Abstract

The purpose of this DNP project is to describe the development of a free health clinic in the western North Carolina community. The process will include the use of a community needs assessment to influence the formation of an inter-professional leadership team for the purposes of providing chronic and primary care to the underserved and uninsured of the community. This will include a clinic start-up checklist, budget overview, a cost analysis, and organizational strategies for this program for persons interested in developing a free health clinic.

This paper will describe process for clinic startup, resource referrals, community partnerships, clinic relationship with a local academic medical center, and lessons learned during the process of development. Outcomes for this project will include demographics and number of patients seen, volunteer recruitment and retention, and a cost analysis after the first six months of operation.

Keywords used: medically uninsured, ambulatory care facilities, medically uninsured, patient centered care, medically uninsured, uncompensated care

Development of a Free Health Care Clinic

in western North Carolina

Rachel P. Zimmer

East Carolina University

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Introduction

Overview of the Problem

The nonpartisan Congressional Budget Office estimated that 31 million people would remain uninsured and underserved despite the recent landmark passage of the Affordable Care Act in 2010 (National Association of Free Clinics (NAFC), 2014; Smith, Yoon, Johnson, Natarajan, & Beck, 2014). After the Affordable Care Act (ACA) was passed, there were a total 24 states that refused to expand Medicaid, and the passage of the ACA has been estimated to only benefit about 11 million of the 47 million uninsured people by the year 2022 (NAFC, 2014). The ACA was not developed for the purpose of universal health coverage, and it has still left substantial gaps in insurance coverage for millions of people in America. These gaps included lack of coverage for undocumented immigrants, people who could not afford coverage, people who were eligible for coverage but resided in states that did not expand Medicaid, and lack of specialty care access for the uninsured (Coughlin, Long, Sheen, & Tolbert, 2012; Emerson, Hull, Cain, Novotny, Larson, & Levine, 2012; NAFC, 2014). In North Carolina, 1,008,000 people were estimated to be uninsured in 2013, with over 1/3 of the uninsured being undocumented immigrants (McCarthy, 2013; NAFC, 2014). This has left the undocumented population with few options for primary care, with free clinics filling the gap.

Free clinics have been defined as medical clinics that provide health care services to people regardless of their ability to pay for services (NAFC, 2014). These safety net clinics have provided care for the many uninsured in America over the last 70 years. The clinics historically have cared for mostly female, low-income, uninsured people under the age of 65, and of the people who use free clinics, 83% of them have come from working households (Darnell, 2010; Hall, 2013; Lynch & Davis, 2012; Madden et al., 2011; NAFC, 2014; Notaro et al., 2012).

Studies have shown that people who utilize free clinics for health care had lower rates of emergency room utilization, better rates of chronic disease management, and better overall health outcomes (Hall, 2013; NAFC, 2014).

Purpose of the Project

The purpose of this DNP project was to assess the healthcare needs of an underserved community and form a free health care clinic, called Grace Clinic to serve those needs. This was done by forming an interprofessional leadership team to strategically plan the mission and development of a free clinic to provide comprehensive health care to the underserved and uninsured of the community. The Theory of Caring was used as a framework to guide the team during the development process and as a basis for care (Watson, 2005).

This paper will describe process for clinic startup, resource referrals, community partnerships, clinic relationship with a local academic medical center, and lessons learned during the process of development. Outcomes for this project will include demographics and number of patients seen, volunteer recruitment and retention, and a cost analysis after the first six months of operation.

Structured Review of the Literature

Methods

A comprehensive review of the literature for free medical clinics, and care for the uninsured and underserved was conducted. The databases utilized during the search included the PsychINFO and PubMed of the National Library of Medicine.

For PubMed, the following Medical Subject Headings (MeSH) terms were used: “medically uninsured” and “ambulatory care facilities”; “medically uninsured” and “patient centered care”; “medically uninsured” and “uncompensated care”. Medically uninsured is

defined in the PubMed MeSH term as "Individuals or groups with no or inadequate health insurance coverage. Those falling into this category usually comprise three primary groups: the medically indigent; those whose clinical condition makes them medically uninsurable; and the working uninsured." (MeSH Browser, 2015). Patient centered care is defined in the PubMed MeSH term as "Design of patient care wherein institutional resources and personnel are organized around patients rather than around specialized departments." (MeSH Browser, 2015). Ambulatory care facilities is defined in the PubMed MeSH term as:
"Those facilities that administer health services to individuals who do not require hospitalization or institutionalization." (MeSH Browser, 2015). Uncompensated care is defined in the PubMed MeSH term as: "Medical services for which no payment is received. Uncompensated care includes charity care and bad debts." (MeSH Browser, 2015).

Using the terms "medically uninsured" and "patient centered care" yielded 33 articles for the PubMed search. Using the terms "medically uninsured" and "uncompensated care" yielded 367 articles for the PubMed search. Using the terms "medically uninsured" and "ambulatory care clinics" yielded 300 articles for the PubMed search. Inclusion criteria included: articles published in the last 5 years (2010-2015), English language, human subjects, and full text available resulted in 134 articles. Only those articles pertaining to the United States (US) health system were included due to the unique payment and regulatory policies (as well as incentives and penalties) of healthcare in the US. Each article was reviewed for relevancy in terms of topic and content, and included in the review if from a peer reviewed journal and provided information specific to free or charitable clinics. This resulted in a final count of approximately 75 articles for review.

Uninsured and Poor Access to Care

The review of literature shows that over the last two years in America, free and charitable clinics have increased in number by 40% due to patient demand and need. However, contributions to free clinics have conversely decreased by 20% during this time period (NAFC, 2014). Uncompensated care for the uninsured is rising with costs of $24.9 billion in 2003 and $56 billion in 2008, and costs are projected to continue to rise to about $80 billion by 2016 (Mas, 2013; Smith, et al., 2014). As costs are rising, access to primary care is declining. The Academy of Medical College estimated that the primary care provider shortage would reach 63,000 by 2015, and 130,000 by 2025 (NAFC, 2014). According to Smith, et al. (2014), fewer than 18% of medical students are planning to practice primary care after finishing their training. Even patients who are insured with Medicaid had trouble obtaining primary care access. In 2011, a survey of physicians found that 31% of physicians refused to treat patients with Medicaid because of the low compensation associated with their care (Smith et al., 2014). Few physicians who were surveyed viewed it their professional responsibility to provide care for the underserved, and some physicians stated that they hesitated to treat the uninsured due to worries of liability (Emerson, et al., 2012). These providers also felt that they were unable to provide adequate care when patients have lack of resources to pay for care needed (Emerson, et al., 2012). In fact, most ambulatory care centers have historically been reluctant to treat the uninsured or to be actively involved in helping the uninsured obtain health insurance (DeVoe, 2013).

Effects of Lack of Insurance on Health Outcomes

The lack of access to care due to cost prevents the uninsured from receiving preventative care services, and has been associated with higher rates of death and illness. Lack of insurance is also strongly associated with disproportionate rates of chronic disease, specifically, diabetes,

hypertension, obesity, and asthma (DeVoe, 2013; Emerson, et al., 2013; Iddins, et al., 2015; Hwang, Liao, Griffin, and Foley; 2012; Lynch & Davis, 2012; Madden, et al., 2011). Many studies have shown that the uninsured were less likely to receive preventative care, consistent care, or well-coordinated care, and more likely to receive delayed care for acute and chronic health problems due to lack of access and high out of pocket expenses (DeVoe, 2013; Emerson, et al., 2012; Hall, 2013; Lynch & Davis, 2012; NAFC, 2014; Shepherd, Locke, Zhang, & Maihafer, 2014). Lacking health insurance is also found in studies to be an independent risk factor for poorer outcomes in disease states such as diabetes (Hall, 2013; Madden et al., 2011). Therefore, people who do not have health insurance were more likely to miss school or work due to preventable illness, which in turn, led to a decrease in work productivity and education (Denham, Hay, Steiner, & Newton, 2013). Premature death due to preventable causes had been documented to be 25% higher in the uninsured population compared to the insured (Devoe, 2013). In many cases, the uninsured could only obtain healthcare by utilizing the emergency department, avoiding health care until the problem exacerbates to secondary or tertiary stages, or by using community-based medical centers that accept the uninsured (Shepherd, et. al, 2014).

This phenomenon had led to academic health centers disproportionately caring for the uninsured. Rising health care costs have influenced some academic medical centers to delay or limit care for the uninsured population in an effort to save money which has contributed to the uninsured turning to the emergency room for care (Denham, et al., 2013). Use of the emergency room for ambulatory sensitive conditions had been proven to be a more costly, less effective route of care, and was associated with overall poorer outcomes and higher costs (Hall, 2013). In fact, costs due to emergency room use for non-emergent care by uninsured patients have risen 23% between the years of 1997-2007 (Block et al., 2013; Hall, 2013).

Types of Safety Net Clinics

As previously stated, the lack of access to health care attributes to premature death and illness in the uninsured population. Access to quality care helps to reduce emergency room use for primary care needs as well as help to overcome the many barriers to care that the uninsured face (Hwang, et al., 2012; NAFC, 2014). There are four different types of clinics that provide care to the uninsured, including Federal Qualified Health Centers (FQHC), rural health clinics, free clinics, and private clinics.

FQHCs include all clinics that receive grant funding under Section 330 of the Public Health Service Act, located in urban or rural settings. FQHCs are located in underserved areas and are required to provide primary and preventative services to patients who are uninsured, or who have Medicaid, Medicare, or private insurance (Beasley, Coffey, & Haldeman, 2009). The FQHC must keep a payer mix of mostly insured patients, or will not be profitable as a health care entity (Beasley, Coffey, & Haldeman, 2009). The FQHC must have a board of directors, provide minimal services, and must provide care to all age groups (Rural Health Information Hub, 2016).

