Article

Free Clinics and the Need for Nursing Action in Uncertain Political Times

Policy, Politics, & Nursing Practice
0(0) 1–8

DOI: 10.1177/1527154418777864
journals.sagepub.com/home/ppn
SAGE

Marie Ghazal, DNP, MS, RN[1,2] and Betty Rambur, PhD, RN, FAAN[2]

Abstract

Free clinics have been a source of health care for uninsured and low-income Americans for half a century and serve some of the nation's most vulnerable within their home community. Despite parallels to nursing's significant involvement in the formation of free public clinics and commitment to care for all, there is paucity of nursing literature about free clinics. This article details the history of U.S. free clinics and the intersections among free clinics and value-based care, health reform, and tax reform, including the Patient Protection and Affordable Care Act of 2010 and the Tax Cuts and Jobs Act of 2017. Challenges impacting free clinics are detailed, as well as strategies nurses may employ to support survival of free clinics and enhance service to their target populations. Roles for nurses in free clinic governance, management, and practice are described as well as suggestions for research, education, and public policy.

Keywords

Affordable Care Act, free clinics, safety net, safety net clinics, Tax Cuts and Jobs Act of 2017, uninsured

Free clinics have been a source of health care for uninsured and low-income Americans for over 50 years, beginning with the first free clinic to open in 1967. This philosophy of care builds on nursing's significant involvement in the care of the poor and underserved in their community. Volunteer public health nurse Lillian D. Wald—the founder of modern-day public health nursing—and colleague Mary Brewster, for example, provided preventative health care, education, acute care, and long-term care for the poor in New York City tenements starting in 1893 (Ridgway, 2017). Yet, despite nursing's rich history of providing care to some of the nation's most vulnerable populations within their home community, there is a lack of literature that details policy and practice actions nurses can take to support a contemporary model of such care, free clinics. This article aims to address that gap. What follows, therefore, is a description and brief history of free clinics; details about their value in a shifting political landscape inclusive of health and tax reform; and implications for nursing education, practice, and policy.

Definition, History, and Current Status

Free clinics operate as independent 501(c)(3) tax-exempt organizations, or as affiliates of one, and rely on donations, fund-raising, and grant support to provide a range of medical, preventive, behavioral, dental, and pharmaceutical services. Services are primarily delivered through volunteers, students, and partnerships for in-kind services. Although by definition, all services are free of charge to patients who seek care, a nominal fee may be charged or a donation accepted. Most free clinics have income limits that potential patients must not exceed to be eligible for services. Thus, they treat the uninsured and underinsured who fall within those specific low-income brackets. For tax purposes, free clinics are categorized as "free and charitable" by the U.S. Internal

[1]Rhode Island Free Clinic, Providence, RI, USA
[2]College of Nursing, University of Rhode Island, Kingston, RI, USA

Corresponding Author:
Marie Ghazal, Rhode Island Free Clinic, 655 Broad Street, Providence, RI 02907, USA.
Email: mghazal@rifreeclinic.org

Revenue Service. The latter term, *charitable*, is used to encompass clinics that accept a donation at the time of a patient visit or use a low-cost sliding fee scale. The National Association of Free and Charitable Clinics, an organizing body that advocates for issues and needs of members, reported that in 2016 approximately 1,200 free and charitable clinics provided care to 1.8 million individual patients in 6 million visits. To provide this care they mobilized 190,000 volunteers, which included 94,000 health care providers and 96,000 non–health care personnel (National Association of Free and Charitable Clinics, 2017).

In contrast to free clinics, Federally Qualified Health Centers (FQHCs) receive enhanced Medicare and Medicaid reimbursement and must serve an underserved population (Health Resources and Services Administration, 2018). Examples of FQHCs include community health centers, migrant health centers, health care for the homeless centers, and public housing primary care centers (National Association of Community Health Centers, 2016). Like free clinics, these nonprofit, community-directed health care providers serve low-income and medically underserved communities. FQHCs, however, are staffed by paid clinicians and employees. In contrast, free clinics are not federally funded, generally do not bill for services, and are staffed primarily by volunteers.

