Vermont Free & Referral Clinics Case Study

Olivia Brimmer, Ananda Corr, Marcell Papp

Community Development & Applied Economics, University of Vermont

PA6230OL1: Non-Profit Administration

Sarah Henshaw

December 7th, 2025

Executive Summary

Vermont's Free and Referral Clinics (VFRC) collaboration advocates for a more inclusive, equitable, and accessible healthcare system. It is a collaboration between eight free and referral clinics in Vermont, who utilize a shared services model to reduce administrative burden as well as a coordinating body and collective impact models to advocate for change at a state-level and collaborate with shared learning and resources.

This case study uses public documents, internal documents, and an interview with the executive director of VFRC to explore what lessons we can take from VFRC's collaborative efforts, including the behaviors, characteristics, tools, and training that could benefit other non-profit collaborations. Some highlights of this analysis include:

Strengths:

- Deeply rooted shared values
- Openness to learning from and supporting other member clinics
- Executive Director with strong educational background in organization's focus areas
- Strong focus on awareness and visibility
- Strong investment in organizational growth and health
- Volunteer networking and organization

Challenges:

- Resistance to change from some member clinics
- Historical tendency to avoid visibility
- Limited staff capacity
- Exclusivity within board of directors
- Lack of uniformity between member clinics
- Low capacity for data collection and reporting

Demographic/ Description of the Collaboration/ Shared Service

The Vermont Free and Referral Clinics collaboration began as the Vermont Coalition of Clinics for the Uninsured in 1998. This remains the legal name of the organization, although rebranding is ongoing. There are currently eight member clinics, five provide direct clinical care, including medical and dental services depending on the clinic, and three are referral clinics. A referral clinic does not provide clinical services, instead focusing on connecting people to resources, assisting in navigating the healthcare system, and other related support services.

While the member clinics provide services to individuals, the Vermont Free and Referral Clinics (VFRC) is an organization providing support to their member clinics and advancing advocacy at a state level. VFRC is recognized by the IRS as a 501c3 organization. Their mission has recently been updated to read, "Vermont's Free & Referral Clinics (VFRC) advocates for a more inclusive, equitable, and accessible healthcare system." (VFRC, 2025) VFRC also aims to reduce the administrative burden on its member clinics while each clinic is able to maintain autonomy as independent non-profits. This reduction in administrative burden comes largely in the form of grant management and distribution. The executive director of VFRC performs grant management and grant funding distribution on behalf of their member clinics. Additionally, VFRC offers bundled professional liability insurance which reduces administrative burden and costs for individual clinics. From an organizational perspective, the board of directors is composed of eight members, one from each of the member clinics. Olivia Sharrow serves as the executive director, a role she took on when she was hired in 2021.

VFRC resembles a shared services model because of the administrative work that VFRC does on behalf of their member clinics. Grant administration is a time consuming task, and collaborating on managing funding for multiple organizations can increase capacity for

non-profits. They also resemble a coordinating body model because of the shared purpose of their member organizations, the use of VFRC as a unified force for state-level change and advocacy, and the resource, information, and lesson sharing between clinics.

