	91%	5%	4%
Urgent/Acute Medical Care (n=21)	57%	24%	27%
Case Management (n=21)	57%	10%	38%
Laboratory (n=21)	52%	48%	10%
Gynecological (n=21)	48%	38%	24%
Complementary Therapies (n=19)	47%	32%	32%
Vision Screening (n=22)	36%	46%	38%
Dental Care (n=22)	38%	46%	36%
Sexually Transmitted Infection Treatment (n=21)	33%	67%	10%
Mental Health Treatment (n=21)	33%	62%	27%
Immunization (n=21)	33%	33%	38%
Specialty Services (n=20)	35%	55%	35%
HIV Testing (n=21)	27%	67%	10%
TB Testing (n=21)	27%	57%	19%
Family Planning (n=21)	27%	43%	33%
Eyeglasses (n=22)	23%	55%	41%
Prenatal/Obstetrical Care (n=20)	5%	50%	50%
X-Ray (non-dental) (n=22)	0%	59%	46%
Substance Abuse Treatment (n=20)	0%	80%	25%

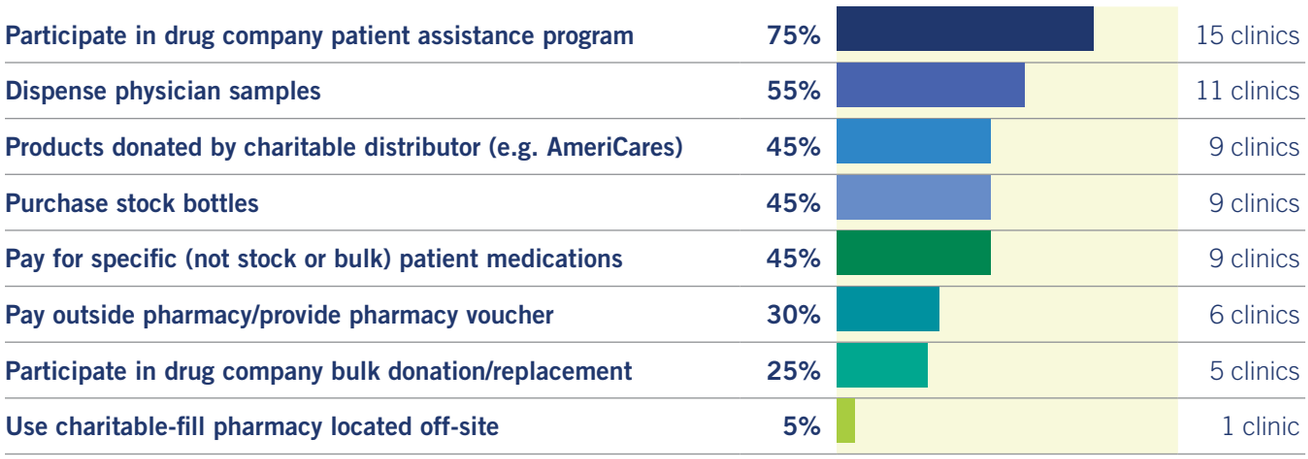
NOTE: *Clinics could select both "On-Site" and "Refer Out" for the same service, where applicable (e.g. offering STI testing and referring out for treatment).*

Fourteen respondents wrote in additional healthcare services that they provide on-site or refer out, including: acupuncture, blood draw, dermatology, muscular skeletal, podiatry, physical therapy, diagnostic services, school physicals, social work, and neurology.

Clinics also support patient primary care and chronic disease management **by providing free or low-cost prescription drugs.** In 2013, 12 clinics filled a total of 142,609 prescriptions through on-site licensed pharmacies or dispensaries.

Clinics use a variety of strategies to increase patient access to prescription medications. For example, three clinics are licensed/certificate/permitted pharmacies (13%) and 11 are dispensaries (48%), while 39% (9) do not have a pharmacy or dispensary on site. Only 3 out of 23 respondents do not provide some sort of medication support. The majority of clinics participate in patient assistance programs offered by drug companies, as shown in Figure 6.