The first contemporary free clinic, the Haight-Ashbury Free Medical Clinic, opened during the summer of 1967 in San Francisco, California, to address the acute emergencies of drug abuse among adolescents. The clinic soon expanded as a general medical clinic for adolescents and young adults, who were deemed to be a needy ''hippie'' subculture by clinic founders (Smith & Rose, 1968). Building on the success of the Haight-Ashbury Free Medical Clinic, and consistent with the social milieu of that era's ''Great Society'' movement that spawned an array of programs targeting poverty and inequity—for example, food stamps (now called Supplemental Nutrition Assistance Program), the launch of Medicare for the elderly and Medicaid for the poor, Head Start, Job Corps, and Community Health Centers to name but a few—59 more free clinics opened between 1967 and 1969.

By 1971, a total of 135 new free clinics were operating in the United States, of which 42, the largest number in any state, were located in California. Schwartz (1971), in the first national survey of free clinics, concluded that they offered an innovative model of care to a needy population and were a manifestation of broad societal change. Stoeckle, Anderson, Page, and Brenner (1972) further described free clinics not only as settings for community-based health services for underserved people, particularly youth and ethnic minorities, but also as agents of organizational reforms and political acts to influence education, care, and treatment. They suggested that the free clinic approach of open access, simplified care, and other practices might be adapted and reinvented to serve a broader range of needs than just health care (Toms & Walker, 1973). Later authors cite free clinics as vital to the health care safety net (Geller, Taylor, & Scott, 2004). Over the years, free clinics became known as places of valuable care offered by retired physicians, nurses, and nurse practitioners (NPs; Johnson, 2010; Reynolds, 2009; Wells, 2010; Wilson, Lester, & Simson, 2000) and, more recently, as places that benefit both the community and the volunteers personally as they develop greater understanding of issues facing underserved populations (Gorski et al., 2017). The most recent census of free clinics reported operations in 49 states and the District of Columbia. Services offered typically include chronic disease management, physical examinations, acute and urgent care, provision of medications, and medication management (Darnell, 2010).

Why Do Free Clinics Exist?

The U.S. health care system is recognized as the costliest system in the world and one that does not guarantee access to all Americans (Schneider, Sarnak, Squires, Shah, & Doty, 2017). Free clinics have evolved to address gaps in care and, as their history describes, serve populations unable to afford or access health care. These individuals may also use FQHCs, emergency rooms, or other services; yet, the free clinic may be their first entry into the health care system.

Although one of the principle goals of the Patient Protection and Affordable Care Act (ACA) of 2010 was to decrease the number of uninsured and therefore potentially directly impact the need for free clinics, the data thus far suggest ongoing need for free clinic services. States that opted to expand Medicaid coverage have cut their uninsured rates in half, from 18.4% in 2013 to 9.2% in 2016 (Frostenson, 2016), but states that opted out of the expansion continue to have high rates of uninsured visits to health care facilities (Angier et al., 2015). Still other groups never gained access to ACA-supported options for health insurance. Undocumented immigrants, for example, were excluded, with only those ''lawfully present'' eligible for ACA-supported coverage starting January 1, 2014 (National Immigration Law Center, n.d.). Thus, the need for free clinic services continued even after passage of the ACA.

The need for free clinic services likely will accelerate. Specifically, the 2016 congressional and presidential elections dramatically altered the ACA-directed path toward universal health insurance coverage, with outcomes that directly impact low-income individuals and families. Cost-sharing reductions, for example, an element of the ACA that enabled insurance companies to lower the cost

of insurance premiums for eligible low-income individuals and families, were eliminated by President Trump through an executive order—a presidential action with the force of law—on October 12, 2017 (Pear, Haberman, & Abelson, 2017). Estimated to cost the nation $7 billion in 2017 and rise to $16 billion in 2027 (Congressional Budget Office, 2017), these funds were designed to reimburse insurance companies for reducing the amount of cost sharing—copayments, coinsurance, and deductibles—that would otherwise be borne by low-income individuals and families purchasing health insurance in the individual market exchange. Although the percent of individual market enrollees benefiting from the cost-sharing reductions varies by state, nationwide 57% of those in the individual exchange market in 2017 benefited from cost-sharing reductions (Kaiser Family Foundation, 2017). At the time that this article went to press (April 2018), reductions in cost-sharing payments were not expected to be reinstated (Luthi, 2018). This will likely result in a 19% average increase in the cost of health insurance premiums for those low-income individuals who had previously benefitted from the ACA insurance cost-sharing provisions (Kamal, Semanskee, Long, Claxton, & Levitt, 2017). In the long run, this will lead to a decrease in the number of people able to afford health insurance and an increase in the number of insurance companies exiting the exchange marketplace due to shifting rules and marketplace uncertainty.

