



2014 Annual Outcomes Report

Improving the health & well-being of the uninsured in North Carolina

Made possible by the generous support from



2014 NCAFC ANNUAL OUTCOMES

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2014 NCAFC ANNUAL OUTCOMES SURVEY MAJOR FINDINGS

- **Patient Volume:**
 - The total number of patients was 87,043 (70 member organizations reported)
 - The total number of patient visits was 170,569, with medical, behavioral and dental equaling total visits (61 member organizations reported)
 - **Number of Volunteers: (70 member organizations reported)**
 - Total number of volunteers was 7,627
 - Total number of hours volunteers worked was 368,923 hours
 - **Number of Prescription Medications Provided: (63 member organizations reported)**
 - 987,527 (30 day supply or less) prescription medications were provided
 - **Diabetic Control: (51 member organizations reported (*n=2,157))**
 - ★ ▪ 75% of diabetic patients had a most recent A1c \leq 9%
*2014 NC HRSA reported, 72.5% of diabetic patients with A1C \leq 9%
 - **Hypertension Control: (52 member organizations reported (*n=2,288))**
 - ★ ▪ 67% of hypertensive patients age <60 years (w/o diabetes &/or chronic kidney disease) PLUS all hypertensive patients any age (with diabetes &/or chronic kidney disease) whose last blood pressure measurement was < 140/90
 - *2014 NC HRSA reported, 61% of hypertensive patients with a blood pressure < 140/90
 - 68% of hypertensive patients age \geq 60 years (w/o diabetes &/or chronic kidney disease) whose last blood pressure measurement was < 150/90 (*n=228)
 - **Hospital Utilization: (47 organizations reported ED visits, n=2,799) (46 organizations reported hospital admissions, n=1,654)**
 - 62% of free clinic patients reported a decrease in ED visits
 - 63% of free clinic patients reported a decrease in hospital admissions
 - **Primary Access to Care: 44 member organizations reported (n=4,386)**
 - 75% of clinic patients consider the free clinic as their primary access to ambulatory health care services
- Value of Investment**
- For every \$1 spent, \$6.21 in healthcare services were provided

*N = number of patients measured

*US Dept. of Health & Human Services – Human Resources & Services Administration (HRSA) <http://www.hrsa.gov/data-statistics/>

Community Health Centers (Federally Qualified Health Centers) track a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs and revenues.

2014 NC HRSA Program Data <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=NC>

BACKGROUND

In January of 2004, the North Carolina Association of Free Clinics (NCAFC) and its member clinics embarked upon a partnership with the Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation. The underlying foundation of this partnership was to:

- Support existing free clinics by providing a measure of sustainable funding for ongoing operations
- Expand access to health care for the uninsured by helping communities create and establish free clinics in underserved areas
- Enable free clinics to create new programs or expand capacity of existing programs
- Aid in improving technology used by free clinics
- Recognize excellence in the operation of North Carolina's free clinics

OUTCOMES FRAMEWORK

In 2008, NCAFC continued its partnership with BCBSNC Foundation with a second 5-year funding commitment. Having achieved many of the goals set forth for the first five years, the next phase of the partnership began shaping a framework of success defined by health gains. Rather than solely focus on how many received care, the question became "Did the care received improve patients' health?" NCAFC worked with BCBSNC Foundation and a team of member free clinic representatives to develop a standardized set of health metrics in order to:

- **Enhance our ability to prove a significant return on investment**
- **Strengthen our position in North Carolina's health care safety-net**
- **Demonstrate the positive impact we have upon those we serve**

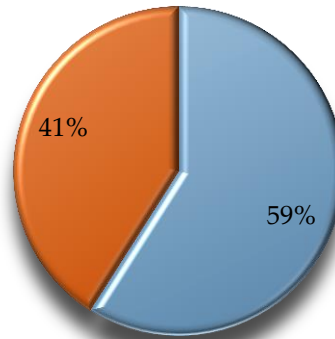
Member clinics of NCAFC who complete the Annual Outcomes Survey are eligible for grants based on their volume of services, clinical outcomes performance scores and improvement from the prior year. The BCBSNC Foundation defines their return on investment in terms of health gains for low-income North Carolinians. As a result of this work, North Carolina is widely regarded as the most progressive Free Clinic Association in the nation and serves as a model for other states.

NCAFC continues its partnership today with BCBSNC Foundation with an even greater emphasis on health outcomes and return on investment. As always, NCAFC advocates and supports its member clinics as they navigate today's uncertain environment under health care reform. With their flexibility, innovation and ability to leverage volunteer and in-kind resources, free clinics remain a critical and essential part of North Carolina's health care safety net.