Figure 6. CLINIC STRATEGIES TO ARRANGE MEDICATION FOR PATIENTS (n=20)



IV. Maximizing Resources

Key Finding #3: In 2013, free and charitable clinics sustained a vital healthcare safety net with charitable contributions from individuals, foundations and corporations, over 151,824 volunteer hours, and in-kind donations of medications as well as diagnostic and specialty services.

Individual donations, foundation grants and United Way funding are three largest sources of support for free and charitable clinics. The relative frequency of responses is given in Table 5, on the next page. These findings underscore the importance of individual contributions, showing that not only do all clinics receive funding from individual donors, but that individual donations comprise a significant source of funding for the majority of clinics.

Table 5. LARGEST SOURCES OF SUPPORT

Source	% Total Frequency
Individuals/Events	95%
Foundations/Grants	72%
United Way	27%
Religious Organization/Faith Community	23%
Corporations	18%
Patient Fee/Earned Income	18%
Local Governments	14%
Hospitals	14%
Civic Groups	14%

NOTE: *The Total Frequency indicates the number of times each source was identified as one of the top three sources of support for clinics.*

Key Finding #4: Free and charitable clinics are sites of continuous learning, clinical training and medical education for students, residents and practitioners, as 78% of responding clinics provide valuable hands-on training for the healthcare professions.

The survey revealed that clinics rely heavily on individual giving – both in terms of financial donations and volunteer hours. By utilizing student interns, volunteers and residents in the healthcare professions, free and charitable clinics create a win-win situation: students, volunteers and residents receive training and supervision while patients receive care at little or no cost to the clinic.

More than three-quarters (78%) of clinics provide clinical training or supervision. As shown in Table 6, nursing students receive training or supervision at 61% of those clinics. Half of the clinics that provide clinical training or supervision educate medical students or residents.

Table 6. CLINICAL TRAINING OR SUPERVISION (n=18)

Clinical Training or Supervision Provided	%
Nursing students	61%
Medical students or residents	50%
Other	50%
Social work students	22%
Dental students	17%
Psychology students	6%

"Other" included pharmacists, nurse practitioners, and Master's of Arts in Management students.

V. Responding to Changes in Healthcare

One of the high-priority research questions for the IAFCC was how the rapidly changing healthcare landscape, most notably the implementation of the Affordable Care Act, would impact the future of free and charitable clinics. The expansion of Medicaid eligibility, the individual mandate to purchase coverage, and the increased emphasis on clinical outcomes and quality improvement present significant opportunities as well as potential challenges to the free and charitable clinic sector.

This section takes a closer look at the impact of ACA on clinics and patients; clinic openings, closings, mergers, and expansions; and the adoption of innovations in healthcare such as Electronic Health Records and Quality Improvement systems.

Key Finding #5: During January, February and March 2014 – the first three months of the Affordable Care Act implementation – patients continued to seek out free and charitable clinics for services.

Nine clinics provided information about the number of unduplicated patients served during the first three months of 2014. The data indicates that the number of patients visiting clinics after ACA implementation remained level with the number of patients visiting clinics before ACA implementation.

> *"While we understand some decrease in patient population may change over time due to the Medicaid expansion in Illinois, we currently are not seeing much of a decrease in our population. During the first quarter of this year, our clinic saw more new patients in 2014 than the same time period in 2013."*

When asked about the impact of the Affordable Care Act on their clinic, the most common response (11/22) was that they had facilitated patient enrollment in Medicaid or private insurance. The second most common (9/22) response was that the clinic had not felt any impact from ACA.