Rural health clinics (RHC) must be located in a rural (non urban) setting in an underserved area. RHCs are unincorporated, structure and can be profit or nonprofit. They receive funding through enhanced Medicaid and Medicare reimbursements, or through private insurance (Beasley, Coffey, & Haldeman, 2009). An advanced practice provider (nurse practitioner or physician assistant) must be onsite at a RHC for at least 50% of the time and there must be a minimum of six kinds of labs available onsite (Beasley, Coffey, & Haldeman, 2009). The RHC is not required to have a board of directors, or to provide minimal services (Rural Health Information Hub, 2016).

Free clinics are non-profit community or faith based clinics that provide primary or chronic care services for little or no cost. They do not accept patients with Medicaid, Medicare, or private insurance and rely heavily on volunteer support as well as partnerships with health care organizations (Beasley, Coffey, & Haldeman, 2009). Free clinics are 501(c)3 organizations or affiliates of one. Most of the funding for free clinics come from the private sector including private donations, grants, the United Way, and local or state governments (Beasley, Coffey, & Haldeman, 2009). The purpose of free clinics are to act as a gateway to established primary care for patients who do not have private insurance and who cannot afford the sliding scales of the FHQCs or RHCs (Beasley, Coffey, & Haldeman, 2009).

Benefits of Free Clinics

Evidence in the literature supports the hypothesis that people who receive care at free clinics have been shown to use the emergency department less for non-emergent care and were more likely to need a hospital admission when they did go to the emergency department for care (Hall, 2013; Hwang, et al., 2012; NAFC, 2014). Hwang, et al. (2012), studied and compared free clinic users to non free clinic users and found the free clinic users did not use the emergency department for chronic disease management, but instead for sprains, superficial injuries, intervertebral disk disorders. People who were uninsured and who did not use free clinics for care were more likely to go to emergency department for mental health disorders, hypertension, and diabetes, according to the study.

In 2010, Darnell performed the first survey of free medical clinics in the United States since the 1970s, and was also the first to study how free clinics related to the communities in which they resided (Darnell, 2010). He found that free clinics did not seem to always be established based on community need, but instead based on gaps in safety-net provider coverage

(Darnell, 2010). Free clinics were very likely to provide medical care, but rarely provided the diversity of health services needed to address the comprehensive needs of patients (Lynch & Davis, 2012).

There were over 1,000 free clinics in the United States that collectively served over 1.8 million people and provided 3.5 million visits in 2006 (Darnell, 2010). Most clinics relied on charitable funding (90%), while only 41% of free clinics received government funding (Darnell, 2010). Most clinics ran on less than $100,000 per year. For every dollar donated to a free clinic, $5 of medical services is provided to the population that the clinic served (NAFC, 2014). In 2012, the top three conditions treated in free clinics nationwide were cardiovascular disease, diabetes, and hypertension (Notaro, et al., 2012). Free clinics mostly offered patients care for medical conditions (73%), provided health education (77%), chronic care management (42%), dental services (33%), vision screening (11%), and pharmaceutical prescriptions (6%) (Johnson, 2010; NAFC, 2014; Notaro, et al., 2012).

North Carolina has one of the largest networks of free clinics in the United States with over 80 free clinics in 55 counties (Hoban, 2013). In 2013, free clinics in North Carolina provided care for over 100,000 of the 1.6 million uninsured in the state (Hoban, 2013). Most of the patients seen in the clinics were the working poor, including farmers, self-employed, and immigrants (Hoban, 2013).

Limited Literature on Free Clinic Development

Free clinics have been documented to fulfill a great need for the uninsured. However, despite this need, free clinics have been overlooked in literature until the last few years (Darnell, 2010; Smith, et al., 2014). Some potential reasons for the lack of literature on free clinic development may have been due to the unstable nature of free clinics. Historically, free clinics

had been small and informally run. A Mideast survey found that 75% of free clinics had been operating for less than 10 years (Johnson, 2010). There is also a lack of scholarly articles devoted to the successful development and operational processes of free clinics. Instead, most scholarly literature focuses on surveys of either patients or providers.

Concepts and Definitions

Free Clinic: "Volunteer based, safety-net health care organization that provides a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals who are predominately uninsured. Free clinics are 501(c)(3) tax-exempt organizations or operate as a program component of an affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered free clinics provided essential services are delivered regardless of patient ability to pay." (NAFC, 2014)

Interprofessional teamwork: "The levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care" (IPEC, 2011)

Patient centered care: "Design of patient care wherein institutional resources and personnel are organized around patients rather than around specialized departments." (MeSH Browser, 2015).

Uninsured: People who "have no health insurance (or other source of third party coverage) for the services furnished during the year." (CMS, 2014).

Safety net clinic: clinic sites that provide health care opportunities for individuals that would otherwise be unable to access health care services due to a variety of barriers. (Oregon Health Authority, n.d.).

Theoretical Framework

Jean Watson's Human Caring Theory is used as a framework to guide the development and organization of Grace Clinic.

> This theory/philosophy involves making explicit human caring and relationship-centered caring as a foundational ethic for healing practices; it honors the unity of the whole human being, while also attending to creating a healing environment. Caring–healing modalities and nursing arts are reintegrated as essentials to ensure attention to quality of life, inner healing experiences, subjective meaning, and caring practices, which affect patient outcomes and system successes
>
> alike. This work places human-to–human caring as central to professional nursing responsibilities, the role and moral foundation for the profession. Preserving human dignity, relationships and integrity through human caring are ultimately the measures by which patient's evaluate their often cure dominated experiences. (Watson, 2005, p.51).

Watson's Human Caring Theory uses Caritas Nursing to bring caring and love into personal and work life. The ten Caritas processes are as following:

1. Embrace altruistic values and practice loving kindness with self and others.
2. Instill faith and hope and honor others.
3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping-trusting-caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another's story.
6. Use creative scientific problem-solving methods for caring decision making.

7. Share teaching and learning that addresses the individual needs and comprehension styles.
8. Create a healing environment for the physical and spiritual self which respects human dignity.
9. Assist with the basic physical, emotional, and spiritual human needs.
10. Be open to mystery and allow miracles to enter.

(Watson, 2007)

Watson's theory is being used as a guide to make human caring an integral part of the development, vision, and culture of Grace Clinic. A summary of the goals of the Watson Caring Institute (2015) are to transform the medical model of care to a model of caring science by introducing caring and Love (Caritas); to deepen caring-healing relationships between practitioner and patient; to translate the Caritas into the clinic's organizational systems and programs; and to ensure caring and healing for the public. Some caring in action indicators that will be integrated into the clinic will include:

- Making human caring integral in the language and mission of the clinic
- Selected use of caring modalities in the clinic environment for self and patient (i.e. therapeutic touch, music)
- Posting posters in clinic environment that reinforces caring practices, and offers positive affirmations
- Engage in caring rounds after clinic time to discuss ways compassion was demonstrated in the care of patients
- Selecting volunteers based on "caring" orientation

Methodology

Needs Assessment

A needs assessment was performed prior to the opening of the free clinic to help inform the needs of the communities within Forsyth County, as well as the possible locations for a sustainable free clinic.

Population.

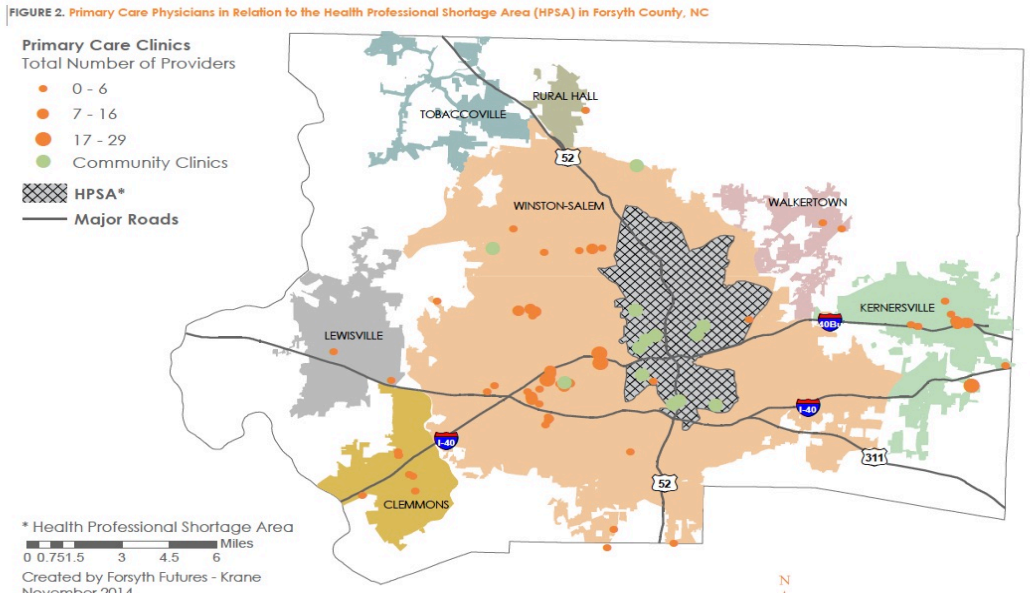
The eastern community of Winston Salem, NC (between the zip codes of 27101-27105) was documented as being the poorest region of Forsyth County with a poverty rate of 15.6% in 2013 (US Census Bureau, 2013). About 58,400 people lived in these two zip codes, and 58% of the people who resided in these zip codes are African American (Chapman et al., 2014). Housing patterns today continued to reflect the segregation patterns that emerged in this city during the 19th and 20th century, (City of Winston Salem, 2009). Hispanics were also a growing part of the population in Winston-Salem, with an 831% growth in ten years from 1999-2009 (City of Winston Salem, 2009).

Primary Care Services.

The availability of health care providers is also a determinant of health care access. An area is considered to be a Health Professional Shortage area if several criteria are met, one being the population-to-clinician ratio, which must be 3,500:1 for primary care, 5,000:1 for dental care, and 30,000:1 for mental care (Forsyth Futures, 2014). In 2012, Forsyth County had a population-to-clinician ratio of 812:1, a population-to-dentist ratio of 1,914:1, and a population-to-mental health professional ratio of 4,276:1. No shortage of primary care physicians as a whole was reported in Forsyth County, but there was shown to be unequal access to primary care (Forsyth Futures, 2014).