Cuts in cost-sharing reductions are just one of several contemporary policy actions that impact the cost and availability of health insurance and thus reinforce the value of free clinics. The massive tax reform bill signed in to law by President Trump on December 22, 2017 is another. The Tax Cuts and Better Jobs Act of 2017 effectively removed the ACA individual mandate that required all Americans to have health insurance or pay a penalty. Although the overall impact of these policy changes and others yet to come is uncertain, several trends are clear; it is likely that fewer will have health insurance, and more will be underinsured or inhibited from seeking care in more traditional settings because of high cost sharing. Potential cuts to entitlement programs, such as Medicare and Medicaid, lurk in political dialogues about the burden of rising health care costs for state and federal governments. Thus, regardless of ongoing health policies and politics, many people will not be able to afford care. Free clinics can help fill this void, and nursing action is needed to support their vibrancy.

Implications for Nurses

Nurses' long history in public health advocacy and commitment to reducing disparities (Giger et al., 2007) highlights key free clinic roles for nurses. These include serving as advocates and ambassadors at community and policy levels and through direct clinical participation as providers within free clinic settings. In addition, partnerships among free clinics and an array of value-based settings such as patient-centered medical homes and accountable care organizations (ACOs) offer nurses new ways to support free clinics while sharpening highly valued contemporary skills and abilities (Randall, Crawford, Currie, River, & Betihavas, 2017). These opportunities will be discussed in turn, as well as new threats to the survival of free clinics stemming from the 2017 revision of the U.S. tax code effective 2018 and onward.

Advocacy

As a first step, nurses can expand their awareness of free clinics in their community, state, and region. This can be done by researching local health resources for the uninsured or by contacting the National Association of Free and Charitable Clinics. Information about each clinic is available on the association's website and may illustrate particular opportunities for nurse advocacy and involvement.

Governing board engagement by nurses is particularly important to free clinics, as nurses can powerfully articulate the role of free clinics to nonclinical governing board members and those unfamiliar with the particular challenges of people within the free clinic service region. Moreover, taking the next step to serve as a free clinic governing board member offers valuable career development for nurses. As a local community resource largely dependent on local support, free clinic board members are influential ambassadors who offer needed connections, visibility, programs, and financial support. In addition, a variety of skills are required to promote evidence-based integrated care, manage staff and volunteers, secure grants, develop partnerships, and cultivate donors. These broad skill sets are an ideal match for nurses at both the management and governance levels; indeed, innovative nurse leaders can create opportunities for free clinics despite the many challenges inherent in volunteer programs, limited resources, and dependency on donors and grants.

Nurses can also influence policies and practices that directly affect free clinics. On the federal level, nurses' policy advocacy directed to their congressional delegations for ongoing support of the Free Clinic Federal Tort Claims Act (FTCA) Program (Section 224(o) of the Public Health Service Act) is particularly valuable. The FTCA program protects free clinics' qualifying volunteer workforce in a manner similar to malpractice insurance. It covers harm including patient death that is a result of medical, surgical, dental, or related functions performed by any free clinic volunteer health care practitioner,

board member, officer, employee, or independent contractor (Health Resources & Services Administration, n.d.). Without such coverage, many potential volunteers are unwilling or unable to commit to free clinic work, and the clinics could not otherwise provide malpractice coverage or finance it. Nurses' advocacy through calls, e-mails, or letters to their congressional delegation to encourage sustained funding of the FTCA program offers a simple yet sound strategy to support viability of free clinics.

Other advocacy avenues that benefit free clinics have implications to the broader nursing workforce and the nation's health system at large. An example is removal of state restrictions that impede full practice authority. Richards and Polsky (2016), for example, used the ''secret shopper'' methodology to determine wait times for new patient primary care visits and found that states with a broader NP scope of practice had more ready access to primary care. Full NP scope of practice in every state could enhance primary care access though increased free clinic utilization of comprehensive NP services.