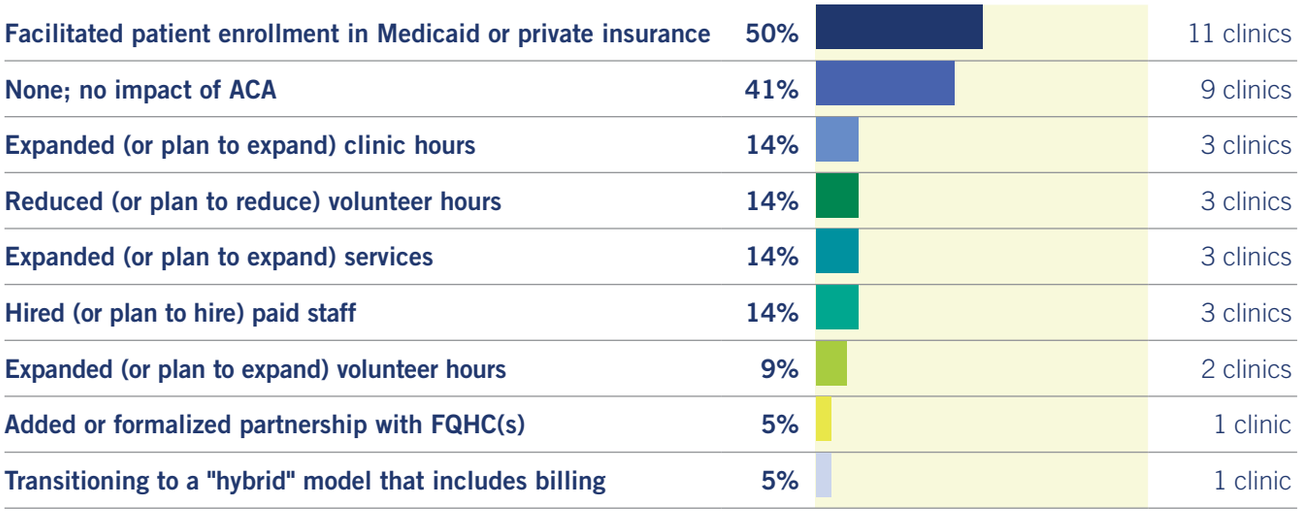
> *"For many of the homeless we serve, life will not change much for them with the ACA: clinics and hospitals still do not let them in the door, and the clients do not know how to navigate the system."*

> *"The need for free clinics will remain huge – both to meet the needs of those who do not benefit from ACA coverage as well as for those who are newly insured but still need access to services (e.g. adult dental) that are not mandated per ACA."*

> *"The majority of the clients we serve do not qualify to register for the ACA."*

Figure 7 displays the range of survey responses. No respondents reported making cuts (or planning for cuts) to clinic hours, paid staff, services, or clinic sites. However, as discussed in Section 1, 10 of the free clinics in Illinois that have transitioned to FQHCs, merged and/or closed in the past two years did not respond to the survey.

Figure 7. IMPACT OF THE AFFORDABLE CARE ACT (n=22)



No clinics indicated that they:

- **Reduced (or plan to reduce) clinic hours**
- **Reduced (or plan to reduce) services**
- **Transitioned (or planning to transition to) FQHC**
- **Opened (or planning to open) new sites**
- **Closed (or planning to close) one or more sites**
- **Cut (or plan to cut) paid staff**

As shown in Table 7, when asked about the impact of ACA on the availability of referral providers, the majority of respondents reported that the amount of services available through referrals to external providers had either remained the same or was still unclear at this time. This was true across the board for a range of external providers.

Table 7. THE IMPACT OF ACA ON THE AMOUNT OF SERVICES AVAILABLE THROUGH REFERRALS TO EXTERNAL PROVIDERS

External Provider	% of Clinics			
	Expanded	About the same	Reduced	Not clear at this time
Hospitals (n=20)	10%	30%	10%	50%
Labs & Other diagnostics (e.g., x-ray, MRI) (n=20)	5%	40%	5%	50%
Specialty care providers (e.g., surgeons, ophthalmologists) (n=20)	5%	25%	15%	55%
Dentists (n=20)	5%	35%	5%	55%
Pharmacies (n=19)	11%	31%		58%
Counseling centers (mental/behavioral health) (n=19)	5%	26%	11%	58%
FQHC's (n=17)	18%	23%		59%

"Medical professionals are assuming everyone now has insurance but many cannot afford it. We still need specialists to take some pro bono cases!"