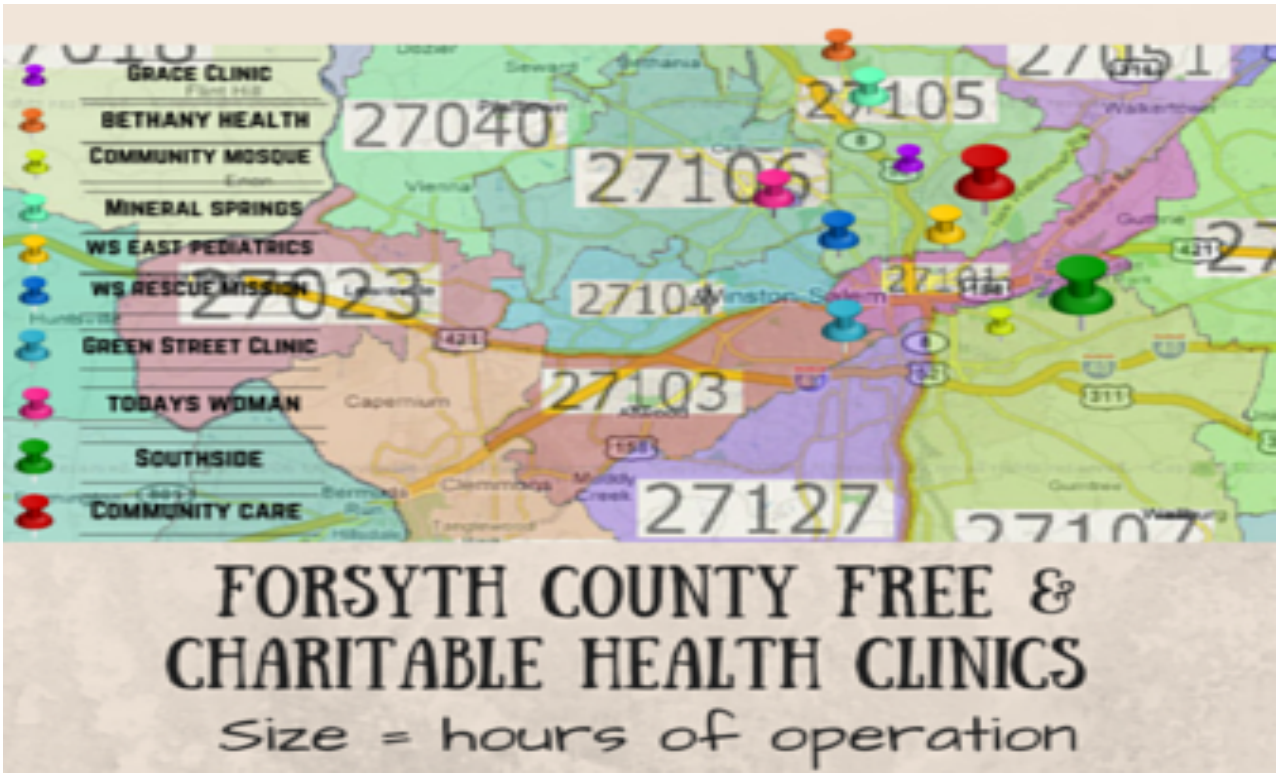
One of the reasons for unequal access is that 24% of residents under the age of 65 in Forsyth County were uninsured in 2012, an increase from 19% in 2008 (Forsyth Futures, 2014). There were 8% more people uninsured in Forsyth County than the top US performer. Even many people who worked were lacking insurance, approaching 22% (US Census Bureau, 2013). The Downtown Health Plaza (DHP), in eastern Winston Salem, provided free or sliding scale acute and primary care. However, to schedule a new patient appointment with DHP, one must wait about three to four months as stated by Monica Brown, the DHP office manager (personal communication, May 3, 2016). Southside and Community Care Clinic (CCC) are two FQHCs that are situated on the eastern side of Forsyth County, and are both accepting new patients, but Southside requires a $25 copay, and CCC also has a waiting period before patients can be seen due to large volume of new patients. Most private and academically owned primary care offices were situated on the western or central areas of Forsyth County (see Figure 1) and was difficult for the east Winston Salem community to access (Forsyth Futures, 2015).

Figure 1. Primary Care Clinics in Forsyth County



Forsyth Futures. (2014). Understanding access to health care. Retrieved from: file:///Users/ raegrace2448/ Downloads/ACH_FinalDraft%20(1).pdf

Figure 2. Free Clinics in Forsyth County



Acute Care/Urgent Care Services.

Forsyth County is the home of two major medical centers. Forsyth Medical Center and Wake Forest Baptist Medical Center have extended their services to include many primary care, specialty offices, and urgent cares throughout the county. Many (50.9%) of the emergency room visits to Forsyth Medical Center and Wake Forest Baptist Medical Center were from uninsured patients in 2012 (Forsyth Futures, 2012). Forsyth Futures also stated in 2014, that 50% of emergency room visits by the uninsured were due to ambulatory sensitive conditions that could have been treated outpatient.

Transportation.

The Winston Salem Transit Authority provides fixed bus routes based on routes that provided mass transit to the black sections of the city during segregation. It provides Medicaid transportation to doctor appointments and dialysis, and offer a discounted fare for Medicare recipients (Luck, 2015; Winston Salem Transit Authority, 2016). The fixed routes impede effective travel for the residents of Forsyth County. Many people complain that it takes hours to complete a simple grocery trip or doctor's appointment. The Winston Salem Transit Authority has acknowledged that these routes are inefficient and have been working to provide new routes with shorter transit times, increased access for passengers, and increased frequency of bus service (Luck, 2015). Other modes of transportation within Forsyth County that can be utilized by residents include taxicab service, and a variety of volunteer transport services that provide transportation to grocery stores, food pantries, and doctor's visits for free.

Project Design

The purpose of this DNP project was to establish a free health care clinic, called Grace Clinic, in a western North Carolina community, based on a community needs assessment and

resources in the community. The author had used the community needs assessment and personal professional experience of providing nursing and medical care for the indigent and uninsured population to determine the need for a safety net clinic in the chosen community.

Information gained from the community assessment was used by the author to present the community needs to the executive leadership of a local academic medical center and FaithHealth in May 2015. FaithHealth is an initiative of the Faith and Health division of the academic medical center that was developed to improve the health of patients by engaging faith communities into covenants with the medical center. FaithHealth engaged church volunteers then work together with health care professionals to be health care liaisons for the patients that they serve (Wake Forest Baptist Health, 2016). The church that was selected for the free clinic was pastored by an employee of the FaithHealth division and was also located in the 27105 zip code previously identified as a community with barriers to health care access.

The academic medical center and FaithHealth division agreed to support the free clinic with resources and funding, with the go-live date of September 19, 2015. A leadership team formed to develop a new free faith-based health care clinic at the partnering church with the goals of utilizing an interprofessional team for the purposes of providing free acute and chronic health care to the people in this and surrounding communities.

Setting

Grace Clinic was developed as a free health clinic in western North Carolina, and partnered with a non-profit academic medical center. This setting was chosen based on the community needs assessment, as well as the church's interest in hosting a health care clinic in the community. The clinic was run by a volunteer staff of physicians, nurse practitioners, physician assistants, nurses, social workers, church members, administration assistants,

pharmacists, FaithHealth volunteers, and certified nursing assistants, and was open on the third Saturday of every month from 9-2 pm. The clinic was set up in a rectangular building that allowed for multiple private rooms and also provided a large waiting area for patients (See Appendix C).

Population

The population served by the clinic included any uninsured individual over the age of 18 who lives in western North Carolina in the zip codes of Forsyth, Guilford, Davie, or Davidson counties. No income parameters were used to include/exclude patients in the free clinic. If patients were insured, they were triaged to appropriate services and providers within the community, but were not seen by a health care provider for medical care.

Key Stakeholders, Facilitators and Barriers

In order to achieve success with this project, key stakeholders were engaged. The administration of the non-profit academic medical center agreed to support the clinic for purposes of serving the community. FaithHealth, an organization housed within the hospital, funded and provided administrative support for the clinic. The pharmacy and laboratory of the hospital also provided charitable services for the clinic's use. Other key stakeholders of this project included the individuals of western North Carolina who received care at the clinic, the people who volunteered in the clinic, the churches associated with FaithHealth, and a local community pharmacy.

Facilitators of this project included the leadership of FaithHealth and volunteers who helped with the development and funding of the clinic. The church housed the clinic without charging rent, which allowed for low overhead costs. Volunteers were passionate about serving the uninsured and were faithful to fulfill their duties after signing up to help. The Spanish

interpreters were community leaders and spent time in the community promoting the free clinic on local radio and new stations.

Barriers to running a free clinic included financial limitations, regulatory procedures, lack of access to specialty referrals, nurse practitioner barriers to independent practice, and mobilization of volunteers in an organized manner. Other barriers included the lack of an existing electronic medical record for communication to other providers and hospitals in the community, and the fluctuating schedules of the lead volunteers, which limited the amount of time that could be devoted to the logistical needs of the clinic. Funding levels for startup were meager at around $2,000, but a substantial number of resources were donated to help offset the startup costs of the free clinic.

Goals and Objectives

This project was aimed at providing free high quality health care to the uninsured of a western North Carolina community. The overarching goal was to engage volunteer healthcare providers and community volunteers to help provide preventative, chronic, and acute care services to the uninsured in a compassionate manner. The clinic utilized an interprofessional model of care with multiple members of the staff caring for an individual during their visit with the clinic. An interdisciplinary model was chosen because literature stated that 88% of patients reported being highly satisfied with care when provided by an interdisciplinary team (Lynch & Davis, 2012).

The author provided a checklist for starting a free clinic (see Appendix E) and organizational strategies for this program as well as a detailed budget for the start up and costs associated with the clinic for the first six months. Demographics, services provided, and education were tracked after each clinic day (see Appendix B). The author monitored and

discussed the development of relationships within the community and hospital system. The process of volunteer recruitment and motivation was also documented and described for this project. Lastly, the author described how Watson's Theory of Human Caring is integrated into the clinic's formation and daily activities.