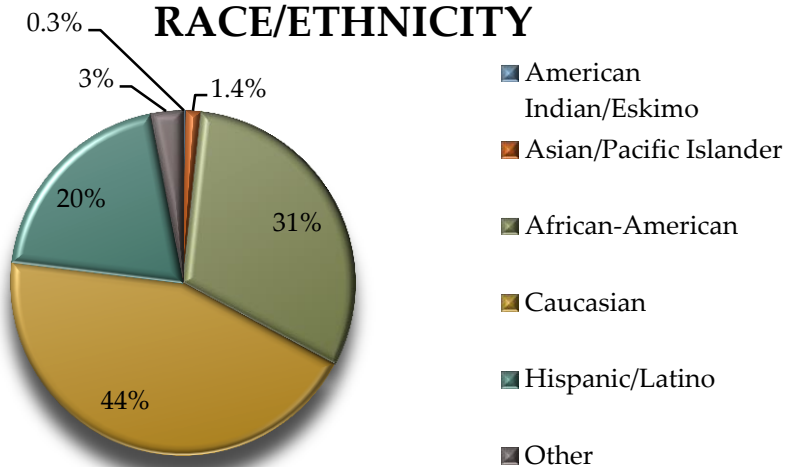
FREE CLINIC PATIENTS: A SNAPSHOT

GENDER

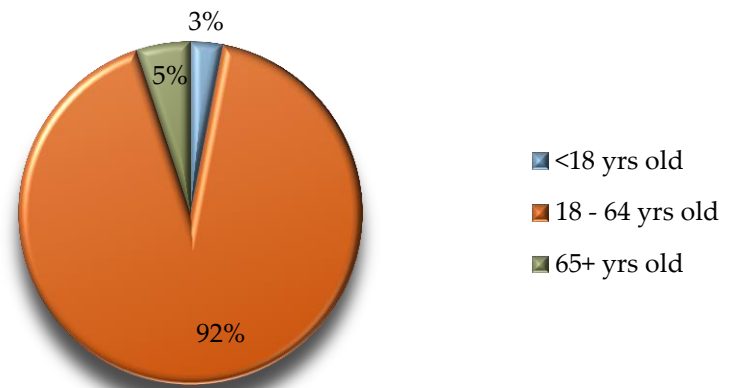
■ Females ■ Males



RACE/ETHNICITY

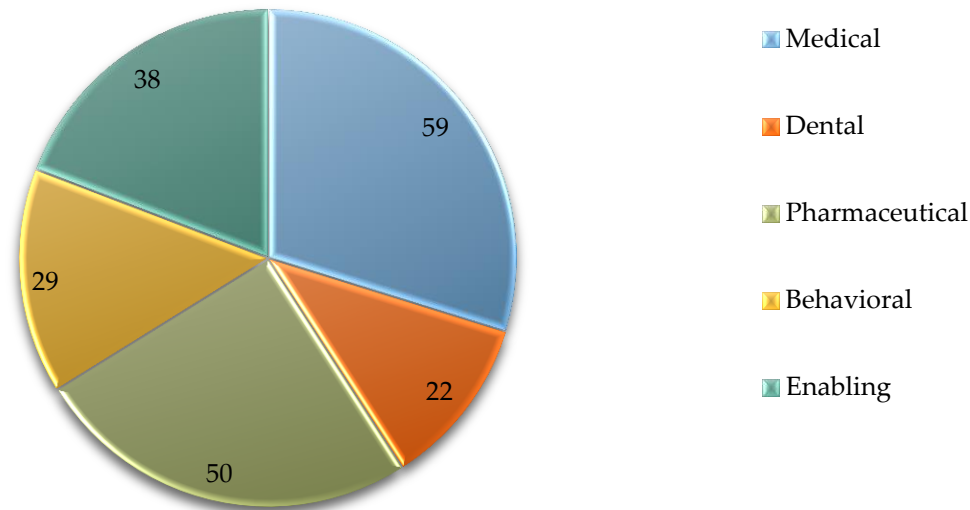


AGE



FREE CLINIC SERVICES & OPERATIONS

SERVICES PROVIDED (By # of Clinics)

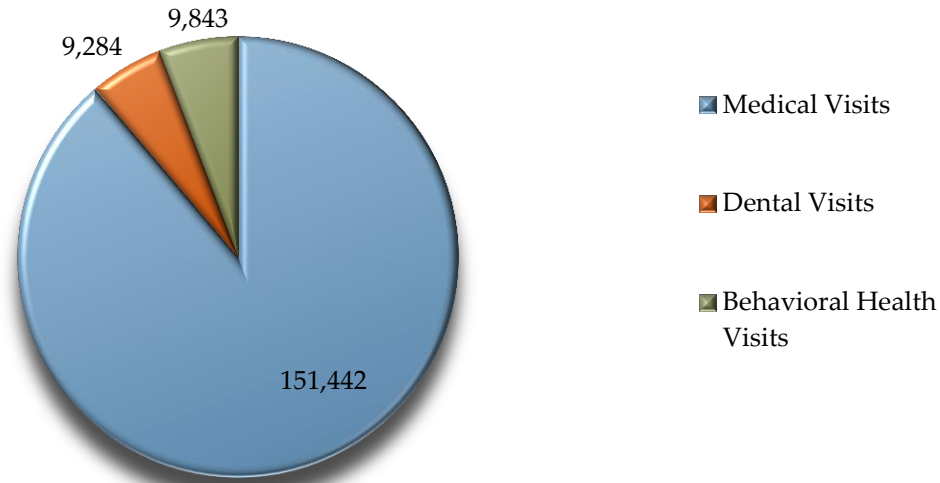


*Operational Hours (On-site)	Administrative Hours (On-site)	Dental Hours (On-site)	Medical Hours (On-site)	Pharmacy Hours (On-site)
Total/Month	8,697	604	5,931	3,323
Average/Month	126	18	100	71
# of Clinics Reporting	69	19	59	38