Respondents had the opportunity to answer the question **"What do you want Free Clinic stakeholders to know about how the Affordable Care Act has impacted your clinic?"** Fifteen clinics responded, and 14 of those responses (93.3%) expressed some form of concern with ACA implementation, including gaps in coverage, costly private insurance with high deductibles, limited availability of physicians willing to see patients with Medicaid, and lengthy delays in Medicaid application processing. Additional responses are included in Appendix A.

GAPS IN COVERAGE

"The doughnut hole still exists and hasn't changed. The only positive thus far is that in a major medical event, the patient may be able to obtain Medicaid after the fact. However, this in no way helps patients get their chronic COPD meds at a reasonable cost to keep them out of the hospital."

"To date only 246 patients have been moved to Medicaid or private carrier insurance. The balance simply does not qualify for Medicaid or cannot afford private carrier insurance. In most cases the deductible in private carrier insurance is too high to manage."

"Patients who became unemployed in the past year or so have shared that they are not eligible for anything but insurance with a high deductible because of the tax return in the prior year shows too much money to qualify."

"The Bronze level policies are nothing more than catastrophic insurance plans and do not help patients who may need primary, ongoing, outpatient services."

"Some of the cheaper plans are not accepted by hospitals in our area."

ACA CONFUSION AND MEDICAID DELAYS

"Our patients were very confused about the ACA. Many did nothing because they did not understand what the ACA was all about."

"Some have applied for expanded Medicaid this spring but the processing time on these applications are several months."

"Many people are caught in limbo, particularly with medications. Many cannot get PAP medicine until they produce a Medicaid denial letter, but Medicaid is 90 days behind. These patients have to go without meds, or our clinic is picking them up."

LACK OF PROVIDERS FOR MEDICAID EXPANSION POPULATION

"Even though we have successfully implemented the ACA through the marketplace or Medicaid, there is still a lack of providers to care for the low income medically uninsured of Lake County."

"Patients who qualified for the expanded Medicaid program still do not have access to local physicians. Primary physicians in our rural area are not taking new patients regardless of insurance. We are serving our patients and are accepting new patients who may have a Medicaid card."

"For anyone over the Medicaid limit but under a fair living wage, the ACA has created a new set of difficulties. Many of the lower cost plans have high deductibles that bar patients from seeking healthcare. While our policy has always been to see only patients who were uninsured, we are considering how to best serve the population of those who have some medical insurance but not enough to be useful."

Key Finding #6: Free and charitable clinics are nimble and able to adapt to rapid changes in healthcare delivery.

The survey revealed the adaptable nature of the free and charitable clinic sector. As Table 8 shows, many clinics are in the process of adding services to respond to the changing healthcare landscape. Although the majority of respondents did not plan to add services, these results nonetheless demonstrate the flexibility of free and charitable clinics.

Table 8. SERVICES ADDED OR PLANNED TO ADD BETWEEN JANUARY 2013-DECEMBER 2014

Service Area	Added/Planning to Add
Medical/Nursing	6
Dental	4
Vision	2
Pharmacy	2
Mental/Behavioral Health	4
ACA enrollment	1
Dermatology Clinic	1
Acute Care	1
Cardiology Clinic	1
Gynecology	1
Shared Medical Appointments - Diabetic Classes	1

In addition, two new clinics opened in the first five months of 2014: Kendall Free Clinic in Yorkville and Tzedakah Christian Health Center in Decatur. In both cases, clinic founders responded to local unmet healthcare needs by taking on the task of creating, staffing and fundraising new clinics into existence.