Practice

With regard to practice, there are opportunities for nurses to advance the sustainability of free clinics while concurrently enhancing their career trajectory. Volunteerism by registered nurses and advanced practice nurses provides an opportunity to practice in a community setting in part-time positions and fulfill occasional roles. The latter can be particularly attractive to nurses who wish to maintain expertise but do not want the commitment of a regular, paid position due to family or other obligations. Nurses who are phasing toward retirement or who seek practice hours for licensure renewal after their license has lapsed are also a potentially rich source of volunteer support. As they renew and refresh their career, they simultaneously expand free clinic capacity and enhance access to care for vulnerable populations.

Free clinics also offer hospital-based nurses who wish to gain experience in primary care an important practice opportunity. The growing mismatch between many nurses' acute care orientation and experiences and emerging primary care needs (Wojnar & Whelan, 2017) creates new avenues for partnerships that meet the workforce needs of free clinics while contributing to ongoing professional development of nurses. Faculty might volunteer in free clinics and bring students there for practice experiences, providing student skill-building caring for individuals and families with acute, emergent, and chronic conditions. This approach also creates valuable practice experiences in a venue that can foster students' understanding of social determinants of health. It also offers learning opportunities in care management and community network development, important nursing skills that may not be easily accessed in traditional inpatient settings.

Finally, free clinics depend on volunteers, which require thought and persistence. Not only do free clinics develop systems to recruit, retain, and manage volunteers, they create innovative relationships to build their volunteer capacity. Coordinating volunteers is a complex and often delicate undertaking because adequate free clinic staffing requires a steady flow and deep bench of individuals whose availability may fluctuate due to other responsibilities and commitments. Nurses can use their organizational skills to provide volunteer coordination expertise to free clinics, regardless of their licensure status.

Value-Based Care Brings New Opportunities to Nurses and Free Clinics

Although embedded within a community and reflecting its values and characteristics, free clinics have traditionally operated somewhat independently of mainstream health care. Yet, to improve population health, strong ties among hospitals, home health agencies, and other services are necessary. As comprehensive value-based care becomes increasingly pervasive, free clinics may be involved with organizations assuming accountability for outcomes of care, such as advanced primary care patient-centered medical homes; those taking accountability for outcomes and population costs of care, such as ACOs; or those receiving bundled payments, a single payment for an entire episode of care across the care continuum. These new opportunities for free clinics also present challenges; free clinics traditionally have provided episodic care rather than longitudinally coordinated case-managed care and specialty care. Nurses with care management expertise or within alternative payment delivery models such as PMCHs, ACOs, and bundled payment have the potential to shape the evolution of free clinics toward novel partnerships with entities delivering care within these value-based configurations.

Partnerships with such value-based care models also require complex measurement and analytics infrastructures to enable the required tracking of outcomes. Sustained and consistent tracking of metrics is a challenge for many free clinics because the cost of the enabling information technology hardware, software, and staffing is prohibitive. Nevertheless, it is a particularly inviting time for health systems in new payment models such as bundled payments and risk-bearing ACOs, to partner with free clinics. Notably, a risk-bearing ACO accepts accountability for the *total cost of care* for a population. As such, the ACO has a

marked financial incentive to assure that effective care is available in the least expensive community setting. Similarly, bundled payments reimburse entities at a fixed rate, regardless of the amount of resources used.

In January 2018, the U.S. Department of Health and Human Services announced 32 new bundles; all require quality metrics inclusive of all-cause inpatient readmissions (Castellucci, 2018). This is one example of a metric that free clinics can positively impact. Optimally, management of patient conditions at free clinics would reduce inpatient hospitalizations and readmissions—both of which are outcomes of significance to both ACOs and bundled payment entities. Care by free clinic volunteers that is coordinated with hospitals and other health services has been found to decrease preventable inpatient stays, inpatient readmissions, and emergency department use (Garner, 2016). This ultimately leads to reduced visits by the uninsured, lower costs (Hwang, Liao, Griffin, & Foley, 2012), and a more reasonable level of hospital charity care. Subsequent to any hospitalization (and prior, when possible), uninsured patients can be referred to free clinics, which can reduce avoidable readmissions by linking the uninsured individual with a primary care provider for oversight throughout an episode of care and beyond.