Resources Used

Financially, the clinic was given up to $2,000 for startup costs, as well as additional monies for ongoing costs as negotiated by the clinic director. A local church provided space for the clinic free of charge once a month (see Appendix C).

The hospital's pharmacy provided residents to volunteer and provide education at each clinic. There was a small formulary of medications that include albuterol nebulizers, acetaminophen, furosemide, ibuprofen, naproxen, and diphenhydramine for administration onsite if needed. Policies were developed to identify the process for administration of medications by clinicians or pharmacists in the clinic.

Donations of materials to the clinic included three oxygen concentrators, an automatic external defibrillator, two exam tables, ten blood pressure cuffs, tourniquets, lab collection tubes, and room dividers. A local community pharmacy provided medications to the Grace Clinic patients at a reduced cost of $4 for a 30-day supply of a limited formulary of medications. The laboratory of the hospital provided a limited amount of labs for no cost to the clinic as well as a courier for the transportation of the labs to the hospital for processing.

Process of Clinic Development

Lead team member roles

The core of the leadership team consisted of both clinicians and community members. The pastor and deacons of the church where the clinic was housed were also included in the

leadership team so that the interests of the congregation were represented. The church volunteers also helped organize and train church volunteers, marketed the clinic to the community, and provided transportation to patients in need of assistance to get to the clinic for care. The program administrator for the clinic worked as a community liaison by fostering relationships with other free health care clinics, nonprofits, and churches. The program administrator was also an employee of FaithHealth, and was in control of the startup budget for the clinic. The FaithHealth consultant for Grace Clinic researched and negotiated legal and regulatory issues related to opening Grace Clinic. There was a researcher who assisted the lead team with data collection for health outcomes measures and cost analyses for the Grace Clinic. She was also the health coach lead and educator for the church volunteers who were helping at the clinic. The author was the clinical director and founder of the Grace Clinic. Her responsibilities included forming clinic structure and flow, recruiting and retaining volunteers, operations management, ensuring adherence to legal and regulatory guidelines, marketing of the clinic to the community, providing policies for safe care, monitoring quality assurance, and forming community partnerships. There was also a lead nurse coordinator and case manager whose responsibilities included management of supply inventory, coordination of nurses during clinic days, management of health education materials, and referrals to community resources.

Clinic Development Strategies

Starting in May of 2015, the leadership team spent two months preparing for the opening of the clinic with weekly team meetings. Examples of the agenda items discussed during the team meetings included the following: marketing strategies, population to be served/location of clinic, the model of care and clinic flow, budget for first year, supply costs and needs, orientation, mission statement, lab and pharmacy partnerships, volunteer roles and recruitment

strategies, community partnerships, safety for patients and volunteers, and legal/regulatory considerations.

Legal/Regulatory

Discussions were held with risk management and compliance officers of the academic medical center to determine what legal and regulatory requirements needed to be met prior to opening the clinic. The compliance team suggested that the clinic confirm adequate hand washing stations throughout the clinic, exit doors for emergencies, sharps containers, locked lab storage with courier pick up plan, locked cabinets for provider/nurse license storage and patient records, locked room for clinic supplies, and forms ensuring patient privacy and consent to care.

A meeting with the legal team of the academic medical center was held in June 2015, prior to the opening of the clinic as well. Items discussed and negotiated during the legal meeting included potential tax exempt 501(c)(3) status, volunteer safety, extension of hospital liability coverage for health care providers, general liability requirements for the church, and legal use of the hospital's electronic health records.

Safe exits in the clinic, locked storage of volunteer and patient files, and adequate access to hand washing stations (or hand sanitizer) were ensured to be available throughout the clinic. Forms were created and translated to Spanish to ensure the patient's consent to care and privacy protection (see Appendix D). Quality of the Spanish translated documents was ensured after a professional Spanish translator within the partnering academic medical center reviewed and corrected the documents.

The team discussed 501(c)(3) designation and decided that since the clinic was housed in a church, it would fall under the non-profit protection of the church. However, if the clinic size and volume grow, the team will plan to apply for 501(c)(3) designation at the beginning of next

year for access to grant funding. The partnering academic medical center agreed to extend professional liability coverage to any providers, nurses, or employees who volunteer at the Grace Clinic, with the advice that volunteers who worked outside of the academic medical center should seek their own private liability coverage. The academic medical center also agreed to give the volunteer doctors and nurses view-only access to the hospital's electronic health record after a contract was negotiated between the free clinic and the academic medical center, and HIPPA agreements were signed by the volunteers.

After six months clinic existence, consideration was given to the development of 501(c)3 status for the purposes of liability protection, tax-exempt status, and increased fundraising potential of the clinic (NAFC, 2014). Love Out Loud (LOL), a local 501(c)3, promoted and connected the free health clinic to other community agencies that are complementary to the clinic's mission. Discussion occurred with the director of LOL for the purposes of potentially coming under the LOL 501c3 status, which was confirmed by the director as an option.

Volunteer recruitment

The success of the free medical clinic was dependent on the many hours devoted by volunteers as well as multiple community partnerships. Volunteerism was critical to maintaining low clinic expenses and overhead. The volunteers were participating in an interprofessional model of care, with a workforce that includes three-four clinicians, three nurses, one-two social workers/case managers, two registrars, one pharmacy resident, one certified nursing assistant, and two ministers (See Appendix C). There was a rotating schedule of providers, nurses, and other volunteers (n=22) for the remainder of 2015 and early 2016.

Many of the team members worked at the local academic medical center, and the clinical director was able to recruit doctors, advanced practice providers, and nurses from within the

hospital via peer to peer contact, emails to fellow colleagues, endorsement on the FaithHealth website (www.FaithHealth.org), social media, and brochure distribution within the academic medical center and community. The author also met with the Dean of the Physician Assistant (PA) program at the academic medical center and discussed ways to involve the physician assistants that work within the academic medical center in the free clinic. The chief resident and resident faculty leader was approached, and helped recruit upper level physician residents to volunteer at the free clinic. Finally, the nurse manager of the free clinic emailed peers in case management to help recruit volunteers from within the academic medical center and neighboring hospital.

Flyers were handed out to potential volunteers, and an orientation packet was also given to each one prior to their first day at the clinic. An orientation day was also provided to all potential volunteers three weeks before the clinic opened in September. Recruitment for volunteers also occurred in multiple community nonprofit meetings, church ministry fairs, and nursing fairs.

Marketing Strategies

Prior to opening the clinic, the leadership team had community meetings with nonprofit groups, including Love Out Loud, World Relief, the local health department, and a local food ministry with the goals of introducing the clinic's purpose, target population, and hours of operation. The local food ministry and the hospital transitional care team distributed clinic promotional brochures to community members of local town the clinic presides in. The church volunteers went door-to-door in the local community to pass out flyers and provide specifics about the clinic.

Free clinic information was posted on Gener.us, which is a non-profit connector website, as well as in a circulating LOL newsletter. A Facebook® page called Grace Clinic at New Light Missionary Baptist was created to help with the recruitment of volunteers and to disperse up to date information about the clinic. A journalist from local newspaper was invited to join the clinic on opening day, and wrote an article about the clinic's purpose and availability (see Appendix H). As stated above, the Spanish interpreters promoted the clinic through avenues of radio, news, and flyers. The clinic director was also interviewed about the free clinic on local Hispanic radio program.

Community Partnerships

Multiple meetings with other free clinics in the community were held with the purpose of forming strategic partnerships. An introductory meeting was held with a local medical director of a long-standing free health care clinic for guidance in regards to clinic set up and strategies for success prior to opening the Grace Clinic. A local pharmacy partnered with the clinic by opening the on Saturdays for the purposes of serving the clinic patients, and by providing the patients with a formulary of low cost supplies and medications. The local academic medical center provided lab services and pick up of lab work from the free clinic for no cost. In addition to lab support, the academic medical center also offered legal and regulatory expertise to help guide the clinic's formation and sustainability.

New partnerships have been formed between the free clinic's leadership and the Vice President (VP) of Population Health at the academic medical center with intent to synergize the existing free clinics in Forsyth County with the goals of providing comprehensive care to the uninsured populations in an effective and comprehensive manner. This partnership would involve gathering together the region's free clinic directors with the goal of developing strategies

that will improve communications between clinics as well as provide a streamlined, centralized model for potential patients to be vetted before going to a free or low cost clinic for care.

There are also plans to partner with another church in the community in the fall of 2016 based on the community's health needs survey and conversation with community leaders, which revealed interest in wellness and preventative services to a growing young, Hispanic population.

Feedback from patients served at Grace Clinic helped to identify need for more community-based options for counseling and mental health referrals. The existing free to low cost system for mental health providers in the community offered mainly group counseling, which the patients found to be "more depressing than helpful" (T. Mitchell, personal communication, December 19, 2015). This feedback resulted in partnerships between the free clinic and local counseling centers for the purposes of offering low cost options for patients by utilizing the services of counseling interns for ongoing, individualized sessions with patients who suffered with depression, anxiety, or mental health disorders.

Partnerships were also formed with the academic medical center's primary care offices to provide a referral track for the patient's seen at the free clinic. The local primary care office agreed to open up two patient slots per day for the care of patients referred by either the free clinic or by the FaithHealth team. This allowed for a more streamlined process to connect patients to longitudinal primary and specialty care.

Results

Between the months of September to February, six clinics were held, serving 47 unique patients, and providing 50 encounters of care. Of the people seen, 21 were males and 26 were females. Ages of the patients ranged from 18-82, with median age in the late 40s, early 50s and mean age 52 years old. Five of the patients had insurance or pending Health Exchange or

Medicaid coverage, while 42 patients were uninsured. Thirty-four patients (72%) were served from the target zip codes 27105, 27101, and 27107, while patients were also served from High Point (n=2), Kernersville (n=3), and Lexington (n=2). The remaining patients came from other zip codes within Forsyth County.

