

## Research Article

# The Perspectives of Non-Profit Social Service Organizations on the Value and Scope of Free Clinic Services: A Qualitative Study

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## ABSTRACT

**Introduction:** Approximately 1 in 11 people are uninsured in the United States. For many that are uninsured with limited health care resources, free clinics may be their only opportunity to seek care. The purpose of this study is to explore the needs of the community through the perspectives of representatives from nonprofit social service organizations that have worked with a free clinic.

**Methods:** Four focus groups were conducted at a free clinic with 20 participants in October-November in 2016. Thematic analysis was performed to identify themes in issues relating to health, most urgent health issues, and ways to improve services for the underserved populations.

**Results:** The free clinic represents a form of community support that could significantly benefit from increased inter-organizational partnerships. Nonprofit social service agencies are particularly well suited to work with free clinics to ensure

that emerging health issues in underserved populations are given proper attention. In addition, a number of non-health issues such as lack of affordable housing and health literacy are directly impacting the wellness of the community the clinic serves.

**Discussion:** Focus group results indicate a wide range of health and non-health issues which are affecting the wellness of the underserved populations. Nonprofit social service organizations and free clinics are encouraged to bridge resources and prevent duplicate efforts to increase feasibility for the common goal of improving community health outcomes.

**Conclusion:** Future studies should implement and evaluate such inter-organizational collaborations. Future works should also examine the impact of the collaborations on access to care and health outcomes among underserved populations.

**Keywords:** Community capacity; Free clinics; Social capital; Underserved population

## Key points:

### What is known about this topic?

- The majority of free clinic patients are socio-economically disadvantaged with little or no income and at increased risk for various health concerns including physical health functioning, oral health and depression in the US.
- For many of the uninsured who have geographical access to a free clinic, free clinics may be their only opportunity to seek preventive care and treatment.
- Community support and volunteer labor are essential roles in the safety net clinic system.

### What the paper adds?

- The free clinic represents a form of community support that could significantly benefit from increased inter-organizational partnerships.
- The underserved populations utilizing a free clinic have a wide range of unmet health needs.
- A rise of non-health issues such as lack of affordable housing, language barriers, and low health literacy may directly affect the wellness of that the clinic serves.

## Introduction

Access to care is an important health determinant [1,2]. People with limited access to care tend to have poor health outcomes [3-5]. Although the rate of the uninsured has decreased after the Affordable Care Act was enacted in 2014, the US Census reported approximately 9% of the population was still

uninsured in 2015 [6,7]. For many of the uninsured who have geographical access to a free clinic, free clinics may be their only opportunity to seek preventive care and treatment due to limited health care resources [8]. In general, the majority of free clinic patients are socio-economically disadvantaged with little or no income and at increased risk for various health concerns including poor physical health functioning, oral health issues,

and depression [8,9]. According to a nationally sampled study, nearly 1 in 4 free clinic patients reported they would not seek care if free clinics did not exist [10].

The oldest free clinics have been in operation since the 1950s [11]. Currently, there are over 1200 free clinics operating in the United States [12]. Free clinics depend upon the philanthropic services provided by volunteer health care providers including physicians, nurses, lab technicians, and non-clinical volunteers [13]. Free clinics often face financial challenges, are operating on small budgets, and are dependent on individual charitable contributions: thus free clinics heavily rely on community support such as volunteer medical professionals [10,11]. Most free clinics do not have resources to provide comprehensive care [8]. Hence, the consistency of quality of care varies [14]. Nonetheless, free clinics are extremely valuable and serve as a medical home to many underserved populations including low income families, immigrants, refugees and individuals experiencing homelessness.

In brief, community support and volunteers are essential resources in the safety net clinic system. The web of cooperative relationships between community members facilitates a collective problem-solving resolution for the community. This phenomenon has been described as social capital [15]. Research shows social capital mediates the relationship between income inequality and mortality [16]. Additionally, neighborhood deprivation is inversely linked with community bonding such as social cohesion and civic participation [17]. Through the lens of social capital theory, the collective good of a community can be “spilled over” to those who lack access to resources [18]. In this regard, social support, provided by free clinics, is a collective good for the community. Free clinics contribute to increasing access to health care services among underserved populations in the community.