Over the past five years, at least four clinics expanded capacity by transitioning to or merging with FQHCs. At the same time, seven clinics closed due to a founder retiring, difficulty raising funds and/or staffing shortages.

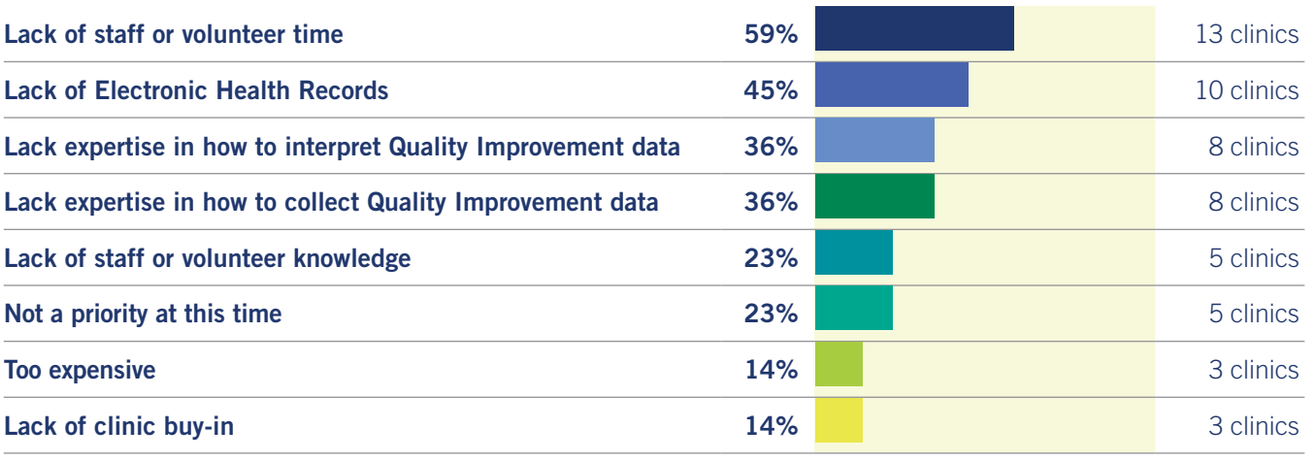
The ongoing opening, closing, merging, and service expansion among free and charitable clinics point to the dynamism of free clinics as well as their vulnerability. While small groups of committed individuals can and do create and sustain clinics, the often-skeletal structures remain precariously exposed to the vicissitudes of funding streams and volunteer availability.

Key Finding #7: Free and charitable clinics are participating in healthcare innovations, with 83% of clinics utilizing data-driven quality improvement strategies and 52% using Electronic Health Records, though inadequate funding and lack of staff/volunteer time continue to be significant obstacles.

Changes to the healthcare system have been accompanied and supported by rapid technological innovations, most notably the system-wide adoption of Electronic Health Records (EHR) and a move towards data-driven quality improvement. To what extent are free and charitable clinics participating in these innovations?

The majority of free and charitable clinics have adopted the use of quality improvement (QI) strategies to measure outcomes and develop goals for improvement. Eighty-three percent of clinics (19/23) reported implementing QI activities, with 76% (16/23) of respondents collecting clinical outcomes data and 71% (15/23) collecting surveys of patient satisfaction and experiences with care (Figure 9). However, clinics do report challenges in the full implementation of QI strategies, primarily having to do with a lack of staff or volunteer time and expertise, as shown in Figure 8.

Figure 8. MAIN CHALLENGES IN IMPLEMENTING QUALITY IMPROVEMENT STRATEGIES (N=22)



Notably, the second most common challenge to implementing QI is the lack of Electronic Health Records, which is not surprising given that 48% (11/23) of respondents do not have an EHR system installed and in use at their clinic (Figure 10). Of those 11, two clinics planned to acquire a system within one year and two reported that it would take more than one year to acquire an EHR system.