Why the Collaborative Formed

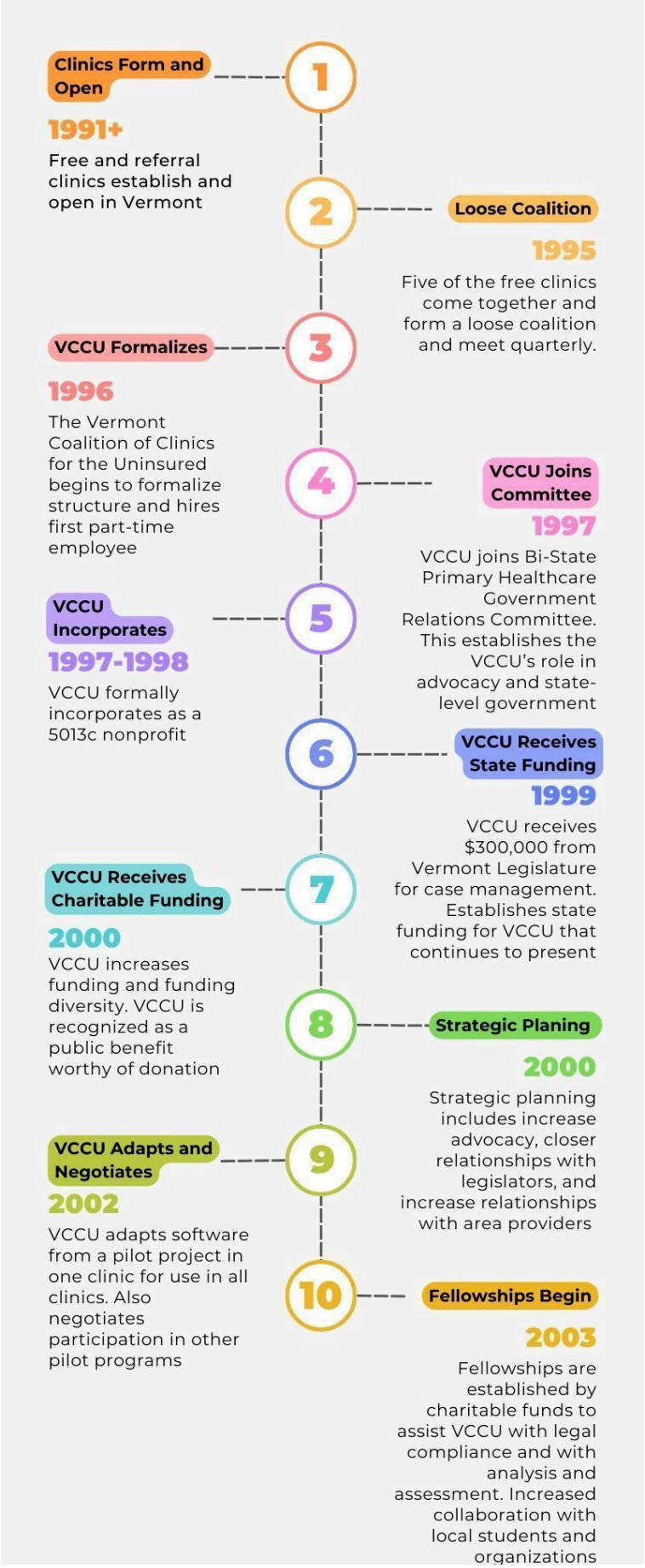
In the early 1990's, a number of free and referral clinics opened across the state of Vermont to address the uninsured population and bring healthcare to rural areas. Prior to 1998, these clinics operated 100% independently, relying on personal relationships between clinicians to facilitate collaboration and resource sharing. Each clinic served its own locale, had its own business model, organized separately, and most importantly, applied for grants and funding individually. In 1998, what had previously been a loose coalition of five clinics in the middle and southern portions of the state, came together to form a 5013c NonProfit. This became the Vermont Coalition of Clinics for the Uninsured (VCCU), a first of its kind collaborative in New England. The coalition had one primary goal: to organize and pool clinic resources to apply for state and federal aid as one entity. In this way, the clinics would have more power to acquire a larger sum that could then be distributed amongst them.

As time went on, the organization grew, and so did their mission. VCCU added 4 more clinics to their membership. State policy changes in 2006 altered who was eligible for programs. Clinics began to see higher numbers of patients who were not uninsured, but rather could not afford their healthcare deductibles or copays. The culture around Healthcare in Vermont was shifting, and people needed a voice. What was once an ad-hoc collaboration centered around grant application, expanded to an advocacy coalition whose focus bifurcated into two distinct arms: On one side, funding securement with expanded grant management, and on the other side, state-level advocacy for healthcare policy. This larger, membership non-profit, who aimed to bring healthcare to the wider state, decided to rebrand.

In 2019 the Vermont Coalition of Clinics for the Uninsured became the Vermont Free and Referral Clinics (VFRC). The current version of the VCCU bylaws, (last updated in 2023) states:

“The mission of this Corporation is to support member free clinic programs in Vermont that identify gaps and provide access to care, via on site or referral services, to uninsured and under-insured people”.

Timeline of Collaboration/ Shared Service



11

Settlement

2004

VCCU is awarded settlement money to pay for medications

12

State Funding Increase

2005

State funding is increased to $500,000 annually

13

Insurance Bundle

2005

VCCU bundles professional liability insurance to reduce costs for member clinics. Shared services lower burden on individual clinics

14

State Funding Changes

2006

State funding is again increased, now to $640,000. Funding is now tied to Medcaid and VHAP enrollment

15

ACA Implementation

2014

VCCU member clinics remain as a safety net for people missed by the healthcare system

16

Rebrand Begins

2019

VCCU begins to rebrand as Vermont Free and Referral Clinics. Rebrand encompasses current work and reflects patient population changes

17

Increase in State Grant Funding

2023

40% increase in legislative grant funding from Vermont

18

Mission Statement Changes

2025

Board of Directors votes to change mission statement to encompass more activities of the VFRC

Key Behaviors & Characteristics of Member Organizations & Leadership

Shared Values

The Vermont Free & Referral Clinics (VFRC) network brings together eight independent nonprofit clinics that share a fundamental belief that healthcare is a human right. While this value is the most central, the clinics also share several other values that support their collaboration: a commitment to dignity and respect for patients, a belief in low-barrier access to care, and a dedication to serving Vermonters who are often overlooked by the broader healthcare system. These values help sustain the network by giving members a sense of common purpose even when they are facing very different local challenges or serving distinct populations. In interviews, it was clear that this shared understanding of their role in the healthcare safety net is part of what keeps clinics invested in the collaborative.