*Hours include multiple sites

FREE CLINIC VOLUME

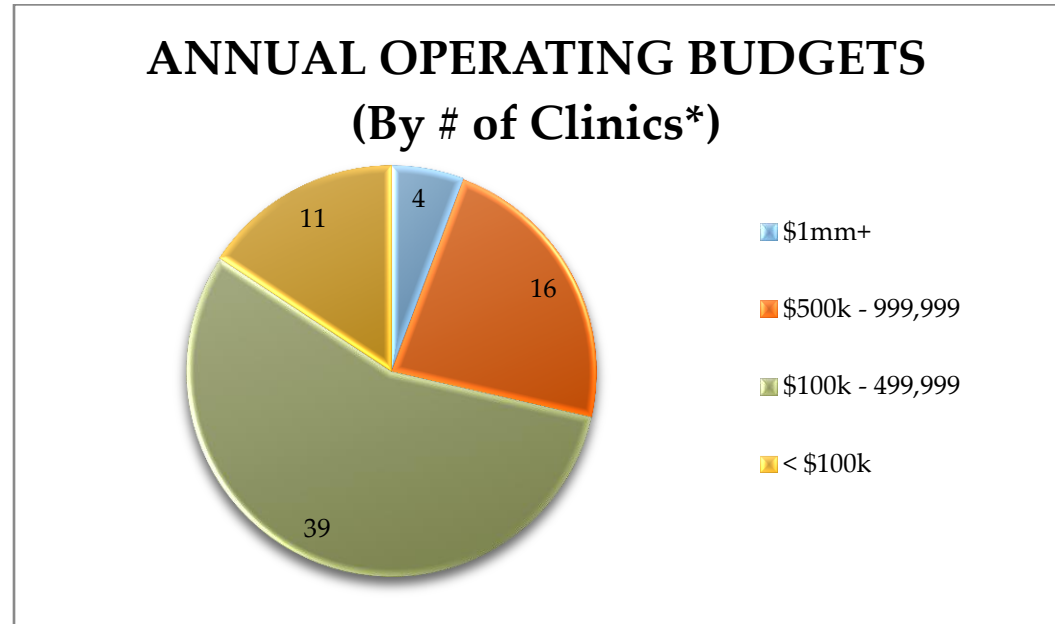
**PATIENT VISITS
(By Type of Visit)**



	Unduplicated Patients 70 members reported	Medical Visits 59 members reported	Dental Visits 22 members reported	Behavioral Visits 29 members reported	Total Patient Visits	Prescription Medications Provided*** 63 members reported	Total Rx Value
Total	87,043	151,442	9,284	9,843	170,569	987,527	\$130,826,524
Average	1243	2,567	422	339	2,437	15,675	\$2,076,611

*** Prescription Medications dispensed as 30 day supplies or <

FREE CLINIC'S VALUE OF INVESTMENT (VOI)



	Value of Service*	Operational Expense	VOI**
Total	\$204,911,065	\$28,439,288	\$6.21
Average	\$2,927,301	\$406,276	\$5.95