This handoff, however, requires that mainstream providers have a heightened awareness of free clinic services, including free clinic strengths and limitations. Culturally adept education and preventative services, for example, are often more readily available in free clinics than mainstream providers because they are generally nested within a community and reflect the community's culture and values. Typically, free clinic providers also have a heightened awareness of other services available to the low-income individuals they serve and an appreciation of barriers to care, such as homelessness or lack of transportation. Nurses, therefore, regardless of their practice setting or role, can appreciate the issues involved in providing frontline community-based care and then craft care pathways, inclusive of free clinics services, as appropriate, for individuals and families.

Health Information Technology Skills and Free Clinics

Nurses can also offer free clinics their valuable expertise in areas that augment direct patient care. This includes patient education, motivational interviewing, patient navigation, case management, and health information technology (HIT). These volunteered efforts by nurses can create an impact throughout the free clinic system of care. To illustrate using HIT as an example, electronic health records support communication among providers, facilitate the interface of free clinics with area health agencies and systems, and enable free clinics to be part of a seamless system of care. These networks support the timely flow of information among care sites and were deemed integral to the positive outcomes heretofore cited (Garner, 2016).

Electronic health records can also support medication reconciliation among settings and episodes of care. Yet, the cost of information technology is a prohibitive factor for many free clinics, as are issues of rapid obsolescence and interoperability. Nurses who are proficient in the deployment of HIT thus provide a valuable resource for the advancement of technology in free clinics. Taken as a whole, there are many ways nurse volunteers can support the mission of free clinics. Nurse volunteerism has the potential to improve how nurses engage with their communities, expand the role of nurses as public health professionals, and foster the social desirability of healthful living (McCollum, Kiolver, Ojemeni, Brewer, & Cohen, 2017).

Free Clinics and Nursing Research

Research by nurses to explore the value, contribution, and challenges of free clinics can offer novel perspectives that support empirically-based policy development, organizational design, and—optimally—best practices toward sustainability of high-quality free clinics. Rich, untapped areas of inquiry include these questions:

(a) What are the costs and outcomes of matched individuals who are served by free clinics and those who live in regions that lack them?
(b) How does the use of free clinics vary through state expansion and contraction of Medicaid status?
(c) How might Medicaid work requirements—such as those approved in Kentucky, Indiana, and Arkansas in the first quarter of 2018 (Abutaleb, 2018); in formal review in seven states, Arizona, Kansas, Maine, Mississippi, New Hampshire, Utah, and Wisconsin (Kaiser Family Foundation, 2017); and planned by governors in at least four states, Alabama, Louisiana, South Carolina, and South Dakota (Williams, 2018)—impact free clinic use?
(d) What are the predictors of retention among volunteers?
(e) What workplace conditions enhance retention of volunteers?
(f) Are nursing students who are socialized within free clinic environments more likely to serve vulnerable populations after graduation?
(g) Are baccalaureate nursing students who are socialized in the primary care environment offered by free clinics more likely to work in primary care upon graduation?

Table 1. Impact of Current Policies Changes on Free Clinics.

Policy action	Potential impact on free clinics
Presidential Executive Order eliminated cost-sharing reduction payments to insurance companies.	1) Higher health insurance premium costs are then passed from the insurance company to the impacted public → reduction in the affordability of health insurance → increase in the number of uninsured → increased demand for free clinic services[a] AND 2) Insurance market volatility and uncertainty → insurance companies leave the health insurance marketplace → fewer, or in some cases zero, insurance products remain in a state's health insurance exchange → increase in the number of uninsured → increased demand for free clinic services[a]
Medicaid work requirement, a state-led process requiring federal approval. Specifically, a federal agency, the U.S. Centers for Medicare and Medicaid Services (CMS), provided Section 1115 waiver guidance to state Medicaid directors. If sought by the state and approved by CMS, work requirements, termed *community engagement*, are a condition for Medicaid eligibility.	Individuals cannot meet the work requirements and lose Medicaid coverage → increase in uninsured → increased demand for free clinic services[a]
Tax Cuts and Better Jobs Act of 2017	1a) Increase in the standard deduction for income tax decreases the incentive for charitable giving as a form of tax relief → decrease in charitable giving→increased financial strain on free clinics OR 1b) Tax relief → greater after-tax earnings and disposable income among wealthier American → increase in charitable giving → decreased financial strain on free clinics 2) Elimination of the tax penalty the ACA imposed when not insured → increase in the numbers of uninsured → increased demand for free clinic services[a]
Free Clinic Federal Tort Claims Act Program (Section 224(o) of the Public Health Service Act).	Expanded by the ACA to include volunteers in free clinics, funding covers the cost of volunteers' medical malpractice insurance, a necessary element when recruiting volunteers

Note. ACA = Affordable Care Act.
aAn increased demand for free clinic services can only be met if there are new sources of revenue and human capital to meet it.