In addition to social capital, community capacity is important for free clinics to better serve patients. Community capacity is defined as the characteristics, skills and resources needed to empower community change and is both a process and an outcome of a community change [19,20]. To build community capacity, the following factors are essential: participation by community members; leadership; skills and resources; inter-organizational networks; a sense of connectedness; an understanding of community history; community power; values; and critical reflection within the community [19,21-23]. Enhancing community capacity empowers individuals to be proactive and positively change in their own lives [24]. Community capacity sustains the effect of community partnership, and thereby influences the determinants of health and overall wellness in the community [25]. In practice, collaborative work between nonprofit social service organizations and healthcare professionals can leverage existing resources, prevent duplicate efforts, and increase efficiency, thus increase the maximum potential to meet the needs of underserved populations. This is particularly relevant for volunteer-dependent nonprofit organizations including free clinics where resources are severely limited.

The importance of social capital and community support has been repeatedly documented in literature. Leveraging

social capital and building community capacity can benefit the community as a whole [17-20]. Specifically, community organizations can create vehicles for self-reflection, identify common issues, and form health alliances that can improve community health [19,26,27]. Therefore, it is important to examine perspectives of nonprofit social service organization representatives on the needs and expectations for a free clinic.

The purpose of this study is to explore community needs for free clinics through the perspectives of representatives from nonprofit social service agencies which are partners of the clinic. The overarching goal is to examine potential areas of improvement that can be made in how a free clinic responds to community health needs. In exploring these community partners, the mutual interests and common community health-related issues identified by the social service agency representatives can be utilized to develop future interventions for free clinics and other agencies which work with underserved populations, and to improve quality of service and community health outcomes. This study utilizes focus groups to explore topics in depth rather than quantitative surveys. Particularly, focus groups offer participants an opportunity to interact with other individuals involved in a specific endeavor and exploit an open dialogue [28].

## Methods

### Overview

The free clinic in which the study was carried out is located in an urban area in the intermountain west. The non-profit clinic began serving uninsured low-income individuals and families in 2005. The clinic is funded by donations and non-governmental grants and aims to “reverse the cycle of poverty and suffering created by poor health” by providing free to low-cost care [29]. A range of services are offered at the free clinic, including preventative care, a diabetic specialty program, and health education. In 2015, the majority of the patients at the free clinic were between ages 31-64 [29]. Over 300 volunteers and six full-time paid staff keep the clinic open five days a week. The clinic had 16,166 patient visits in 2015. Approximately half of the clinic patients are Spanish speakers. The principal investigator of this study (AK) has had a research and educational collaboration with the clinic since May 2012.

### Study procedure

This study was approved by the University of Utah Institutional Review Board (IRB). The target population for this study was community service providers such as professionals in the fields of social services, health services, and other clinical settings who are employed at nonprofit social service organizations that partners with the free clinic. Recruitment for these representatives began approximately three weeks prior to the first focus group. Prospective participants received an email about the study and were invited to sign up for one of the four available focus group times. Four focus groups were conducted at the free clinic in October-November 2016. Focus groups were held during lunch hour and each lasted between 60-90 minutes. Participants were given a free lunch as well as a \$20 gift card to a local grocery store.

A focus group guide was developed by the research team and the staff of the clinic based on the previous studies conducted at the clinic and literature review. The guide (Appendix A) included 5 questions focusing on social capital (i.e., “How can you and the [clinic] work together to better serve the community?”) and 4 questions on community capacity (i.e., “If the [clinic] is to expand to provide more services, what additional services do you see most fit for the community?”) Each focus group began with a brief introduction of the moderator and assistants, followed by the purpose of the study. Additionally, participants were asked to fill out a demographic survey. Focus groups were audio-recorded after consent was received. Each focus group was led by one moderator and two assistants who were either graduate or undergraduate students. The same moderator (HM) facilitated all of the focus groups for consistency.