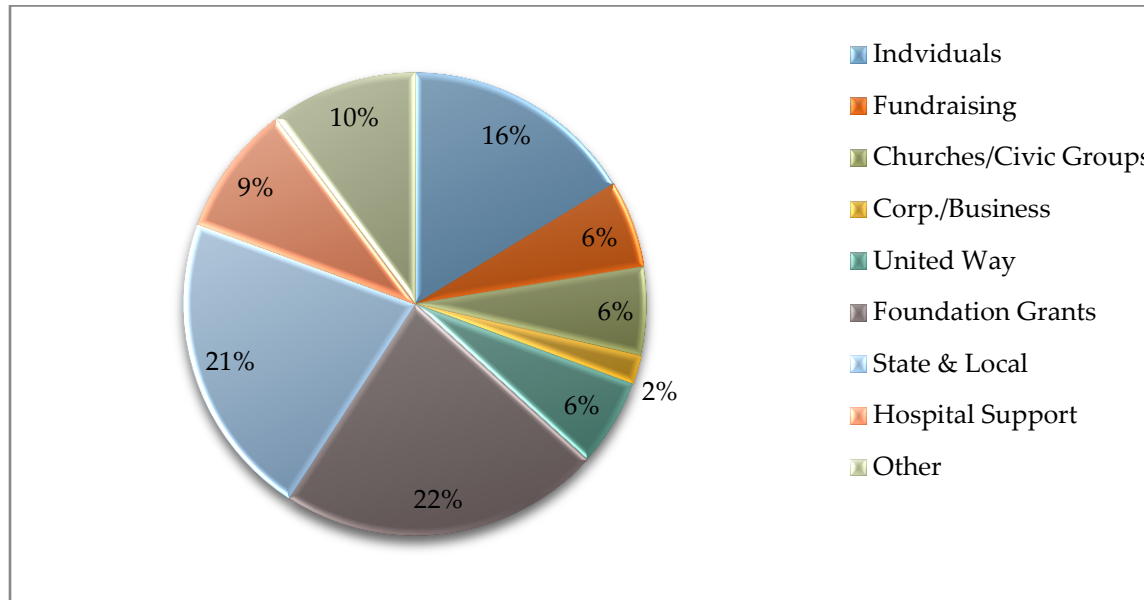
FOR EVERY \$1 SPENT, FREE CLINICS PROVIDED \$6.21 IN HEALTHCARE SERVICES

*Includes services arranged for and directly provided by Free Clinics

**Total VOI = (Total Value of Service - Ops Expense / Ops. Expense)

FREE CLINIC'S FINANCIAL SUPPORT

FINANCIAL RESOURCES (% of Income Per Source)



Income by Source	Individual Donors	Fundraising	Churches and Civic Groups	Corporations and Businesses	United Way	Foundation Grants	State and Local	Hospital Support	Other
Total	\$4,674,296	\$1,738,253	\$1,781,006	\$683,179	\$1,059,815	\$6,832,843	\$6,341,138	\$2,981,984	\$3,386,087
Average	\$82,579	\$34,083	\$32,382	\$14,536	\$55,995	\$110,207	\$179,931	\$199,198	\$192,971
# of Clinics Reporting	65	51	55	47	35	61	48	26	50

FREE CLINIC STAFFING & VOLUNTEER TIME

# of Employed Staff (FTE Units)	Physicians	Mid-Level (PA's & NP's)	Nurses & CMA's (RN's, LPN's & CMA's)	Pharmacists	Pharm-Techs	Dentists	Hygienists & DA's	PAP Coordinators	Total FTE Units (All Positions)
Total/Year	8.68	32.09	65.82	20.33	30.81	.80	9.22	37.83	402
Average/Year	0.72	1.04	1.65	.88	1.28	.10	.92	1.07	6
# of Clinics Reporting	12	31	40	23	24	3	10	36	65

*Employment totals = FTE Units

# of Volunteers	Physicians	Mid-Level (PA's & NP's)	Nurses & CMA's (RN's, LPN's & CMA's)	Pharmacists	Pharm-Techs	Dentists	Hygienists & DA's	PAP Coordinators	Total Volunteers (All Positions)
Total/Year	1031	185	1130	265	307	219	239	86	7,627
Average/Year	17	4	17	7	12	8	3	5	109
# of Clinics Reporting	60	45	59	35	22	23	20	8	70

Volunteers	Hours Worked
Total for Yr.	368,923
Average for Yr.	5,270
# of Clinics Reporting	70

HEALTH GAINS OUTCOMES

Health gains outcomes were measured for free clinic patients diagnosed with diabetes, hypertension and/or COPD, using the following evidence-based clinical practice guidelines for standards of care:

- American Diabetes Association – www.diabetes.org
- Joint National Committee 2014 Evidence Based Guidelines for Management of High Blood Pressure in Adults – www.jnc8.jamanetwork.com
- Global Initiative for Chronic Obstructive Lung Disease – www.goldcopd.org

METHODOLOGY

Free clinics utilized the following methodology for tracking patient health outcomes:

- 1) Assessed their total active patient base of patients having a diagnosis of diabetes, hypertension and/or COPD as of January 1, 2014. An active patient was defined as anyone treated for diabetes, hypertension &/or COPD in the past year.
- 2) From this population of patients, the free clinic then randomly selected 50 diabetic, hypertensive &/or COPD patients to track for outcomes. This process established a “fixed cohort” group of patients whose outcomes measurements were tracked for 2014. If the free clinic had < 50 patients with a diabetes, hypertension &/or COPD diagnosis, the total number of patients (< 50) was tracked for outcomes measures.
- 3) Patients within the fixed cohort who were discharged from clinic services during 2014 for any reason (i.e., moved out of county, began receiving Medicaid or health insurance, etc.) were considered lost to follow up and not included in final calculations even if the patient re-enrolled for services later in the year.

DIABETES OUTCOMES

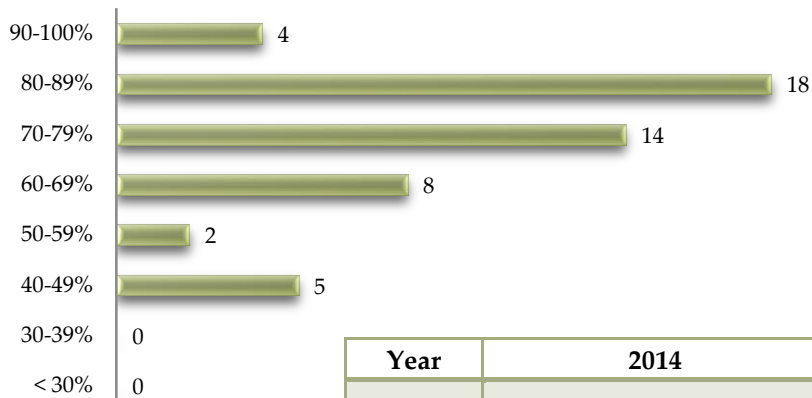
For 2014, 51 free clinics reported outcomes for 2,157 diabetic patients as follows:

- 75% of patients most recent A1c level was $\leq 9\%$
- 22% of patients most recent A1c level was $>9\%$
- 45% of patients received a diabetic retinal exam
- 71% of patients received a comprehensive foot exam
- 60% of patients received a test to assess for early signs or progression of nephropathy

How free clinics compare to each other (by percentage of patients):

MOST RECENT A1C $\leq 9\%$

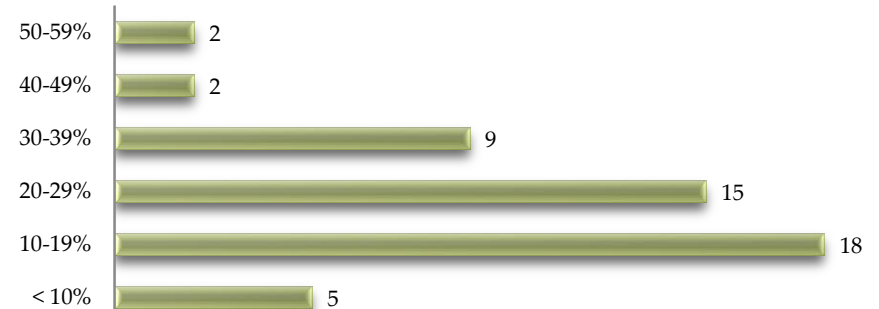
■ # of clinics



Year	2014
Range	43% - 97%
Average	75%

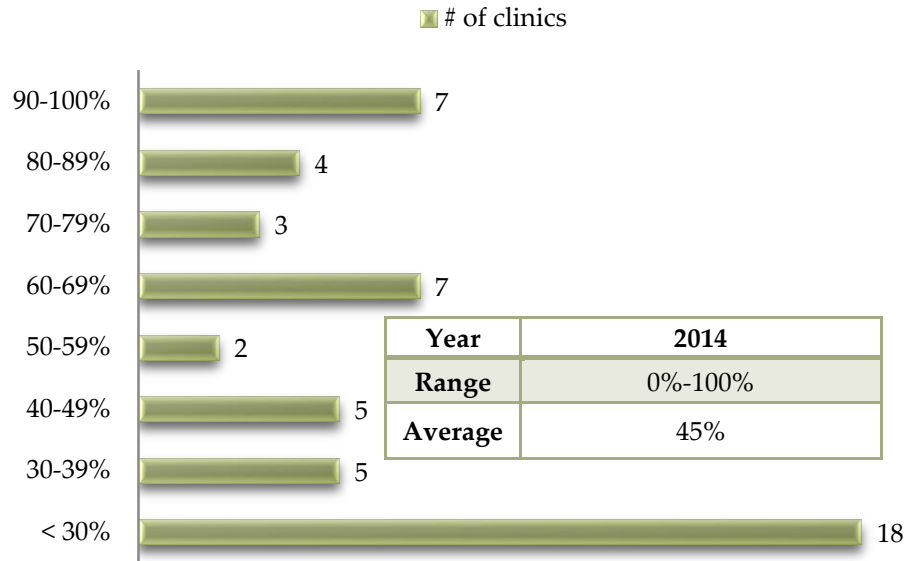
MOST RECENT A1C $> 9.0\%$

■ # of clinics

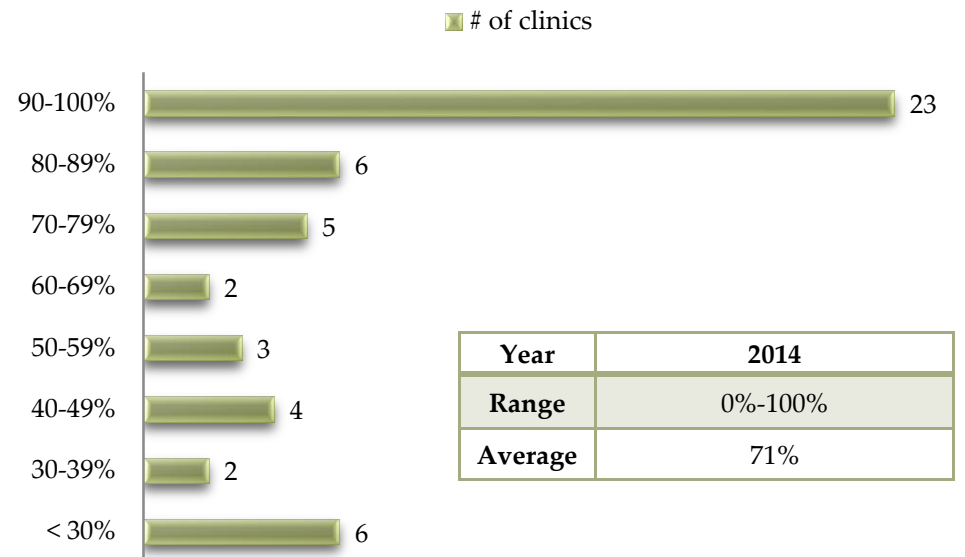


Year	2014
Range	3% - 55%
Average	22%

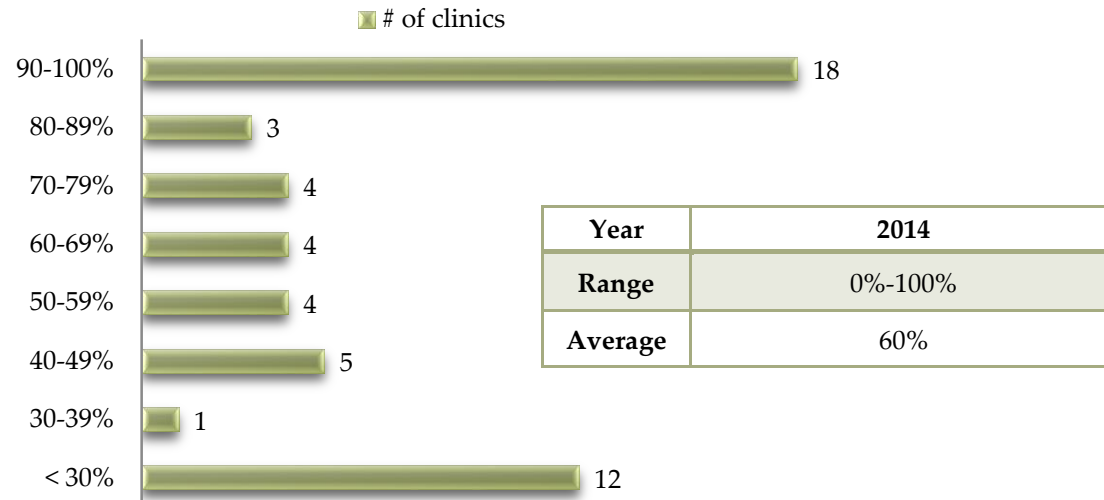
DIABETIC RETINAL EXAM



COMPREHENSIVE FOOT EXAM



TEST TO ASSESS FOR NEPHROPATHY



2014 TOP PERFORMING CLINICS: DIABETES

≥ 85% OF PATIENTS WITH MOST RECENT
A1C ≤ 9.0%

- Ashe County Free Medical Clinic
- CARE Clinic