Trends, Challenges, and Public Policy

Despite advantages of free clinics, threats to their survival include uncertain revenue streams, reliance on a voluntary workforce (Brennan, 2013) and—more recently—questions about ongoing need in an era of ACA health reform. This last concern has been squelched by the orientation of the current Republican-controlled House, Senate, and White House and the dismantling of a key pillar of the ACA, the individual mandate, leaving an uncertain future for the elements of the ACA that remain law. (See Table 1 for a summary of recent policy changes potential impact on free clinics).

Tax reform has also created a new threat to free clinics and many other charitable organizations. The free clinic model is dependent on philanthropic funding streams and typically receives little or no regular government support (Ameringer & Liebert, 2017). Although nurses can help address these threats by contributing to the fund-raising efforts of free clinics, mobilizing other resources (e.g., physical therapy provided by students under supervision, nutrition counseling by dietetics majors), by volunteering, and by recruiting others to advocate and volunteer, the 2017 Tax Cuts and Jobs Act in effect for the 2018 tax season and onward and is expected to dramatically impact Americans' philanthropy. Specifically, the tax law raises the standard tax deduction, the portion of the U.S. taxpayer's income that is not subject to taxation. As a result, it is estimated that 21 million (Gleckman, 2018, January 11) to 30 million (Lieberman, 2017) more Americans will file their income taxes using the standard deduction rather than itemizing deductions because itemizing will no longer offer greater tax relief than simply taking the standard deduction. Lieberman (2017) suggests that—although end-of-year charitable giving has become a staple in many American's lives—as the tax advantage related to itemization evaporates and so, too, will a proportion of the

contributions to charities, particularly impacting organizations whose contributions are garnered from ''middle-class Americans'' (para 6). The overall impact of the U.S. tax bill on charitable giving to free clinics is unknown but represents a disconcerting new threat to their financial viability.

State or federal policies that offer tax relief for volunteer activity could redress this loss of funding through incentivizing volunteer services, but this approach is a nonstarter at the federal level and a very difficult ''sell'' in fiscally challenged states in dire need of tax revenue to meet existing obligations. One promising avenue is to carefully trace the impact of free clinics on state Medicaid costs. A demonstrated inverse relationship between free clinic utilization and Medicaid costs (more free clinics, lower Medicaid costs) would provide valuable empirical evidence for state and federal policy formation.

Conclusion

For over a century, nurses have been at the forefront of public health leading the nation's care for the most vulnerable. Free clinics have served as a significant part of this safety net. In light of ongoing health policy uncertainties, political impetus toward decreased government spending on Medicare and Medicaid, and the likelihood of an increasing uninsured U.S. population in the foreseeable future, free clinics will be necessary to serve some of the nation's neediest and most vulnerable individuals and families. The sustainability of free clinics depends on public policies that support their long-term financial viability (Hacker et al., 2014) and nurses' knowledge and actions. Awareness of free clinics, ongoing advocacy, care network formation inclusive of free clinics, and commitments of time, expertise, and money by nurses offers an important contribution to American society at this uncertain time in U.S. health care policy and practice.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

Abutaleb, Y. (2018, March 5). Arkansas become third U.S. state to add Medicaid work requirement. *Reuters*. Retrieved from https://www.reuters.com/article/us-usa-healthcare-arkansas/arkansas-becomes-third-u-s-state-to-add-medicaid-work-requirements-idUSKBN1GH2PN.

Ameringer, C. F., & Liebert, S. (2017). Free clinics as safety net providers for Hispanic immigrants. *Public Administration Review*, *77*(2), 310–311. doi:10.1111/puar.12720.

Angier, H., Hoopes, M., Gold, R., Bailey, S. R., Cottrell, E. K., Heintzman, J., . . . ,DeVoe, J. E. (2015). An early look at rates of uninsured safety net clinic visits after the Affordable Care Act. *Annals of Family Medicine*, *13*(1), 10–16. doi:10.1370/afm.1741.