Figure 3. Services provided at free clinic

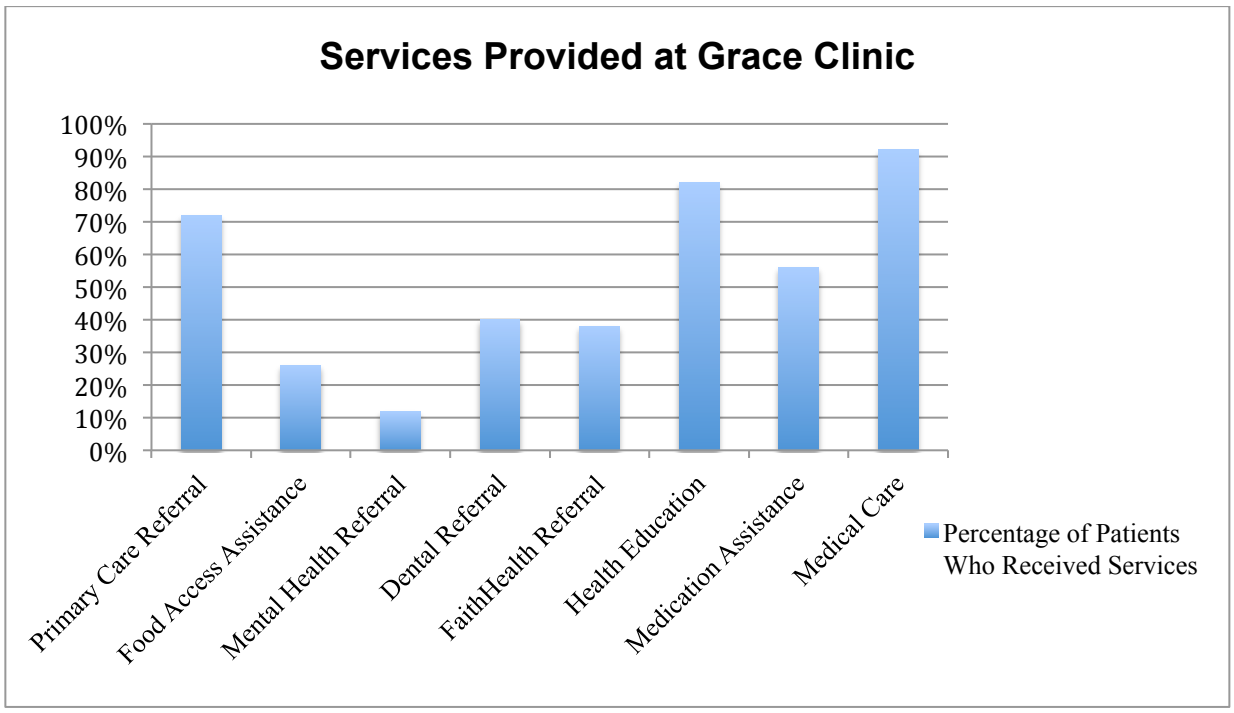


Figure 4. Gender and number of patients seen over six months

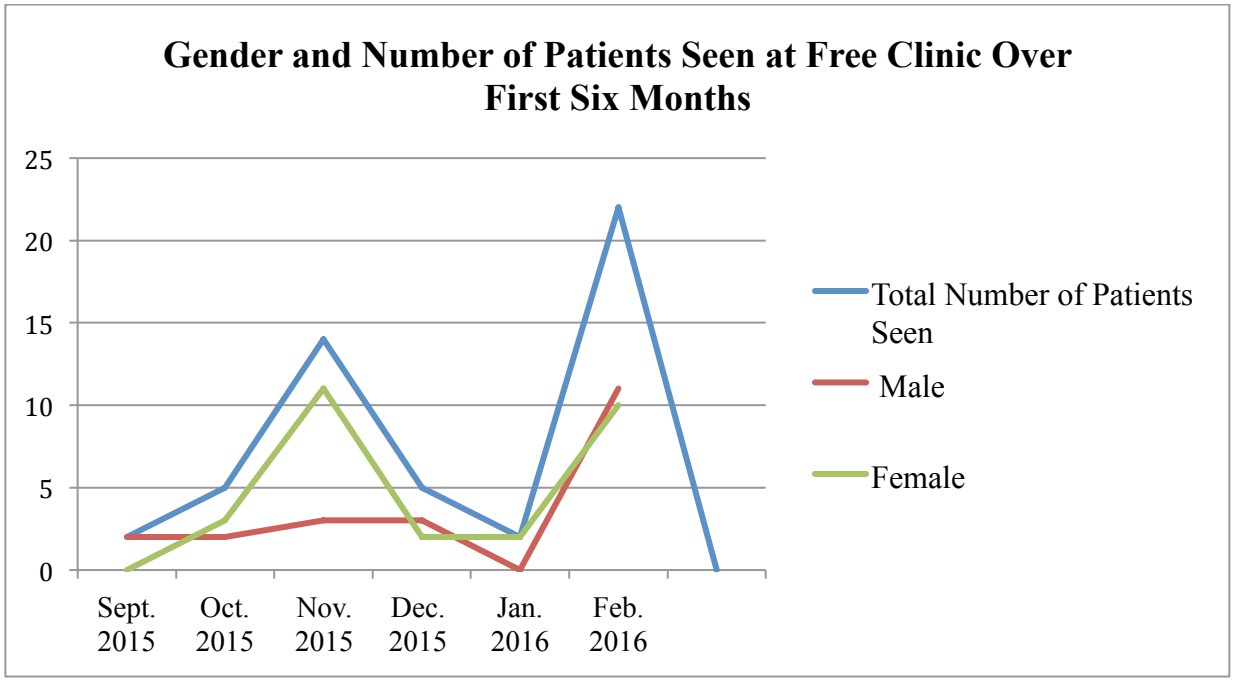
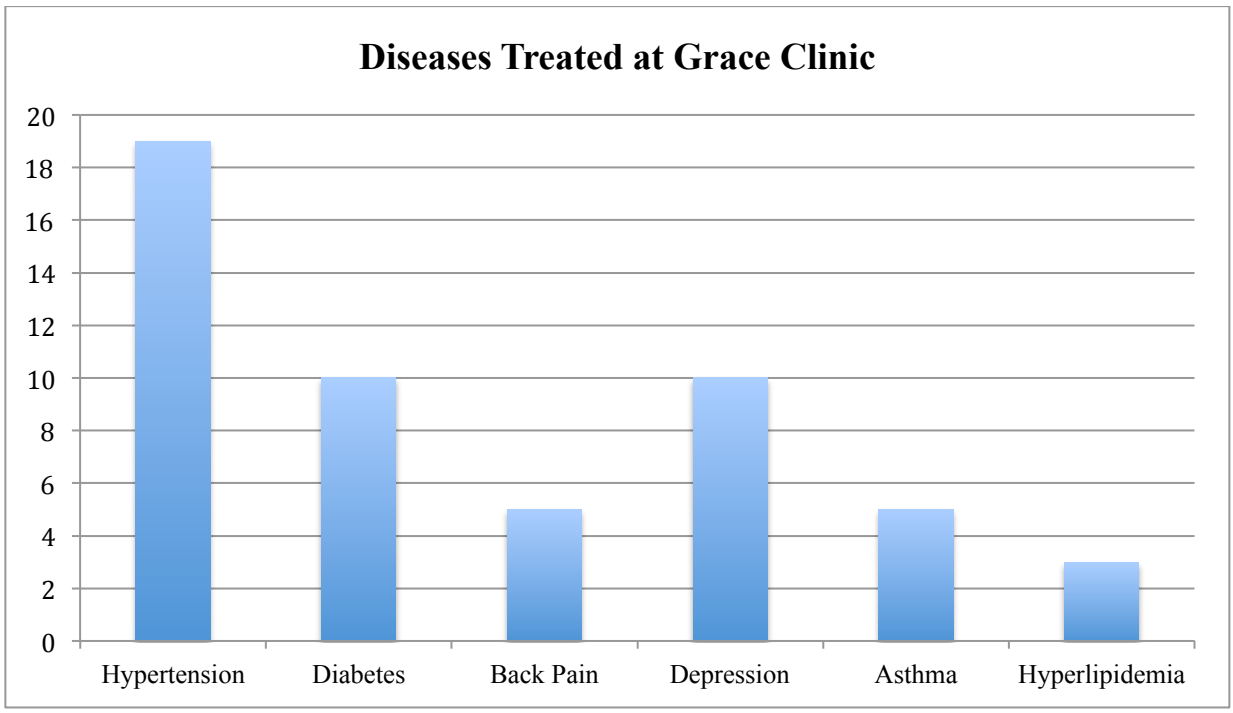


Figure 5. Diseases treated at free clinic



Cost-Benefit Analysis

Background

In review of the literature, only two articles analyzed the return on investment a primary care free clinic in the literature review. The first article analyzed the return on investment for a mobile health clinic providing primary care services to the uninsured, and found that the clinic saved the community and health care system $36 for every $1 spent. They computed these savings by multiplying the state average per visit preventable ED cost with the number of visits they believed to be avoided. This calculation makes the assumption that if the mobile clinic was not available, that 80% of the visits would have resulted in ED utilization (Oriol, et al., 2009).

The second article was a more robust cost benefit analysis and used matched data from a free clinic and the regional hospital serving the same patients to evaluate hospital costs in the

year prior to clinic enrollment compared to those in the year following enrollment. Comparing the annual costs accounted for seasonal variations in hospital use. For a sample (n=207), Fertig, Corso, and Balasubramaniam (2012) reported that the annual non-urgent ED and inpatient costs at the hospital fell by $170 per patient, while the costs of delivering patient care at the free clinic was $505 per patient. This suggests that the reductions in costs must be sustained for at least three years to make up for the high diagnostic and treatment costs associated with delivery primary care to the uninsured.