Figure 9. QUALITY IMPROVEMENT ACTIVITIES IMPLEMENTED

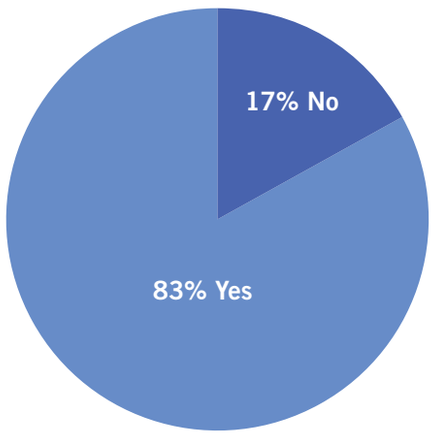
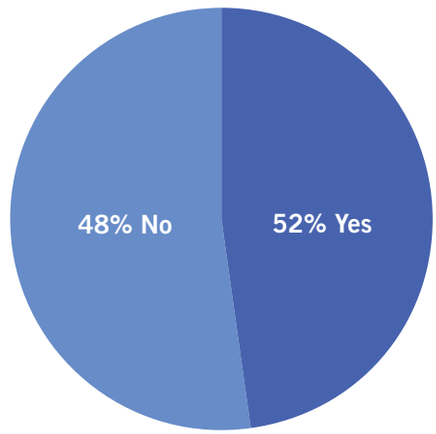


Figure 10. ELECTRONIC HEALTH RECORD UTILIZATION



VI. Conclusions & Next Steps

This report was intended to provide IAFCC and the many stakeholders of the free and charitable clinic network with a real-time snapshot of how free and charitable clinics across Illinois do the vital work of caring for patients, contributing to the healthcare safety net, and responding to the rapidly changing healthcare environment.

Free and charitable clinics have historically served the people who "fall between the cracks." They therefore have unique insights to offer about where these cracks are, how big they are, what caused them, and who is slipping through them. Our initial research suggests that free and charitable clinics will continue to do so even as implementation of Affordable Care Act moves forward. These insights are crucial to informing future policy-making to address the gaps in coverage and care.

It is our hope that these findings inform the ongoing work of all stakeholders—practitioners, funders, corporate donors, patients, advocates, researchers, elected representatives—to ensure that low-income, uninsured, and underinsured patients have access to high-quality healthcare. We suggest the following actions:

Caring for Patients

Free and charitable clinics can (and do) care for patients on Medicaid as well as newly insured patients who cannot afford their deductibles or premiums. In order to provide these services and keep their doors open, free and charitable clinics should be able to charge nominal patient fees to support clinic infrastructure without invalidating necessary protections for volunteering doctors.

Allow free and charitable clinics to charge nominal fees without jeopardizing Good Samaritan Act protections.

Maximizing Resources

Free and charitable clinics provide an exponential return on investment because they leverage pro bono medical services, donated pharmaceuticals and supplies, and in-kind supports.

The continued support of all funders, including individual, foundation and corporate donors, will be crucial to ensuring that all clinics have the resources they need to continue to provide much-needed services.

Responding to Changes in Healthcare

The focus of free and charitable clinics has always been on providing healthcare to those most in need. But today's healthcare system also requires the purchase and use of technology, the collection of data, and the implementation of quality improvement strategies. Many clinics have successfully adopted these measures – but others simply do not have the funds or staff time to do so.

Increase the capacity of free and charitable clinics across the state by providing funding and other opportunities for the purchase and implementation of electronic health records, peer-to-peer cross-clinic learning, and the development and execution of quality improvement strategies.

APPENDIX

"What do you want Free Clinic stakeholders to know about how the Affordable Care Act has impacted your clinic?"