Shared Behaviors That Contribute to Success

A major behavior that strengthens the collaboration is the willingness of clinic directors to learn from and support one another. Although each clinic operates independently, directors regularly share strategies, challenges, and problem-solving approaches. Knowledge-sharing often happens informally—through conversations, emails, or quick check-ins—but VFRC is working toward more structured mechanisms, such as committee meetings and shared planning processes. When one clinic experiments with a useful outreach model or expands a service, others can consider adapting it. This reduces isolation, especially for directors who rely on volunteers and have limited administrative support. The shared learning environment reinforces the idea that even though the clinics are independent, they are not alone.

Influence of Leadership

Leadership—both from the Executive Director and the Board—has shaped how VFRC has evolved. The Executive Director's background in public health and advocacy introduced a systems-level perspective that moved VFRC beyond simply receiving and distributing funds. Historically, the organization avoided visibility, but Olivia's leadership encouraged the clinics to take on a stronger advocacy role. This shift became possible partly because the healthcare landscape changed: rising care costs, shifts in Medicaid, and increasing needs among uninsured and immigrant populations created urgency. Clinics recognized that staying "under the radar" no longer protected them or their patients; instead, being more visible was necessary to secure resources and influence policy.

The Board of Directors has also played a significant role. Historically viewed as somewhat insular, the Board has shifted toward greater openness and reflection. Strategic planning helped clarify shared values and introduced the idea of VFRC as a "network" rather than simply a funding structure. While the Board includes representatives connected to the clinics, part of its growth has involved reconsidering which voices need to be included for effective decision-making. This has initiated conversations about committees, representation, and what leadership looks like in a collaborative where most members are used to having full control over their own organizations.

Shared Challenges

One ongoing challenge is the network's strong emphasis on autonomy. Each clinic is its own nonprofit, and many are hesitant to adopt uniform processes or change established systems. When some directors express concern about "too much coordination," they are often referring to fear that shared processes—like standardized reporting or data systems—might force clinics to operate more similarly than they want, or reduce their control over how they serve their local

communities. This tension is natural in shared-service models but still makes some network-wide initiatives difficult to implement.

Another challenge is the lingering historical culture of low visibility. While many clinics operated quietly to avoid political controversy, this made external communication and advocacy difficult. Without a collective voice, the network struggled to educate the public or policymakers about what free and referral clinics do, limiting their ability to influence funding decisions—even though advocacy was one of the original reasons for coming together. The lack of unified messaging also made it harder for the public to understand the difference between free clinics, referral clinics, and other safety-net providers.

Capacity is also a major limitation. With only one staff member at the association level, VFRC cannot fully support the administrative or communication needs of the network. This affects data collection, grant reporting, and outreach. Despite these constraints, VFRC plays key collaborative roles such as centralized grant management, coordinating advocacy, facilitating peer support, and serving as the statewide point of contact for partners and policymakers.

Reflection

The VFRC network illustrates both the potential and difficulty of collaborative work. Shared values and supportive relationships strengthen the coalition, while autonomy, uneven capacity, and past communication norms create real barriers. Yet the movement toward clearer shared identity and stronger leadership signals that the network is continuing to evolve together.

Key Tools & Practices

Successes

The Vermont Free & Referral Clinics rely on the passion and care that the clinics and their staff have for their patients and their communities. In turn, the clinics rely on the collaborative and administrative force of VFRC to navigate the relationship between the federal state government, and the clinic's healthcare providers. Two main tools and practices have helped to contribute to VRFC's successes.

The first is the VFRC Board's investment in their own growth. They hired an outside consultant to help identify tensions, personal conflicts, and understand where there may be gaps in knowledge or leadership. This was an essential step, as a board is meant to be the guiding body of the organization. VFRC's board has in some ways more power and responsibility than boards of other organizations, since the actual VFRC nonprofit has only one employee, the executive director. In the past, the board relied on the executive director to lead the way, but is working to step more into that leadership role.

The second strength is how the VFRC effectively leverages their network of volunteers and support staff to provide care and coordination to patients. The referral clinics, which do not provide care, but rather help patients find care providers, are able to partner with clinics to get the right care to the right patient. VFRC's network structure keeps the clinics in direct contact, with fewer barriers than traditional healthcare. VFRC focuses on, and is working to take on more of, the administration, so that the clinics and their staff that focus on providing the care.