Cost Benefit Analysis of Treating Hypertension

The author did not have access to the hospital costs per patent, so chose to perform a cost benefit analysis on the management of the top two conditions treated in the free clinic (hypertension, diabetes) versus treatment in an office setting or an emergency room setting. The office and emergency room rates were based off of the 2016 Medicare reimbursement rates as listed on the Centers for Medicare and Medicaid website (CMS, 2016).

In order to calculate the office costs associated with providing a service for a patient seen in the clinic setting, unit cost analysis was performed. A unit cost analysis calculated the cost to provide a service to a patient and takes into account all of the resources that are associated with providing the service. It then breaks down the costs into the smallest practical unit, allowing for working knowledge of the true cost of providing a service (Kullgren & Sibella, 2004).

A unit cost analysis has six distinct steps including: defining the unit (type) of service being provided, determining the number of units provided, calculating the direct costs of providing the service, calculating the indirect costs of providing the service, calculating the value of donated goods/services, and determining the full cost of the unit of service (Kullgren & Sibella, 2004). For the purposes of the project, the internal medicine and registered nurse salary

was based the median salaries of 193,980 and $60,803 respectively as of April 2016 (Physician Internal Medicine Salaries, 2016; Staff Nurse Salaries, 2016). The median wage of $15.50 per hour was obtained from May 2015 data of the Bureau of Labor Statistics (United States Department of Labor, 2015).

In the setting of Grace Clinic, hypertension was the most commonly treated chronic condition treated. For a traditional office visit, hypertension and diabetes management most commonly requires the Current Procedural Terminology (CPT) code of 99213 and 99214 respectively. There are direct and indirect costs associated with a 99213 and 99214 level visit, but for the purposes of this cost benefit analysis, only direct costs are calculated. The 99213 level of care implies a clinic visit that lasts about 15 minutes with the provider, while the 99214 level visit implies a visit that lasts about 25 minutes respectively (CMS, 2016). All of the services provided by the healthcare professionals are done on a volunteer basis, so the only costs incurred during a free clinic visit includes the cost of supplies (about $3/patient). Given the low overhead costs of the free health care clinic, the free labs provided by the academic medical center, and donations from the former, the costs of caring for patients are lower than other comparable free clinics. In comparison, the median emergency room cost of treating outpatient conditions in the uninsured population was $1,178 according to a study performed by the University of California in 2013 (Caldwell, Srebotnejak, Wang, Hsia, 2013).

Table 1. Traditional office costs associated with 99213 level visit for hypertension follow up

Steps	Notes	Calculations
Define the unit of service	An adult hypertension follow up visit	
Determine the number of units provided in the defined time period:	19 hypertension management visits	
Calculate the direct costs:		
Physician labor cost:	Salary and benefits of $193,980 per year/50 work weeks per year/40 work hours per week/60 minutes per hour= $1.62 per minute x 15 minutes required	$24.25
Nurse labor cost:	Salary and benefits of $60,803 per year/50 work weeks per year/40 work hours per week/60 minutes per hour= $0.51 per minute x 10 minutes required	+ $5.10
Receptionist cost:	Salary and benefits of $25,000 per year/50 work weeks per year/40 work hours per week/60 minutes per hour = $0.208 per minute x 5 minutes required	+ $1.04
Disposable resources:	Per supply catalog 44,000 per year/50 work weeks per year/40 work hours per week/60 min per hour= $0.37 per min	+ 7.4
Lab resources:	Per typical charges	+ $15.00
Total direct costs per unit of service:		$52.79
Clinic visit time for patients:	Encounter duration of one hour on average x adjusted median wage (15.50)	+ $15.50
Total direct costs per unit for hypertension visit:		$68.29
Total direct costs for 19 patients in office setting:	Direct costs of $68.29 x 19 patients	$1,297.51

Table 2. Traditional office costs associated with a level 99214 visit for diabetes follow up

Steps	Notes	Calculations
Define the unit of service	An adult diabetes follow up visit	
Determine the number of units provided in the defined time period:	10 diabetes management visits	
Calculate the direct costs:		
Physician labor cost:	Salary and benefits of $193,980 per year/50 work weeks per year/40 work hours per week/60 minutes per hour= $1.62 per minute x 25 minutes required	$40.41
Nurse labor cost:	Salary and benefits of $60,803 per year/50 work weeks per year/40 work hours per week/60 minutes per hour= $0.51 per minute x 10 minutes required	+ $5.10
Receptionist cost:	Salary and benefits of $25,000 per year/50 work weeks per year/40 work hours per week/60 minutes per hour = $0.208 per minute x 5 minutes required	+ $1.04
Disposable resources:	Per supply catalog 44,000 per year/50 work weeks per year/40 work hours per week/60 min per hour= $0.37 per min	+ 7.4
Lab resources:	Per typical charges	+ $15.00
Total direct costs per unit of service:		$68.95
Clinic visit time for patients:	Encounter duration of one hour on average x adjusted median wage (15.50)	+ $15.50
Total direct costs per unit for hypertension visit:		$84.45
Total direct costs for 10 patients in office setting:	Direct costs of $84.45 x 10 patients	$844.50

Table 3. Direct and Indirect benefits associated with free clinic care

Benefits	Notes	Calculations
Direct benefits	Averted hospital emergency room use with average cost of ED use at $1,178 per visit for uncontrolled hypertension	$1,1178
Indirect Benefits	Estimate averted lost patient income ($) during ED visit for care (median hourly wage of $15.50/hour x 4 hours)	+$62.00
Total benefit of averted ED visit per patient:		$1,240
Total benefit for 29 patients:	$1,240 x 29 patients	$35,960

Discussion

Lessons Learned

After each clinic, the lead team completed a SWOT analysis to be used for subsequent clinic days. Some clinic flow changes implemented included: heavier recruitment of social worker volunteers given the high social needs of the uninsured population, partnerships with community mental health providers for the referral of uninsured patients who struggle with depression or anxiety, improved systems of registration for efficiency, splitting of day into two hour increments for volunteer satisfaction, and need for better follow up system during the week after seeing clinic patients. A centralized website listing all of the free clinics in Forsyth county as well as what types of care is provided, resources for the uninsured, and links for clinics that have websites would also be a helpful resource for the uninsured in community.

In terms of overall clinic function, it would have been helpful to have a 501c3 in place prior to opening the doors of the clinic for the purposes of grant funding, clinic growth, team development, clinic vision, and mission. Access to the academic medical center's electronic health record has been very helpful to the providers at the free clinic. However, the providers of care are unable to document their care in the electronic health record, preventing effective communication with other safety net clinics, future primary care providers, and the emergency room.

Finally, the clinic was set in a high needs community of Forsyth County with the assumption that most of the patients seen would be from the community, however, about 1/3 of the patients served are from outside of the targeted zip codes of 27105, 27101, or 27106 of Forsyth County. The clinic is also seeing a larger Hispanic population than first planned for, and there is an increasing need for interpreters for clinic care. Many of the Hispanic patients are

young, under the age of 40, and are interested in learning healthy behaviors as well as requesting preventative health screenings. Based on input from the Hispanic patients, conversations with local Hispanic churches were held by the leadership team for the purposes of establishing a preventative health clinic at a local Hispanic church in Fall 2016.

Implications

Currently, many of the free clinics of Forsyth County function in silos, charting on paper charts, lacking the funding and staffing needed to communicate patient care to other free or charitable clinics, or to the local hospitals that provide care to these patients as well. Duplication of services has been found to occur when referring patients to healthcare access points due to the patient being seen previously by other free or charitable clinics. These concerns have been discussed with the leadership of the academic health center with whom the clinic partners. In order to offer the uninsured population more effective, comprehensive, and coordinated care, there will need to be strategic partnerships developed between the charitable and free clinic leaders as well as the local hospitals.

Free clinics offer a vital service to the uninsured in the community as well as a frontier of healthcare that allows for innovation. The mobile concept of free health care is worth consideration and is utilized by prestigious institutions such as Harvard and Cedar-Sinai to reach the underserved in the communities in which they live. As previously noted, Oriel, et al. (2009) used service data from Harvard's Family Van for 2008, and calculated that the return on investment for the mobile clinic model of care utilized by the Family Van was $36 for every $1 invested in the clinic (Oriel, et al., 2009). Although the start up costs for such a model of care is higher than a traditional free church clinic setting, the return on investment potentials are worth

considering for future propositions within the health care sector as it allows for more intimate relationships with communities and opportunity for sustainable partnerships.

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Appendix A

MEMORANDUM

To: Rachel Zimmer
Int Med-Gerontology

From: Assistant Director, Institutional Review Board

Date Approved: 9/8/2015

Subject: Expedited Review: IRB00035059
Development of a Free Health Care Clinic in Forsyth County

Study Documents:
Protocol Version: Zimmer WF IRB.doc; Other Documents: Zimmer Clinic Data.xlsx

This research study qualifies for expedited review under the Federal Regulations [45CFR46.110]. These regulations allow an IRB to approve certain kinds of research involving no more than minimal risk to human subjects. The risks of harm anticipated in the proposed research are not greater than those ordinarily encountered by the general population in daily life or during the performance of routine physical, laboratory, or psychological exams or tests. [45CFR46.102(i)].

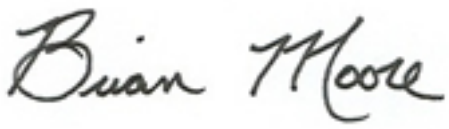
Upon review of the research, the IRB finds that this study is classified as Expedited Category 5.

This research meets the criteria for a waiver of consent entirely according to 45 CFR 46(d).

This research meets the criteria for a waiver of HIPAA authorization according to 45 CFR 164.512.

Based on the information provided, the IRB has determined that HIPAA does not apply to this study.

IRB approval is for a period of 12 months from 9/8/2015**.** Please notify the Office of Research when the project is complete.