Brennan, V. M. (2013). *Free clinics: Local responses to health care needs*. Baltimore, MD: Johns Hopkins University Press.

Bureau of Primary Health Care, Health Resources & Services Administration. (2017). *Free clinics*. Retrieved from https://bphc.hrsa.gov/ftca/freeclinics/index.html.

Castellucci, M. (2018, January 9). CMS launches new voluntary bundled-payment model. *Modern Healthcare*. Retrieved from http://www.modernhealthcare.com/article/20180109/NEWS/180109905/cms-launches-new-voluntary-bundled-payment-model.

Congressional Budget Office. (2017). *Federal subsidies under the affordable care act for health insurance coverage related to the expansion of Medicaid and nongroup health insurance: Tables from CBO's January 2017 baseline*. Retrieved from https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

Darnell, J. S. (2010). Free clinics in the United States: A nationwide survey. *Archives of Internal Medicine*, *170*(11), 946–953. doi:10.1001/archinternmed.2010.107.

Frostenson, S. (2016, September 7). For the first time ever, America's uninsured rate has fallen below nine percent. *Vox*. Retrieved from https://www.vox.com/2016/9/7/12815076/america-uninsured-rate-dropped.

Garner, C. (2016). The value of free clinics. *Nursing Management*, *47*(10), 16–17. doi:10.1097/01.NUMA.0000499565.79892.48.

Geller, S., Taylor, B. M., & Scott, H. D. (2004). Free clinics helping to patch the safety net. *Journal of Health Care for the Poor and Underserved*, *15*(1), 42–51.

Giger, J., Davidhizar, R., Purnell, L., Taylor Harden, J., Philips, J., & Strickland, O. (2007). American Academy of Nursing Expert Panel report: Eliminate health disparities in ethnic and other vulnerable populations. *Journal of Transcultural Nursing*, *18*(2), 95–102. doi:10.1177/1043659606298618.

Gleckman, H. (2018, January 11). 21 million taxpayers will stop taking charitable deductions under the new tax law. *Forbes*. Retrieved from https://www.forbes.com/sites/beltway/2018/01/11/21-million-taxpayers-will-stop-taking-charitable-deductions-under-the-new-tax-law/#735ad8cd238f.

Gorski, H., Gull, B., Harris, T., Garfield, T., Ashby, J., & Kamimura, A. (2017). Volunteer experiences at a free clinic in the United States: A qualitative study. *Diversity & Equality in Health and Care*, *14*(3), 130–135.

Hacker, K., Santos, P., Thompson, D., Stout, S. S., Bearse, A., & Mechanic, R. E. (2014). Early experience of a safety net provider reorganizing into an accountable care organization. *Journal of Health Politics, Policy and Law*, *39*(4), 901–917. doi:10.1215/03616878-2744284.

Health Resources and Services Administration. (2018). *Federally qualified health centers*. Retrieved from https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html.

Health Resources and Services Administration. (n.d.). *What is the Federal Tort Claims Act and how does it apply to my free clinic?* Retrieved from https://bphc.hrsa.gov/ftca/freeclinics/ftcafcfaqs.html.

Hwang, W., Liao, K., Griffin, L., & Foley, K. L. (2012). Do free clinics reduce unnecessary emergency department visits? The Virginian experience. *Journal of Health Care for the Poor and Underserved*, *23*(3), 1189–1204. doi:10.1353/hpu.2012.0121.

Johnson, J. (2010). Free medical clinics keeping healthcare afloat. *The Nurse Practitioner*, *35*(12), 43–45. doi:10.1097/01.NPR.0000390437.90380.29.

Kaiser Family Foundation. (2017). *Total marketplace enrollment and financial assistance*. Retrieved from https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

Kamal, R., Semanskee, A., Long, M., Claxton, C., & Levitt, L. (2017). *How the loss of cost-sharing subsidy payments is affecting 2018 premiums?* San Francisco, CA: Kaiser Family Foundation. Retrieved from https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

Lieberman, L., as interviewed by King, N. (2017, December 27). New tax overhaul law has serious implication for non-profits. *National Public Radi*o. Retrieved from https://www.npr.org/2017/12/27/573739695/new-tax-overhaul-law-has-serious-implications-for-non-profits.

