

due to bleeding risk. The bleeding risk with dual aspirin and clopidogrel therapy is at best comparable to what is seen with OAC therapy. This was shown in the ACTIVE W trial, which also taught us that to obtain protection against stroke, you need OAC therapy.²

Second, dual aspirin and clopidogrel therapy should only be considered for stroke prevention, for which OAC therapy is unsuitable for reasons other than bleeding risk, ie, patient refusal to take OAC therapy or a clear contraindication to OAC therapy. From the ACTIVE A trial we have learned that dual aspirin and clopidogrel therapy is only marginally better than aspirin as monotherapy, but at the cost of increasing the risk of bleeding.³ An important finding in the ACTIVE A trial was that only approximately 25% of the patients had a verified cause of increased bleeding risk that made them truly unsuitable for OAC therapy. This result gives additional credence to the theory that underuse of OAC therapy in atrial fibrillation is more consistent with physicians' rather than patients' values. Hopefully, with the newly presented CHA₂DS₂-VASc stroke risk stratification score and American Heart Association/American College of Cardiology/European Society of Cardiology guidelines for the treatment of atrial fibrillation,^{4,5} more patients will receive the benefits of OAC therapy.

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HEALTH CARE REFORM

A Free Clinic Paradox

Darnell has presented a detailed report of her major national survey of free clinics and an illuminating discussion of how vital this asset is as a component of the nation's health care "safety net."¹ Yet considering the enormous resource base of this fine but

Table. Annual Free Clinic Costs of Patient Care: Harrisonburg-Rockingham Free Clinic

Type of Contribution	Estimated Value, \$
Pharmaceuticals	2 145 770
Hospital treatment and diagnostic services	675 061
Harrisonburg cytology services	9550
Rockingham radiology services	18 133
Harrisonburg medical associates	25 980
Springbrook family medicine	5525
Referrals to specialists in the community	146 652
Total	3 026 671

relatively obscure national health care asset—its thousand or so clinics and countless hours of professional and semiprofessional volunteer health care providers plus paid staff and in-kind community-based contributions—what comes to mind is the economists' major inconvenient truth, "there ain't no such thing as a free lunch."

In the report by Darnell,¹ Table 6 provides an economic comparison between free clinic costs and the nation's federally funded community health centers (CHCs). In that table, annual cost of care per patient is listed for free clinics at \$600 and for the CHCs at \$562. Her reference for the free clinic cost estimate is to a Web page (<http://www.hrffreeclinic.org/sections/statistics>), with the note, "data are not available for all free clinics." Indeed, the only referenced site, the large Harrisonburg-Rockingham Free Clinic, lists its annual operating expenses as totaling \$658 794. With 1112 individuals served annually, the operations expense per individual patient comes to \$592.44. But that is just the tip of the economic iceberg. Since the real cost of services is the value of the opportunities foregone owing to the demands such clinic use places on available resources (including the economic value of the leisure time volunteers relinquish), we need to add to this operations accounting expense the imputed value of community-based forgone opportunities and the in-kind contributions from the community. The list of Harrisonburg-Rockingham Free Clinic annual values is given in the **Table**.

Adding in the operations expenses produces a grand total of \$3 685 465. When this is converted into the annual cost of care per patient, the per-patient value is \$3314.27, which indicates that the real economic cost of a "free clinic" patient is approximately 6 time greater than the cost of the "federally funded" patient. And therein lies the paradox.

Although there are a number of explanations that would reconcile much of the "cost" gap between the 2 types of clinics, the fact remains that the sustainability of the free clinic enterprise will ultimately depend on the size and mix of cash, in-kind contributions, and community volunteers, which in turn will depend on how convinced the community is that all of its contributed resources are being managed efficiently.

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In reply

McConnel has astutely homed in on a topic of active debate among free clinic practitioners. Unfortunately, McConnel's own cost-per-patient calculations disguise the issue's complexity. Consequently, his conclusion that free clinics are 6 times more costly than CHCs is unsound.

Free clinics and CHCs differ in what costs are counted. Community health centers use Table 8A in the Uniform Data System¹ to report staffing, medical care, other clinical services, enabling services, and overhead costs. Unlike the example free clinic—Harrisonburg-Rockingham Free Clinic—CHCs are not allowed to report costs that they do not incur and pay. Community health centers do not report costs associated with specialty care referrals or diagnostic services beyond routine laboratory and radiographic examinations because these generally fall outside their “scope of project.”² Recognizing the difficulties of uninsured patients receiving these services elsewhere,^{3,4} the Harrisonburg-Rockingham Free Clinic, like many free clinics, makes formal arrangements with other health care providers for its patients to receive free or reduced cost specialty care and diagnostic services and has reported these downstream costs as part of its enterprise. Excluding the costs for nonroutine diagnostic services and specialty care referrals would substantially reduce the Harrisonburg-Rockingham Free Clinic's costs.

Free clinics and CHCs differ in how costs are calculated. Take, for example, donated drugs. Here, they represent \$2.1 million, accounting for 71% of the “added-in” expenses. However, a CHC would calculate donated drugs costs at the Public Health Service §340B price, which is 40% to 60% of the average wholesale price. Furthermore, it would not report the costs at all if the drugs are donated directly to the patients—as is the case with Patient Assistance Programs, which account for a sizeable portion of the drugs dispensed by free clinics. Drug costs would be drastically less if the Harrisonburg-Rockingham Free Clinic were applying the government's accounting rules.

There is merit in considering the broader societal costs of free clinics by using some accounting method that captures in-kind contributions and forgone opportunities. However, the fact remains that such a methodology also could be applied to CHCs, which follow the same pattern as free clinics for external referrals. Only with parallel application to both clinic types would there be any valid apples-to-apples comparison. Given the increasing focus on cost-effectiveness, free clinics, CHCs, and other community clinics would be well advised to devise a common cost (and quality) methodology, which would help community members make maximally informed resource allocation decisions.

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Relapse After Hospital Admission for COPD: Are Routine Outpatient Follow-up Visits the Way to Go?

With great interest we read the recent contribution by Sharma and colleagues¹ about the association between outpatient follow-up and reduced risk of relapse after hospital discharge in patients with chronic obstructive pulmonary disease (COPD). Nonetheless, after studying the article we believed that we should make some comments.

Our first comment is a methodological one. The authors have looked at the risk of emergency department visits and readmissions in the 30-day period after hospital discharge because most preventable readmissions occur within this time frame. However, it was recently demonstrated that exacerbations in COPD are not random events but cluster together in time such that there is a high-risk period for recurrence in the 8-week period after the initial exacerbation.² Knowing this, we wondered if the conclusion from the study by Sharma et al¹ remains the same if a 60-day follow-up period is applied.

A second comment is about “rigidly” scheduling follow-up visits after hospital discharge in all patients with COPD. Although an approximate 25% relapse rate in the first month clearly is substantial, let us not disregard the fact that approximately 75% of patients do not show relapse within this period. Thus, scheduling follow-up visits for all patients does not seem to be a very efficient approach. Since a cost-benefit analysis was not presented, it is unclear whether follow-up visits in all patients incur incremental costs compared with emergency department visits or readmissions in some patients. Even when taking patients' health as the most important factor, cost reduction clearly is a factor that needs to be considered. It might be better to establish an evidence-based “relapse risk profile” for every patient at the time of hospital discharge and give specific follow-up attention to, for instance, those with severe obstruction, a history of frequent exacerbations, or comorbidities (especially heart failure), while social factors relevant to relapse risk (eg,