1. It hasn't – the doughnut hole still exists and hasn't changed. The only positive thus far is that in a major medical event, the patient will maybe be able to obtain Medicaid after the fact / retroactively. However, this in no way helps patients get their chronic COPD meds at a reasonable cost to keep them out of the hospital. Also, the folks who need the most help are financially and medically illiterate.... until that issue is solved, these folks aren't going to know that they are even eligible for benefits.
2. [We] had a volunteer Navigator on site weekly to help our patients toward the best healthcare available for them. To date only 246 patients have been moved to Medicaid or private carrier insurance. The balance simply does not qualify for Medicaid or cannot afford private carrier insurance. In most cases the deductible in private carrier insurance is to high to manage.
3. We are still unsure yet of how everything is going to unfold. What we do know, though, is that we desperately need some help / technical assistance with regard to establishing partnerships with FQHCs that should be helping the clients whom we serve. We also know that, for many of the homeless we serve, life will not change much for them with the ACA: clinics and hospitals still do not let them in the door, and the clients do not know how to navigate the system.
4. We have not been open long enough to know the impact of the ACA, since the ACA was in effect when we opened. I will say that we are seeing the communities un-insured numbers declining, but most that I have spoken to are not able to get into a physician, as most physicians in our community are not accepting new patients with Medicaid insurance. We are considering the possibility that we may need to start seeing those with Medicaid insurance as well, but are not sure how to do that.
5. While we understand some decrease in patient population may change over time due to the Medicaid expansion, we currently are not seeing much of a decrease in our population. Since January 1, 2014, our clinic has discharged 34 patients who obtained Medicaid and 2 patients purchased insurance through the healthcare exchanges. During the first quarter of this year, our clinic saw more new patients in 2014 than the same time period in 2013. In our county, it is expected that over 5,000 individuals will remain uninsured in 2016.
6. Our clinic just opened 4/23/2014. If we are slow to grow our practice, we will consider a hybrid clinic to serve a large and growing Medicaid population in our area. I assume the Medicaid expansion has impacted our area more than the ACA Marketplace.
7. An independent study indicates that there will still be over 500,000 uninsured Cook County residents in 2018. (Less than 40% of these residents are undocumented.) The need for free clinics will remain huge -- both to meet the needs of those who do not benefit from ACA coverage as well as for those who are newly insured but still need access to services (e.g. adult dental) that are not mandated per ACA. Additional challenges are presented for those whose insurance status changes ("the churn") as there will be gaps in coverage. Other concerns exist for those who are unable to afford co-pays/deductibles through the plans they enroll in through the marketplace (the "underinsured"). And many who are deemed eligible for the marketplace still cannot afford the options - even with tax subsidies and credits. The wait time for enrollment per Medicaid expansion is lengthy -- and yet services/"charity care" is being denied those whose insurance status is pending. The same challenges are beginning to play out with eligibility for Rx patient assistance programs. Free clinics are uniquely positioned to meet the challenges confronting this very vulnerable population.
8. Even though we have successfully implemented the ACA through the marketplace or Medicaid, there is still a lack of providers to care for the low income medically uninsured of Lake County. Affordable behavioral health and dental care still represent a significant need within Lake County so those deficits need to be addressed to provide a better overall medical environment. Free healthcare clinics are the premier safety net providers and backbone within the State of Illinois and their ability to provide quality healthcare at an affordable level with a volunteer centric model should be wholly supported by funders, elected officials, and residents.
9. As we see it, the ACA has changed the medical landscape for the poor. The Medicaid expansion in IL has allowed the poorest adults access to clinic care, pharmacy and hospitals. For anyone over the Medicaid limit but under a fair living wage, the ACA has created a new set of difficulties. Many of the lower cost plans have high deductibles that bar patients from seeking healthcare. While the policy at [our clinic] has always been to see only patients

"What do you want Free Clinic stakeholders to know about how the Affordable Care Act has impacted your clinic?"