### Data analysis

Responses from the focus groups were transcribed. Two of the co-authors (HM and BG) conducted thematic analysis to identify themes in (1) issues relating to health that need to be addressed, (2) most urgent health issues, and (3) ways to improve outreach or services to the underserved populations. To ensure reliability, another co-author (AK) conducted cross-checking between the two coders. Finally, the fourth co-author (JA) reviewed overall consistency of the analysis. Additionally, participant characteristics were summarized from the demographic surveys.

## Results

### Participant characteristics

A total of 20 participants attended the focus groups at the free clinic. Each participant was a staff of a non-profit social service organization, government agency or other clinical setting that serves the underserved community. Participants, together, served a diverse population including low income families, refugees, and the individuals experiencing homelessness. Most participants were aged 25 to 54 years old (Table 1). A large proportion of participants were non-Hispanic Caucasian (80%), followed by Asian/Pacific Islander (10%), one Hispanic and one Iranian American.

Participants initially became aware of the clinic through partnerships, meetings, or referral programs at work. One participant found the clinic online and a few participants found the clinic by word of mouth from friends, family and a college class. It was the first time for four of the participants to be at the clinic, though the majority of participants acknowledged their organizations have had some level of involvement with the clinic. On average, participants have known the free clinic for 4.9 years, though the time periods ranged from 1 month to 11 years.

### Social capital

Among participants whose organizations had or were currently collaborating with the clinic, most acknowledged their organization has been involved with the clinic for quite some

**Table 1:** Sample demographics (N=20).

Characteristics	Frequency	Percentage
<b>Gender</b>		
Females	8	40%
Males	12	60%
<b>Age</b>		
18-24	2	10%
25-34	7	35%
35-54	8	40%
55+	3	15%
<b>Race/Ethnicity</b>		
Asian/Pacific Islander	2	10%
White-non Hispanic	16	80%
Hispanic or Latino/Latina	1	5%
African or African American	0	0%
American Indian/Alaska Natives	0	0%
Other	1	5%

time, ranging from 2 years to 11 years. Eight participants were not sure if their organization has collaborated with the clinic in the past or were unsure of the length of partnerships because collaborations have been on and off or were established prior to the start of their work at the organization.

### Experiences with the clinic

When asked about impressions of the clinic, participants described mixed impressions. Overall, participants had “a good physical impression” of the clinic, though one person commented “it doesn’t feel like a warm and fuzzy place to come.” In general, participants were “excited,” “thrilled” or “surprised” by the resources the free clinic offered. Many were impressed by the altruistic work that volunteers (i.e., physicians, nurses, community members) have provided. For instance, one participant stated “my first impression was just how well run and organized and clean and altruistic the mission is and I was very, very impressed.” Another participant shared “it was kind of a shock and awe of the amount of resources and community partnerships they had in order to provide low-cost medical services for this population.” However, one participant was “concerned about [clinic] not taking insurance.” The participant further explained he was “disappointed” that the clinic operations “weren’t mirrored with what [another clinic] did,” such as having “a blend of both volunteer service from the community and paid employees,” reflecting an incorrect assumption about clinic operations as the clinic has both volunteers and paid staff.

The most frequently shared negative impression about the clinic was length of wait times that patients experienced before being seen, as illustrated by one participant’s comments:

*“There’s been really long wait lists to get into the clinic... we’d love to get people in but it’s been kind of prohibitive because of the long waits and so the medical need outweighs the amount of time that we can wait.”*

Participants also remarked on how “busy” the clinic “always seemed.” One participant referenced the clinic seeming “crazy overwhelmed” by the amount of work being done in the clinic, as explained by one participant:

*“It always seemed busy, a little chaotic I think that any organization where you have volunteers, that’s pretty normal and knowing there’s so many volunteers in and out...I was crazy, overwhelmed um so I think that like busy a little bit crazy not unorganized but just like a little bit um, yeah, busy.”*

Throughout the time of working with the clinic, whether in their current position or through other channels, some participants shared that their impressions of the clinic have improved, while others felt their impressions of the clinic have not changed. The majority felt there are areas needing improvements such as “actually get patients to go [to the clinic],” “days of operation expanded,” increase capacity,” and “publicizing [the clinic].”