- Community Care Clinic - Boone
- Community Care Clinic of Highland-Cashiers
- Franklin County VIM Clinic
- Healing with CAARE
- John P. Murray Community Care Clinic
- Lake Norman Community Health Clinic
- Matthews Free Medical Clinic
- MERCI Clinic

≤ 11% OF PATIENTS WITH MOST RECENT
A1C > 9.0%

- Broad Street Clinic Foundation
- Community Clinic of High Point
- Community Health Services of Union County
- Franklin County VIM Clinic
- Healing Hands Clinic of Caldwell County
- Matthews Free Medical Clinic
- MERCI Clinic
- Vidas De Esperanza



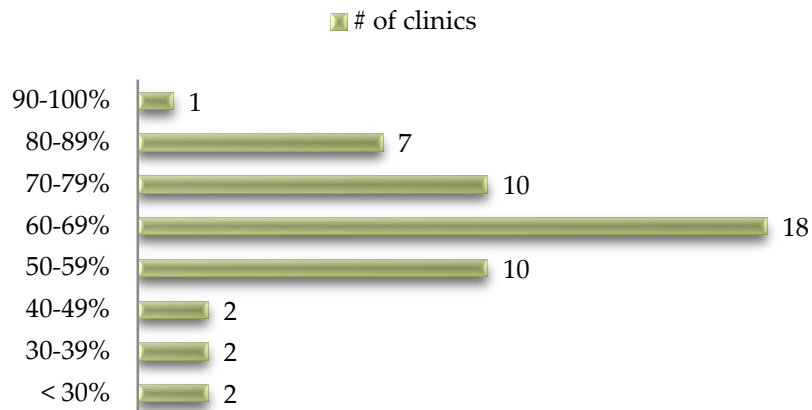
HYPERTENSIVE OUTCOMES

For 2014, 52 free clinics reported outcomes for 2,288 hypertensive (HTN) patients as follows:

- 67% of patients (n=1,539) age <60 without diabetes &/or chronic kidney disease PLUS all patients with diabetes/CKD, whose last BP measure was < 140/90
- 68% of patients (n=228) age ≥60 without diabetes/CKD, whose last BP measure was < 150/90