Brian Moore

Appendix B

Figure 6. Data Collection Tool

Pt #	Date	Age	Gender	Zip Code	Disease Treated	ED visit	Uninsured Status	Medicaid Referral	PCP Referral	Food Assist	Mental Health	FaithHealth Referral	Dental Referral	Health Ed	Med Assist	Notes
1																
2																
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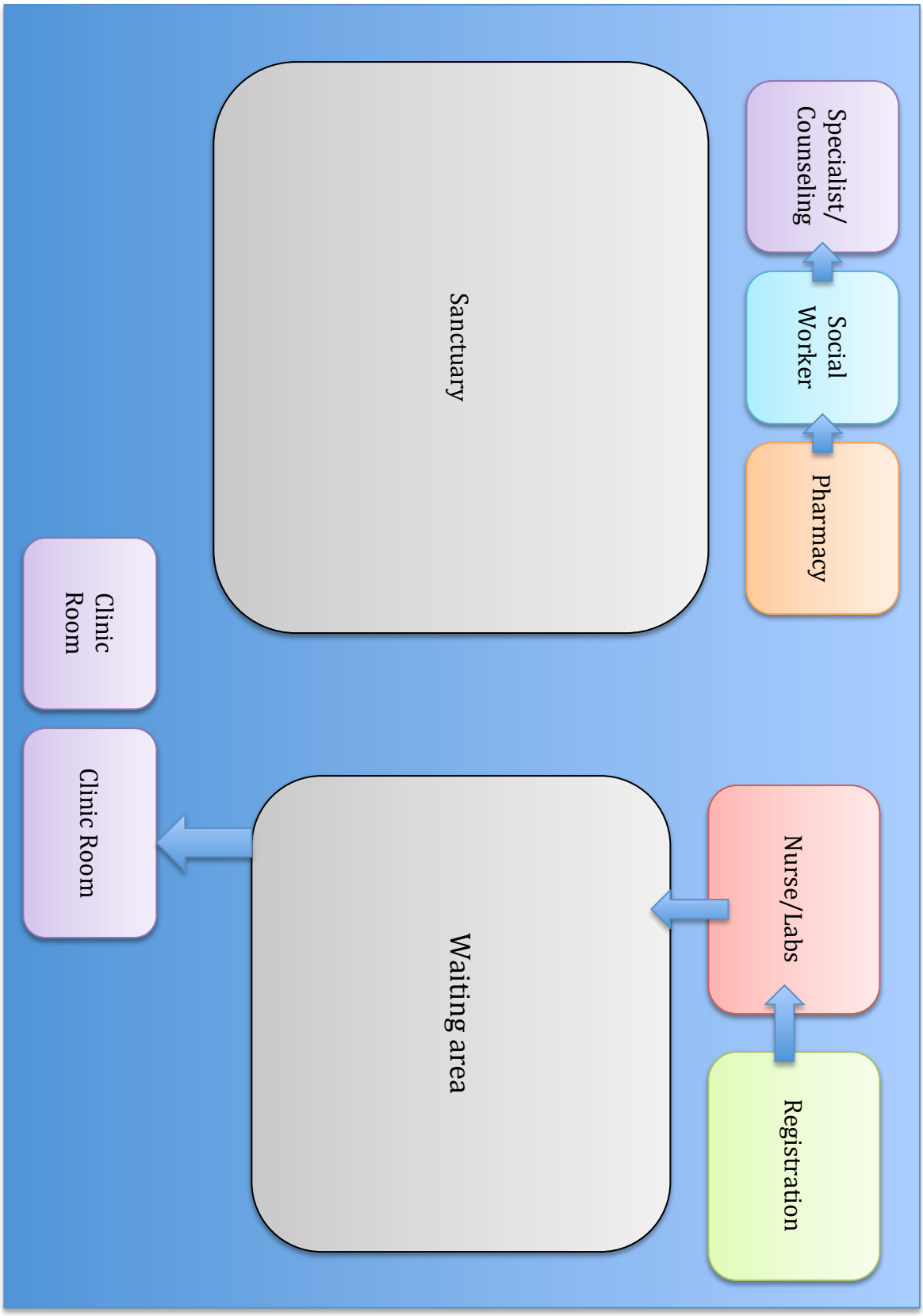
Appendix C

Figure 7. Clinic Flow and Set up



Services Provided

Registration: Collection of patient information including health history, registration of name, address, insurance status, privacy consent, consent to treat, FaithHealth screening for services. Patients are asked to bring license or picture ID and medications

Nurse Room: Separated into two areas (vital signs/labs). Triage, provide patient with color-coded cards for next room, vital signs, blood sugar, weight.

Waiting area: FaithHealth liaison builds report with patient while they are waiting by helping fill out health history if needed and reassuring that they will assist patient through clinic rooms as needed. FaithHealth volunteer liaison stays with patient throughout process, leading them to different stations

Clinic room: Staffed by 2-3 clinicians (doctor, nurse practitioner, or physician assistant) who provide medical care. One room is L-shaped and separated by thick curtains for privacy. Two exam tables are present in large room. Room is stocked with exam paper, reflex hammer, eye chart, hand sanitizer, flashlights

Pharmacy: Staffed by two pharmacy residents who provide education on medications that patient is prescribed. Dispensing of over the counter medications. Assist patients with obtaining medication through prescription assistance programs, local pharmacies.

Social worker: Assess patient for needs and connect with community resources. Medicaid referrals if potentially eligible. Referral to primary care provider through HealthCare Access. Work with FaithHealth liaison to set up transportation to pharmacy, food banks, grocery store if needed.

Specialist: Room set aside for specialty care if a specialist is present. If not, room utilized for counseling or prayer.

_____

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box): ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other		❑ Dr. _____		❑ Hospital		
Other family members seen here:						

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize _____ or insurance company to release any information required to process my claims.			
Patient/Guardian signature		*Date*	

I certify that I do not currently have health insurance _____.

Grace Clinic
1535 E. 15th Street
Winston-Salem NC 27105

Name:
MR:
Date:

336.724.6431 phone

HEALTHCARE CONSENT

CONSENT FOR TREATMENT/CARE & RELEASE OF INFORMATION: I consent to treatment/care, as determined to be necessary, by volunteer health care providers practicing at this facility. I understand that many of the volunteer physicians, nurses, social workers, dieticians, and others on the staff of this volunteer clinic, are not employees or agents of the New Light Missionary Baptist Church Grace Clinic but have been granted the privilege of using its facilities for the care and treatment of its patients. I realize that among those who attend patients at this clinic are medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education. I understand that treatment/care will include a variety of medical services based upon the nature of my condition, including laboratory testing and other routine care such as immunizations. I am aware that the practice of medicine and/or surgery is not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, or procedures. I am aware that agencies may be contacted to help to provide treatment/care at this facility. I consent to the use and disclosure of protected health information about me, including information, if any, regarding HIV status or AIDS, for treatment, and healthcare operations. I agree that my medical records may be sent to the doctor who referred me to this facility and to any health care facility or doctor whom I may be referred..

RELEASE OF INFORMATION: Grace Clinic, its agents, and members of its medical staff may in strict confidence release medical information required in the processing of applications for: continuity of patient care, risk management issues, and education. This information that may be released may pertain to my present clinic visit, previous illnesses, past medical and surgical history recorded in this current admission and special reports made during my stay in order to justify my care. I understand that I may revoke this consent at any time except to the extent that action on the consent has already been taken.

PERSONAL VALUABLES: The facility is not responsible for the personal property or valuables of patients.

I understand that this is a tobacco free facility. I have received a copy of this Healthcare Consent and Authorization Form and a copy of my Patient Bill of Rights. I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY THE FACILITY OR IN PROCESS. MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE AND THAT I HAVE READ AND UNDERSTAND THIS FORM.

_____

Patient Signature Date: _____ Time: _____

If patient is unable to consent or is a minor, complete the following:
Patient is: Unable to consent because:

_____

and I confirm that I am authorized to consent in the patient's behalf:

_____

Signature of Authorized Person Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
__ Interpreter accepted __ Interpreter refused

_____

Interpreter Signature/ID# Date: _____ Time: _____

MRN# _____

Patient Name _____

Grace Clinic# _____

GRACE CLINIC

AUTHORIZATION *for* USE *or VERBAL* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

Name of Health Care Provider or Organization (if known):	Phone # (xxx) xxx-xxxx	Address (include Zip Code)

I CONSENT TO AND AUTHORIZE: GRACE CLINIC, TO RELEASE TO:

Description of information that may be used/disclosed to persons listed above:
Verbally share appropriate information.* (However, may release: demographic information which may include appointment time and location) (*Does not apply to the release of medical records*) * ***(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)***
I authorize Grace Clinic to leave voice mail messages on my voice mail. ☐ Yes ☐ No, Leave appointment reminders only.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will limit my participation with Grace Clinic. It will not affect my ability to obtain treatment from Grace Clinic. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to Grace Clinic located at New Light Baptist Church, 1535 E. 15th Street, Winston-Salem NC 27105. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature of Patient or Personal Representative (*if applicable*) Patient's Date of Birth

_____ _____/_____

Relationship to Patient Requestor's Home Phone/Work
Phone

_____ _____

Authority to Act Date/Time (Required)

GRACE CLINIC
1535 E. 15TH STREET, WINSTON-SALEM NC 27105
336.671.3865

ORIGINAL DATE:
DATES REVISED:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):* ☐ M ☐ F	DOB:
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
PREVIOUS OR REFERRING DOCTOR:	DATE OF LAST PHYSICAL EXAM:

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

Please turn to next page

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug	Strength	Frequency Taken
ALLERGIES TO MEDICATIONS		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No

	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

Appendix E

Checklist for Free Clinic Start Up

Refer to National Association of Free Clinics Operations Manual (page numbers listed)
http://www.nafcclinics.org/sites/default/files/Legal_and_Operational_Guide_for_Free_Medical_Clinics.pdf

Formulate a team to address the following:

- Weekly team meetings
  - Operations planning and challenges
  - Improvements
  - Successes
  - Problem solving
  - Legal/regulatory issues
  - Community partnerships/marketing
  - Outcomes measurement/quality improvement