Participants described their most positive experiences with the clinic as “supporting the community,” and “reliable partnership.” One participant further explained that their most positive experience with the clinic was to “have the ability to rely on [clinic] as a resource for the clients.” On the contrary, the most negative experiences with the clinic included “not knowing who to contact for referral needs” and, as mentioned before, “wait time.” Participants representing several organizations shared that their clients “have a hard time getting in” to see the clinic’s medical professionals. A participant also shared concerns about “the length of time from referral to actual treatment.” “A lack of clearer understanding of services available” was also mentioned, followed by concerns about referring clients to the clinic. For instance, one participant noted: “I was referring some clients over here ... I didn’t hear that [clinic] denied them services until after I kind of lost contact with them...it’s just kind of like can I trust sending patients over here.”

Other negative experiences included transportation needs and the clinic leaving some client health needs unmet, namely, “not [being] able to coordinate certain services” from “getting proper STD testing and HIV services” to “specialty care.” Another participant stated it was “worrisome” to have “clinicians follow the proper guidelines [for STD treatment].” Regarding transportation, one participant noted “this is another great location for some people...how do you get here if you live in [other neighborhoods] or so forth” but concluded that “it’s almost impossible to find the ideal location.”

### **Opportunities for improving community health**

Regardless of the differences in the populations served by focus group participants, all remarked that they believed there were opportunities for increased collaboration between their organizations and with the clinic which would result in an improvement in community health. The following themes emerged when participants were asked “How can you and the clinic work together to better serve the community?” “refugee health screening,” “establish a specific referral contact,” and “partnerships for community outreach.”

For refugee health screening, participants commented on

the increasing need for access to care among refugees in the community. Participants who serve the refugee populations (i.e., government and resettlement agencies) proposed a possible partnership where the free clinic provides “refugee health screening.” For instance, one participant said:

*“...I think it could be explored...letting us know what [clinic’s] needs are in terms of serving refugees and us doing what we can to pull together resources to assist in that effort.”*

Others offered to provide “volunteer training” and “technical assistance” should the clinic need assistance on refugee health screenings. Participants suggested “more communication in terms of what the needs are [for the clinic] because [organizations] have the resources in terms of staff and personnel to get the training [for refugee health screening].”

To remedy the negative experiences previously mentioned, a recurring theme on what the community organizations and the clinic could collaborate on was “knowing the right way to refer clients” to improve access for patients. “Establishing a specific referral service with specific expectations” was suggested to address the issue of not knowing “who to contact exactly [for] all of the eligibility requirements.” Participants implied having a specific referral contact would improve navigation of the referral eligibility. Participants also urged for a reduction in wait time. The wait time at the time of study was approximately two months; some participants commented they would like to “get it down to two weeks.”

Furthermore, participants suggested working together to continue to “identify more patients” and “helping patients [to] access resources, and fill in those safety net gaps.” Participants also recommended “joint community events” such as “health fairs” as one way to boost community outreach while increasing publicity for the clinic. Another potential area for possible collaboration is through the integration of “community health workers.” As one participant described, community health workers are “someone who can relate to you.” Additionally, collaboration between the free clinic in this study and another free clinic that specializes in providing mental health care for the uninsured was mentioned as a potential future collaboration. One participant thought it “would help the patients a lot” if the two clinics “could be in the same building.”

### **Health issues**

Several health issues were identified by focus group participants as extremely important among the populations they serve. The most frequently expressed needs throughout all focus groups were “dental care” and “mental health services.” Regarding dental care, as one participant explained, “dental is a huge problem because...there’s no Medicaid dental [so it affects the] entire low income population [because] accessing dental services is really challenging.” Participants described mental health needs as “on top [as identified issue]” and “always an issue and it’s a lot harder to access mental health resources” than services for other health concerns.