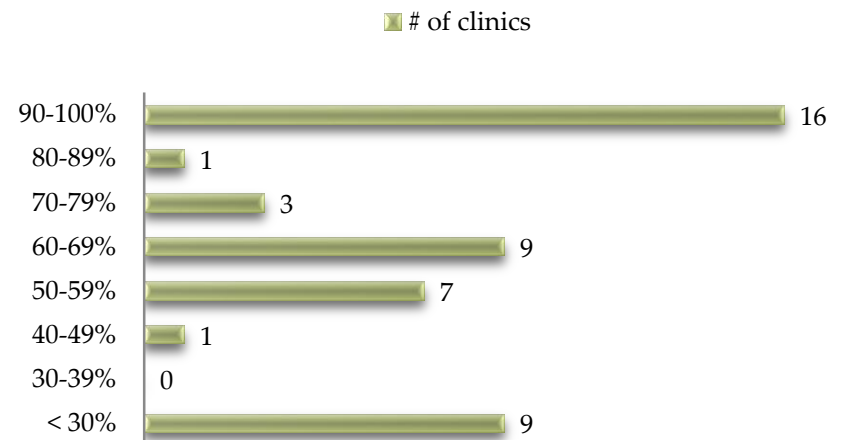
How free clinics compare to each other (by percentage of patients):

% of pts. age <60 w/o diabetes/CKD & all pts. with diabetes/CKD whose last BP measure was < 140/90



Year	2014
Range	8% - 92%
Average	67%

% of pts. age ≥60 w/o diabetes/CKD with whose last BP measure was < 150/90



Year	2014
Range	0%-100%
Average	68%

2014 TOP PERFORMING CLINICS: HYPERTENSION

≥ 74% OF PATIENTS, AGE <60 W/O DIABETES/CKD AND ALL PATIENTS WITH DIABETES/CKD WHOSE LAST BP MEASURE WAS <140/90

100% OF PATIENTS, AGE ≥60 W/O DIABETES/CKD WHOSE LAST BP MEASURE WAS < 150/90

- Bethesda Health Center
- Cape Fear Clinic
- CARE Clinic
- Community Care Clinic – Boone
- Community Care Clinic – Elizabeth City
- Healing with CAARE
- HealthReach Community Clinic
- Helping Hands Clinic of Caldwell County
- MERCI
- Vidas De Esperanza

- Community Care Center – Winston Salem
- Community Care Clinic – Boone
- Community Care Clinic – Elizabeth City
- Community Free Clinic
- Free Clinic of Our Towns
- Free Clinic of Rockingham County
- Good Samaritan Clinic – Morganton
- Good Samaritan Clinic of Jackson County
- Grace Clinic
- Lake Norman Community Health Clinic
- MERCI Clinic
- New Hope Clinic
- Vidas De Esperanza



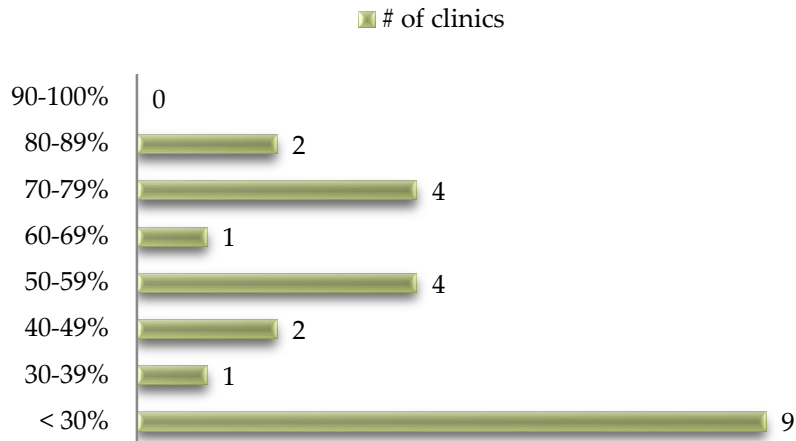
COPD OUTCOMES

For 2014, 23 free clinics reported outcomes for 644 COPD patients as follows:

- 40% of patients had a spirometry evaluation
- 79% of identified smokers (n= 329) received smoking cessation intervention at least annually

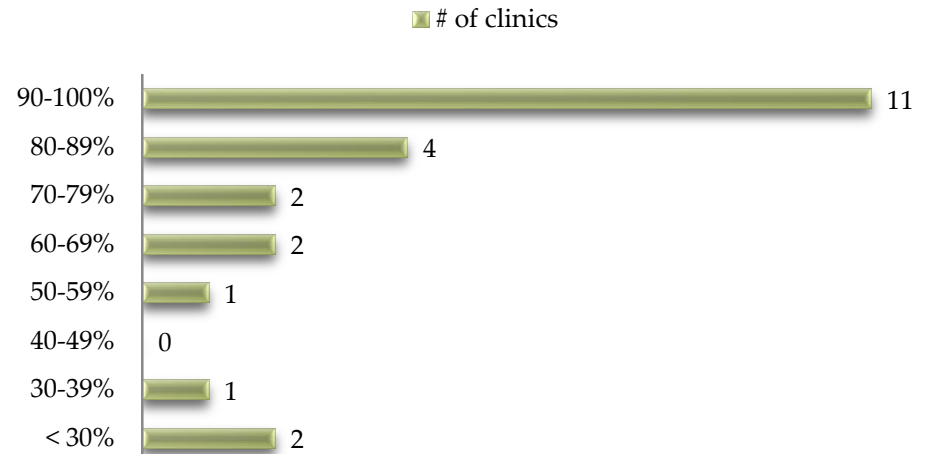
How free clinics compare to each other:

% COPD PATIENTS WITH SPIROMETRY



Year	2014
Range	0%-84%
Average	40%

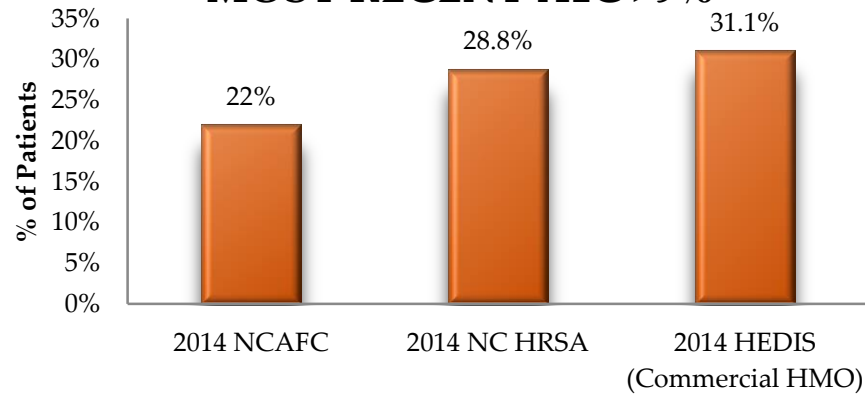
% SMOKERS RECEIVING ANNUAL SMOKING CESSATION



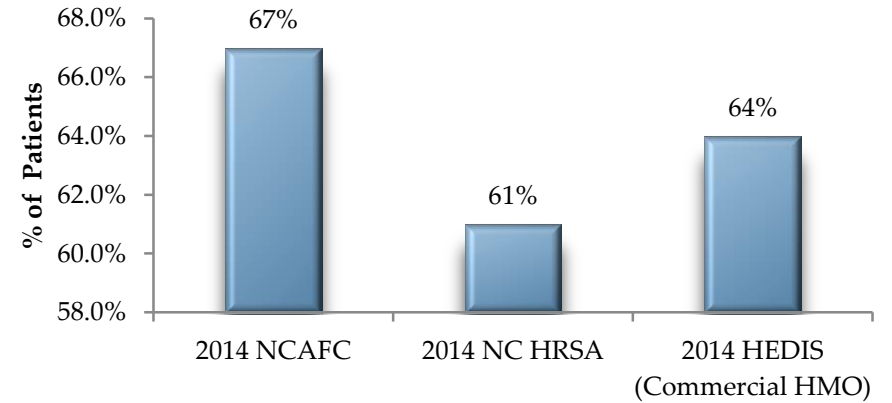
Year	2014
Range	1%-100%
Average	79%

FREE CLINICS IN COMPARISON

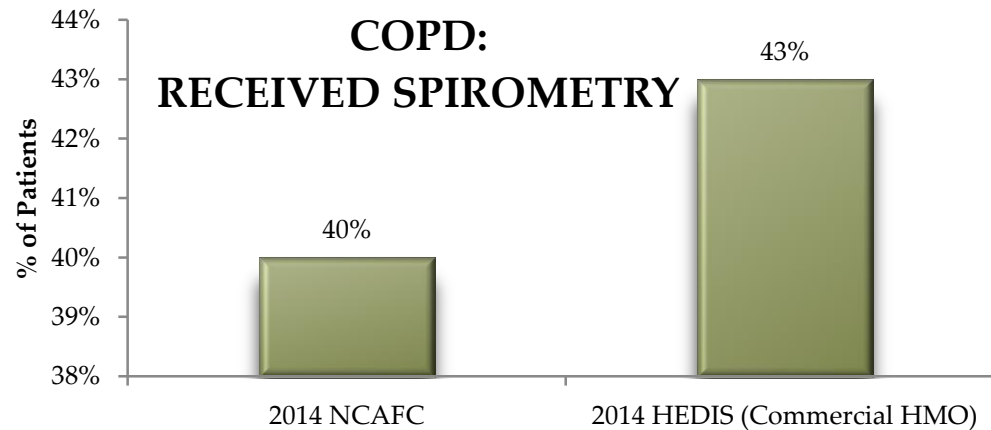
DIABETES: MOST RECENT A1C >9%



HYPERTENSION: BP CONTROL < 140/90



COPD: RECEIVED SPIROMETRY



SELF-REPORTED PATIENT OUTCOMES

NCAFC member organizations performed interviews or written surveys to obtain the patient's view of his/her health gains.

For 2014, Free Clinic patient self-reported interviews/surveys revealed the following:

- ✓ **Decreased Hospital Utilization:** (47 organizations reported ED visits, n=2,799) (46 organizations reported hospital admissions, n=1654)
 - 62% of free clinic patients reported a decrease in ED visits
 - 63% of free clinic patients reported a decrease in hospital admissions
- ✓ **Improved Health:** (49 organizations reported, n = 4,657)
 - 79% of free clinic patients felt their health had improved
- ✓ **Medical Home:** (44 organizations reported, n = 4,386)
 - 75% of free clinic patients considered the free clinic as their primary access to health care services

N = # of patients





NC Association of Free and Charitable Clinics

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