who were uninsured, we are considering how to best serve the population of those who have some medical insurance but not enough to be useful. Meanwhile, paying for healthcare plans that do not provide healthcare is just plain silly. We also see that dental and eye care is not covered in IL. Needless to say, this is not a great idea. We have a free dental clinic but access is limited – there are only so many dental hours we have available! In the Medical Dept, we feel the need to evaluate and re-evaluate. What do our patients need? What are they asking for? What kind of insurance do they have? Do they have reasonable access to quality healthcare? Are they seeing multiple doctors - some covered by insurance plans and some at our offices (creating a dangerous situation for all)? What we are trying to do is LISTEN to our patients, our case management staff and our physicians. We hope that by listening to the needs of everyone, we will be able to establish some order into the current chaos and serve our patients.

10. Medical professionals are assuming everyone now has insurance but many cannot afford it. We still need specialists to take some pro bono cases!

11. Free and charitable clinics are still needed. It's also important to make our stakeholders aware of the funding issues that go along with the change in landscape – ie, funders re-deploying dollars for Medicaid enrollment, or not understanding the existing need for FCCs. Convey to our policy stakeholders that there are some real 'trench' issues that are occurring because of the ACA. Many people are caught in limbo, particularly with medications. Many cannot get PAP medicine until they produce a Medicaid denial letter, but Medicaid is 90 days behind. These patients have to go without meds, or our clinic is picking them up. An additional issue is that some of the cheaper plans are not accepted by hospitals in our area. Some real tweaking is needed to make the ACA fulfill its potential.

12. Patients who qualified for the expanded Medicaid program still do not have access to local physicians. Primary physicians in our rural area are not taking new patients regardless of insurance. We are serving our patients and are accepting new patients who may have a Medicaid card with physician visits, nursing services, lab services. These patients must take their written prescriptions to a local pharmacy. We no longer can get PAP meds for patients with a Medicaid card. These patients are asked for a $10 donation. Patients who may have purchased Bronze level policies are seen here at the clinic for physician, nursing, and lab services as well as PAP and in-house dispensary medications. These are the patients who are at the 150% to 250% of poverty level. These patients are asked for a $15 to $20 dollar donation based on their income. We still have a percentage of patients who remain uninsured. We feel this clinic is minimizing hospital ER visits by patients on the expanded Medicaid program. Patients with a Medicaid card are the patients who will use the ER for primary concerns if services are not available through this clinic or through private practitioners. We also feel the Bronze level policies are nothing more than catastrophic insurance plans and do not help patients who may need primary, ongoing, outpatient services. These are the policies with $4,000-$6,000 deductibles. Lastly, our patients were very confused about the ACA. Many did nothing because they did not understand what the ACA was all about. Some have applied for expanded Medicaid this Spring but the processing time on these applications are several months. The ACA "counselors" that were hired to assist patients were definitely NOT trained well to assist applicants. We had two ACA seminars last Fall for our patients. These were presented by a ACA counselor who was definitely not trained on his purpose. This counselor made it sound as though our patients would have access to primary care either through Medicaid or Marketplace and that the access to healthcare would be seamless!

13. The majority of the clients we serve do not qualify to register for the ACA. Point of Care service is our concern.

14. In February we began asking every patient his or her status in ACA enrollment. Of the 112 who responded, 38 indicated they had applied for Medicaid of which 7 have received notification of accepted Medicaid insurance coverage. 31 have not heard back; many applied in the fall of 2013. Eighteen began to apply for subsidy insurance but indicate it was too expensive (deductibles they could not afford or no prescription coverage). 3 have gotten the insurance w/high deductible. Patients who became unemployed in the past year or so have shared that they are not eligible for anything but insurance with a high deductible because the tax return in the prior year shows too much money to qualify.

Illinois Association of Free & Charitable Clinics

318 Walnut Street

St. Charles, IL 60174

312-863-1780

www.illinoisfreeclinics.org