Luthi, S. (2018, April 5). Is silver-loading the silver bullet? Actuaries wary of the long-term impact of cost sharing reduction cutoff. *Modern Healthcare*. Retrieved from http://www.modernhealthcare.com/article/20180405/NEWS/180409943?utm_source=modernhealthcare&utm_medium=email&utm_content=20180405-NEWS-180409943&utm_campaign=am.

McCollum, M., Kovner, C. T., Ojemeni, M., Brewer, C., & Cohen, S. (2017). Nurses improve their communities' health where they live, learn, work, and play. *Policy, Politics, & Nursing Practice*, *18*(1), 7–16. doi:10.1177/1527154417698142.

National Association of Community Health Centers. (2016). *America's health centers*. Retrieved from http://www.nachc.org/wp-content/uploads/2015/06/Americas-Health-Centers-March-2016.pdf.

National Association of Free & Charitable Clinics. (2017). *The National Association of Free & Charitable Clinics*. Retrieved from http://www.nafcclinics.org/.

National Immigration Law Center. (n.d.). *Affordable Care Act (Obamacare)*. Retrieved from https://www.nilc.org/issues/health-care/acafacts/.

Pear, R., Haberman, M., & Abelson, R. (2017, October 12). Trump to scrap critical health care subsidies, hitting Obamacare again. *The New York Times*. Retrieved from https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html.

Randall, S., Crawford, T., Currie, J., River, J., & Betihavas, V. (2017). Impact of community based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. *International Journal of Nursing Studies*, *73*, 24–33. doi:10.1016/j.ijnurstu.2017.05.008.

Reynolds, H. Y. (2009). Free medical clinics: Helping indigent patients and dealing with emerging health care needs. *Academic Medicine: Journal of the Association of American Medical Colleges*, *84*(10), 1434–1439. doi:10.1097/ACM.0b013e3181b6c3eb.

Richards, M., & Polsky, D. (2016). Influence of provider mix and regulation on primary care services supplied to US patients. *Health Econ Policy Law*, *11*(2), 193–213. doi:10.1017/S1744133115000390.

Ridgway, S. (2017). Profiles in nursing, Lillian Wald, founded public health nursing. *Working Nurse*. Retrieved from http://www.workingnurse.com/articles/lillian-wald-founded-public-health-nursing.

Schneider, E. C., Sarnak, D. O., Squires, D., Shah, A., & Doty, M. M. (2017). *Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care*. Retrieved from http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017.

Schwartz, J. L. (1971). First national survey of free medical clinics 1967-69. *HSMHA Health Reports*, *86*(9), 775–787.

Smith, D., & Rose, A. (1968). Observations in the Haight-Ashbury medical clinic of San Francisco: Health problems in a "Hippie" subculture. *Clinical Pediatrics*, *7*(6), 313–316. doi:10.1177/000992286800700604.

Stoeckle, J. D., Anderson, W. H., Page, J., & Brenner, J. (1972). The free medical clinics. *JAMA*, *219*(5), 603–605. doi:10.1001/jama.1972.03190310033008.

Toms, K. M., & Walker, F. M. (1973). A free clinic for the working poor. *Nursing Outlook*, *21*(12), 770–772.

Wells, M. (2010). Will reform mean the end of free healthcare clinics? *The Nurse Practitioner*, *35*(11), 6. doi:10.1097/01.NPR.0000389050.93028.04.

Williams, M. (2018, February 1). More states jump on Medicaid work requirements bandwagon. *Roll Call*. Retrieved from https://www.rollcall.com/news/policy/states-jump-medicaid-work-requirements-bandwagon.

Wilson, L. B., Lester, L., & Simson, S. P. (2000). Assessing the involvement of retired health professionals in meeting the needs of underserved populations. *Nursing Outlook*, *48*(1), 34–39. doi:10.1067/mno.2000.98119.

Wojnar, D. M., & Whelan, E. M. (2017). Preparing nursing students for enhanced roles in primary care: The current state of prelicensure and RN-to-BSN education. *Nursing Outlook*, *65*(2), 222–232. doi:10.1016/j.outlook.2016.10.006.

Author Biographies

Marie Ghazal is the chief executive officer at the Rhode Island Free Clinic, Providence Rhode Island.

Betty Rambur is the Routhier Endowed Chair for practice and professor of nursing at the University of Rhode Island.