Challenges

Although this organization is strong and effective, the VFCR has been met with challenges. The most salient of which is navigating the relationship between independent

member clinics and creating a shared system. The individual clinics want to continue to operate independently, as unique non-profits, with individual narratives, however this makes it difficult to offer uniform resources across the state and to maintain one, cohesive message. One patient can't simply go to any VFRC clinic and receive the same care. Many patients don't have access to transportation, and couldn't easily go, for example, from Bennington to Springfield. Additionally, the organization, and particularly the board, has a history of exclusivity. Though there is room for non-director board members, the board is currently only made up of the directors from each clinic and the VFRC Executive Director. This means that decisions inside the individual clinics, and at the collaborative level, are both being made by the same people. Many non-profits in the state of Vermont offer board positions to people outside the management structure and from the local community. For example, the Champlain Housing Trust has a group of "resident members" who serve as representatives of the residents of housing trust rental units. Finally, Data collection and reporting remain a challenge for this organization. Without data-minded staff and strong reporting structures, VFRC struggles to communicate externally about the work being done and it is difficult to understand the collective impact of the organization as a whole.

Looking to the Future

1. Inviting more outside voices to the table. This could come in the form of adding new board members who are not clinic directors, like clinic staff or even patients who have had positive experiences and relationships with the organization in the past. Another option could be to network with similar organizations or with other professionals doing similar advocacy and health work. Allowing non-leadership to participate in future development of the organization could help VFRC to gain insight into potential blind

spots. Broadening the horizons of the organization will not only bring diverse experiences, but it will also continue to grow the network. If VFRC hopes to continue to advocate for healthcare in the state of Vermont and to affect policy change, it would be prudent to include not only healthcare workers, but those well versed in public administration, economics, and politics as well.

2. Expanding the staff and capacity of VFRC itself. Though there are, of course, resource implications, hiring another staff member or bringing on a professional consultant could help to shoulder some of the workload. VFRC would be better served by an executive director position aimed at growing the organization and coordinating healthcare advocacy efforts. Another staff member could take on some of the administrative work, especially grant-related. Additionally, finding someone with key skillsets that are missing could aid in some of the areas that VFRC is lacking, like data collection and reporting.
3. Updating VFRC's technical resources and web presence. The current VFRC website is lacking in content and is visually dated. Additionally, the VFRC patient management portal is antiquated. Investing in updates to these tools would help VFRC to have a better presence and allow for a space to host new information as the organization continues to evolve.

Lessons & Best Practices

Shared Language and Identity:

One of the strongest lessons from VFRC's experience is the importance of developing shared language and identity. For many years, each clinic presented itself independently, which limited the collaborative's ability to speak with a unified voice. This lack of collective identity affected advocacy: policymakers did not always understand who the clinics served or the scale of their impact. Through recent strategic planning, VFRC created shared mission and values statements and adopted the term "network," which has helped create consistency in how members describe their work. This shift strengthens advocacy by making it clearer what the network represents and why Vermont needs its clinics.

Role of Relationships

Relationships built the foundation of the collaboration. Directors connected informally, trusted one another, and eventually formalized a network to pursue shared funding. These relationships continue to serve as the emotional glue of the network. However, VFRC's experience also shows that relationships require maintenance—especially as staff change, needs evolve, and external pressures intensify. VFRC is now learning to combine informal trust with more structured communication practices so the collaboration remains strong even as leadership or clinic staffing shifts.

Capacity and Shared Services

One key lesson is that collaborations only function well when they are resourced appropriately. VFRC's model demonstrates how much is possible with just one staff member, but also shows the limits. Shared services—such as centralized grant reporting, statewide advocacy, peer learning opportunities, and coordinated communication—require shared investment.

Without dedicated capacity for data, outreach, or administration, the collaborative cannot fully demonstrate its impact or scale its work.

Adaptability and External Pressure

The network has had to adapt to shifting healthcare realities. Immigration policy changes, rising premiums, and Medicaid fluctuations have increased demand for services across clinics. These pressures pushed VFRC toward a more active role in advocacy. This adaptability is a best practice for other collaborations: the most resilient networks evolve their roles as community needs and political conditions change.

Collective Commitment

A final lesson is that collaboration requires members to care about more than their own organizations. Olivia emphasized that developing a shared understanding of "the work"—what is similar, what is different, and how it should be communicated—was both challenging and transformative. Once clinics embraced the idea of VFRC as a collective entity, advocacy and coordination became stronger. This underscores the importance of seeing the network's success as tied to each clinic's individual success.

Best Practices for Other Nonprofits

- Establish shared mission, values, and language early
- Build and maintain trust through consistent communication
- Balance independence with the need for alignment
- Resource collaboration adequately with staffing and funding
- Use external pressures as opportunities for solidarity
- Embrace visibility to strengthen advocacy and public understanding

Closing Reflection

The VFRC network demonstrates that collaboration is not simply structural but cultural. When organizations intentionally cultivate shared identity, invest in relationships, and communicate openly, they build a foundation that allows collective work to grow stronger over time.