Clinic structure determination

- 501(c)3/operating under tax-exempt entity
  - Pros vs Cons (p. 19-20)
- If incorporating
  - Establish an organizing document
  - Bylaws (formal rules)
    - General Information
    - Describe member duties
    - Board of Directors
- Leadership (establish clear roles and responsibilities)
  - Medical Director (p. 74)
  - Executive Director (Appendix C)
  - Nurse coordinator (Appendix C)
- Location and Hours
  - Perform community assessment to understand the needs and providers of care in the community you are interested in serving
    - Health care providers, social programs, free clinics, public housing, transportation
    - Speak to local clinics and health care providers about their perceptions of care and needs. Form relationships with other health care organizations locally.
  - Speak to local community members about their perception of need and barriers to care
  - Determine location of clinic (establish leasing/renting requirements)
  - Confirm accessibility to the disabled (American Disability Act)
  - Consider an answering service and follow up plan for patients to be seen at the clinic

Legal/Regulatory

- Medical liability
  - The Good Samaritan Law (p. 51-55)
  - Federal Torts Claims Act (p. 55-58)
    - Liability coverage through Bureau of Primary Health Care
  - Volunteer Protection Act of 1997 (p. 59)
  - Charitable Immunity Laws (p. 61)
- Insurance Coverage (p. 64-68)
  - Property and Casualty Insurance (accident coverage)
    - Third party injury
    - Slip and Fall insurance
      - Liability of organization
      - Medical payment coverage
  - Director and Office Insurance
  - General Liability
    - Intentional acts that cause injury
  - Equipment breakdown and Computer coverage
  - Commercial Crime
  - Umbrella Liability
- Regulatory
  - On site testing
    - Partnership with lab for processing and pick up of labs
    - Review CLIA waivers for onsite testing (p. 120)
  - Waste disposal process for both biohazard and non-biohazard materials
  - Security
    - Coordination with law enforcement
    - Panic buttons
  - OSHA and HIPAA regulations
    - Training/procedures
  - Pharmacy Dispensing (p. 82-86)
    - Check Federal and State regulations
    - Need license to dispense (renew yearly)
    - DEA registration if dispensing narcotics
  - Onsite documentation requirements
    - License and credentialing of providers, nurses, social workers, pharmacists, mental health providers, dentist must be kept locked on site
    - Collaborative practice agreements for nurse practitioners and physician assistants
    - Background checks

Volunteer Staffing and Recruitment

- Recruiting
  - Word of mouth

  - Bulletins
  - Speaking at churches/provider meetings
  - Speak to champions in the field (program directors, professors, well known clinicians in community)
- Example of staffing:
    - Physician (1-2)
    - Nurse practitioners/physician assistants (1-2)
    - Nurses (2-3)
    - Social worker (1-2)
    - Pharmacists (1-2)
    - Translators (1-2)
    - Registrars (1-2)
    - Health Coaches (1-2)
    - Office Coordinator (1-2)
- Training
  - Document process and list of volunteers who attend training sessions
  - Orientation
  - Other areas of training:
    - How to handle uncooperative, or mentally ill patients
    - Protection of patient privacy (HIPAA)
    - Community Health Advocacy or Health Coaching
    - Handling of blood borne pathogens (OSHA)
    - Cultural competency
    - Safety and protection
    - Automatic External Defibrillator (AED)

Clinic Operations

- Walk in vs. Appointments
- Policies and Procedures
  - Handling of labs, waste disposal, safety etc.
- Forms for patient intake
    - Translate forms to Spanish
    - 5th grade level
  - Registration
  - Protection of Health Information
  - Consent to care
  - Health history
- Establish a Medical Record
  - Consider paper vs. Electronic health record
  - Locked storage of paper work
  - Review HIPAA (p. 88-100)
- Team huddles
  - Before clinic opens and post clinic to review follow up plans
- Name badges for volunteers
- Clinic space/setup

- Registration area (close to entry)
  - Large desks and chairs for form completion
  - Create space between desks for privacy when interviewing and assisting with forms
  - Numbered system (e.g., numbered cards) where each patient is assigned a number (tracks patient flow)
- Waiting area (close to registration)
  - Chairs
  - Completion of remaining forms
  - Magazines, health related handouts, community resource handouts
  - Refreshments
  - Gospel or relaxing music
- Health Assessment and Lab Area
  - Blood pressure measurement
  - Height and weight measurement
  - Blood glucose monitoring
  - Other testing
  - Hazardous waste disposal
- Clinic area
  - Two medical tables (donated)
  - Privacy partitions or curtains
  - Sink
  - Exit door
  - Space for clinical supplies
- Supply and medical file storage area
  - Locked file cabinets
  - Storage bins (if needed)
  - Bookshelves (if needed)
  - AED (donated)
- Pharmacy consultation area
  - Desk
  - Chairs
  - Laptop (provided by the pharmacist)
  - Locked file cabinets
- Case Management consultation area
  - Desk
  - Chairs
  - Laptop (provided by the case manager)
  - Locked file cabinets
- FaithHealth consultation area
  - Desk
  - Chairs
  - Laptop (provided by the volunteer)
  - Locked file cabinets
- Office area (often reserved for Pastor, Clinic Director/Coordinator, Clinical Lead)

- Desk
- Chairs
- PC
- Fax machine
- Copier/printer
- Telephone

Volunteer Morale and Resiliency

- Pre-opening briefing and reflection
- Blessing of the hands
- Post-closing debriefing
- Rotation model encouraging folks NOT to volunteer every time the doors are open

Logistical/Risk Management/Financial

- Dry run with simulated patients going through the work flow
- Planning for and simulating emergencies
    - Who will contact EMS and/or police?
    - Do these persons have easy access to the street address and contact information?
    - What entrance will be used for ambulance access? Is it stretcher accessible? Is there sufficient space for an ambulance to park nearby?
    - Using a volunteer, have the group talk/simulate their way through a variety of emergency/urgent situations
        - Disruptive patient
        - Disruptive patient requiring PD
        - Cardiac arrest
        - On cardiac arrest patient needing transport
- Church board (if applicable) support of endeavor and understanding of risk management attributes
- Actual discussion with church's insurance broker about coverage for slips and falls, etc.

Resources

- North Carolina Association of Free Clinics
    - www.ncfreeclinics.org
- National Association of Free and Charitable Clinics
    - http://www.nafcclinics.org
- Needy Meds
    - http://www.needymeds.org/free_clinics.taf?_function=list&state=nc

Appendix F
See Excel Spreadsheet attached for breakdown of inventory costs

Clinic Needs	Costs
Supplies	$ 742
Clinic Sign	$500
Estimate cost of Donated items (exam tables, partitions, etc)	$ 1000
Total	$ 2242

Appendix G

Church opens its new free clinic

Posted On 24 Sep 2015 By : WS ChronicleComment: 0

By Timothy Ramsey

For The Chronicle

The New Light Missionary Baptist Church at 1535 E. 15th St. in Winston-Salem opened its Grace Free Clinic for the first time on Saturday, Sept. 19. The clinic will provide certain health services for free and care is provided by licensed physicians, physician assistants, nurses, pharmacists and social workers.

The clinic will provide health management for chronic and acute conditions such as high blood pressure, high blood sugar and high cholesterol, to name a few.

The clinic will be open every third Saturday of the month from 9 a.m. to 1 p.m.

It is the brain child of Sam Hickerson, pastor of New Light Missionary Baptist Church and an employee for Wake Forest Baptist Medical Center, and Gary Gunderson, vice president of Faith

Health at Wake Forest Baptist Medical Center. Hickerson has long had this idea of bringing a clinic to the neighborhood because the local free clinic is overwhelmed.

Those eligible to receive help are persons over the age of 18 who do not have health insurance and live in the designated ZIP code of 27105 and neighboring communities. Those who wish to receive aid need to bring proof of address, photo ID, and a list of current medications and dosage. Transportation is also provided to those who are not able to commute. They also provide transportation to food pantries as well. One of the main goals of the clinic is to alleviate some traffic from the emergency room for non- major health issues and to catch minor health problems before they become major issues. The clinic is staffed by FaithHealth workers from all across the state as well as volunteers from New Light Missionary.

FaithHealthNC is a new initiative to improve health by forging covenants between faith communities and health care providers. Wake Forest Baptist's vice president of Faith and Health Ministries, Gary Gunderson, who came from Memphis, Tennessee, three years ago, said he wanted to come here and "bridge the gap of the African-American community and the Baptist Hospital."

Jeff Williamson, a internal medicine doctor at Wake Forest Baptist, said he spent a couple of weeks in Honduras last month giving aid to those in need and thought, '"I need to do this in my own backyard and help the people of my own community' and I hope we can do more of this."

One of the first individuals to show up to receive help was Rex Jenkins, who came to the clinic to receive antibiotics or pain pills for a tooth he had pulled last week. He works part time and does not have insurance and said, "This clinic is a big help because medication is not easy to come by and it helps a lot".

Beverly Graham, owner of the Medicap Pharmacy, partnered with the clinic to provide low cost prescriptions for as low as $4 to help individuals get the medications they need. The pharmacy will be open every day that the clinic is open. Along with the medications, Graham also helped supply the clinic with low-cost supplies as well. The pharmacy is at 1345 N. Liberty St. in Winston Salem.

For more information, call New Light Missionary Baptist Church at 336-671-3865.

For more information on FaithHealthNC, go to http://www.faithhealthnc.org/.

Appendix H
Letter of Support

Good Morning Rachel,
I am attaching my comments to your paper. The suggestions/revisions are minor. Remember to include the IRB letters as an attachment. Keep working on capturing the implementation/lessons learned and convert to past tense—be consistent throughout the paper in past tense. I believe that you can make these changes easily and support you moving on to SP III.
Excellent work!!!

Dr. Ann King, DNP, MSN, FNP-BC
Clinical Associate Professor
DNP Program
Adult/Geriatric and Family Nurse Practitioner Concentrations
Director HRSA grant "*Enhancing the Primary Care Management of Patients with Multiple Chronic Conditions through Interprofessional Education*"
East Carolina University College of Nursing
email: kingca@ecu.edu
(910) 934-6438 (cell)

East Carolina University
College of Nursing