Others noted needs on “cancer prevention,” “vision care,” “senior care,” “gastrointestinal problems,” “ENT

[Otolaryngology] problems,” and “back pain.” Participants stated that in the specific underserved populations they serve, health issues ranged from “a lot of vision problems” to “a lot of back pain symptomatology that could reflect mental health.” One participant added “disability services is another huge [issue]...I think in general it’s hard but then you add language barriers [then it] gets really cost prohibitive.”

Additionally, “chemical dependency” and “substance abuse” were mentioned as recurring issues in the underserved populations. Holistic health care was another area in need of improvement. As described by one participant:

*“...we can diagnose someone with HIV and then it’s like, here’s your care, but where does it go after that...holistic health care like mental health services, substance abuse services... intertwine into everything that we do.”*

### Issues relating to health

Affordable housing and language barriers were among the most frequently occurring issues that contribute to health problems. Participants agreed that housing is “a huge need” that affects people’s overall wellbeing. As one participant shared,

*“...the overwhelming need for affordable housing for low-income people...is you can’t manage your health when you don’t know where you’re going to sleep that night or everything kind of that hierarchy of needs. You have to have the security of knowing where you can live and can afford to live and I think for the underserved the poor in general I think in this county in particular that’s a huge, huge need.”*

Language barriers, a major issue relating to health outcomes, were described as “a huge problem.” Many participants commented on the “lack of trained interpreters” for uninsured minorities. Staff from one organization commented “[language interpretation is] a resource that we really struggle with sometimes especially as we see more new language speakers arriving.” One example of the language issues is people “misusing their medication because they don’t understand when to take it.” Other participants recalled instances where children or family members acted as interpreters at clinical settings (i.e., gynecology) which were “uncomfortable” and “inappropriate.”

Additionally, “health literacy” and “health education” were brought up as important issues impacting health. One participant commented that patient education on mental health after a diagnosis is “a rising need.” Another participant described the importance of having health educators to explain diagnoses and treatments as “like someone who’s there to help you from a to z.” Others implied health education and preventative care intertwine in long-term care management. As one participant explained regarding resources needed for the community:

*“...I mean you can treat the immediate things but...you want to prepare this individual for the long term...it’s not just this triage system of get what is out you know or done now so I would say preventative care and the health education piece too.”*

### Recommendations from participants

In addition to a call for more dental care and mental health

services, several suggestions were made to improve care at the free clinic. In particular, participants requested “satellite service” or “mobile clinics” as a means to increase capacity and reach further into the community. Another suggestion was to increase awareness on “trauma informed care...keeping up with [awareness] as [patients] come through making sure [volunteers] realize the type of population they’re working with.” Participants also encouraged the clinic to “leverage other collaborations.” One participant stated:

*“I think there’s a lot of services and it’s really disjointed [,] I think we get so siphoned off but really seeing what the partnerships are...just establishing those really strong connections.”*

Others recommended incorporation of “alternative medicines” such as “chiropractic treatment” to accommodate the diversified needs of patients. Additionally, some participants suggested providing “daycare service” at the clinic to allow for more effective and comfortable office visits. As one participant elaborated:

*“...maybe even a daycare while the patients are in there for like certain hours as long as they are being patients that are supposed to be there and cannot afford to take their kids to a babysitter because it’s always uncomfortable having to set your baby down or while you’re getting your vitals taken or when you’re with the doctor...”*

Many participants shared the desire that a more consistent stable of medical professionals and other workers would be available to treat clinic patients. One participant shared that more “stable personnel” is needed to address “a constant process of educating the volunteers and then losing them and then starting over again.” Others commented “a more stable provider force is always ideal” and that it’s best for the clinic “to take the best of the community and that ability to volunteer.”

### Discussion

This study explored health needs and issues related to uninsured underserved populations accessing a safety net clinic. The study identified three key findings. First, the free clinic represents a form of community support that could significantly benefit from increased inter-organizational partnerships. The second key finding is that the underserved populations have a wide range of unmet health needs. Finally, a rise of non-health issues such as lack of affordable housing, language barriers, and low health literacy may directly affect the wellness of the community the clinic serves.

This study demonstrated the potential power of coordinated community social support to better serve underserved populations. From a collective perspective, social capital is comprised of social organizations including networks, norms, resources for action, and community engagement [30-32]. Under this spectrum, building community network can improve the health of individuals in the community [33,34]. The community networks can enable enhanced allocations of scarce resources and improve the collective good of society which is the central theme of social capital. This implies uninsured and underserved

populations will benefit from partnerships and alliances of multiple organizations.

In addition, this study found that there were many unmet needs among underserved populations. The results indicate a large gap of care exists across multiple populations among the underserved, including low-income families, uninsured minorities, refugees, and the individuals experiencing homelessness. In addition, there are specific services which community partners feel are urgently needed by underserved populations (e.g. mental health services, dental care). One strategy to bridge the gap between needed health services and the community may be through the utilization of community health workers, as suggested by the participants. Current literature has documented significant positive outcomes on the incorporation of community health workers [35-38]. There is also growing evidence that the integration of community health works can reduce health disparities [39]. One example of the significance of community organizations is that they can be the “change agents” of the community by being effective health promoters in disadvantaged communities [40]. Another study has found success with community health workers in diabetes care within underserved communities [35]. Community health workers can bridge the needs in care management, in addition to providing culturally competent health education as trusted community navigators with local knowledge to promote community health [36-39].

Another theme derived from this study is the strain of non-health issues on the health and well-being of low-income individuals and families and other underserved populations. Housing, for instance, was brought up on multiple occasions across different focus groups. This finding is consistent with the results from recent studies that have found correlations between housing status and health outcomes [41,42]. To tackle the issues of housing, collective efforts (i.e., partnerships) between local nonprofit organizations, and community members may be one approach to facilitate the building of community capacity. One such example, is the partnership between health and social service organizations that develop health resource centers [43]. In another example, community partnership raised awareness on issues between the environment and health and promoted policy advocacy on relevant projects for the city [44].

In addition to housing, low health literacy poses another barrier to improved health outcomes among underserved populations. Among free clinic patients, higher levels of health literacy are associated with better physical health functioning [9]. Findings from this study suggest more health education is needed to increase health literacy and prevent adverse health outcomes. However, health education programs at free clinics are very challenging to implement [45,46]. Future studies should further explore health education programs that work better at free clinic settings.

### **Study Limitations**

This study has several limitations. While participants came

from various professional backgrounds, some were employed by the same organization therefore it is possible some needs were more emphasized than others. It is also possible participants suppressed or amplified certain statements under the presence of other colleagues (i.e., from the same organization). Another limitation is the small number of focus group participants, 20 in total. If more community partners had participated in the study, health-related concerns other than the ones described in this paper might have been voiced. Finally, while the focus group guide was developed based on the social capital and community capacity concepts, the perspectives and shared experiences of the participants were not necessarily synchronized with the concepts. Future research should use a focus group guide which can better structure the discussions to tie in with these concepts, use different conceptual frameworks, or conduct a quantitative study with a large number of participants.

### **Conclusion**

This study offers valuable insights in the areas for collaboration between organizations. Results indicate multi-tiered issues affecting health exist across different underserved populations (i.e., low income families, refugees, immigrants). Nonprofit social service organizations and free clinics are encouraged to bridge resources and prevent duplicated efforts to increase feasibility for the common goal of improving community health outcomes. The focus groups in this study identified gaps where organizations could partner to improve coverage, but did not explore how partnering organizations may meet these gaps. Future studies should implement and evaluate such inter-organizational collaborations. Future work should also examine the impact of the collaborations on access to care and health outcomes among underserved populations.

### **Declarations of Conflicting Interests**

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

### **Ethical Approval**

The University of Utah Institutional Review Board (IRB) approved this study.

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