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Editorial

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Mind the Gap: Continuity of Care in Student-Run Free Clinics

David Lee, MD, MS[1]; Kaitlyn Quach[2]; Zabrina Abolarin[3]; Josephine Wang[4]

[1]Division of Female Pelvic Medicine & Reconstructive Surgery, Department of Obstetrics & Gynecology, Northwestern University Feinberg School of Medicine, Chicago, Illinois, USA
[2]Oakland University William Beaumont School of Medicine, Auburn Hills, Michigan, USA
[3]Rosalind Franklin University of Medicine and Science College of Pharmacy, North Chicago, Illinois, USA
[4]Yale University School of Public Health, New Haven, Connecticut, USA

Corresponding Author: David Lee, MD, MS; email: david.lee@alumni.med.wmich.edu

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Abstract

Background: Patient continuity of care is closely tied with patient health outcomes, encompassing both consistent access to health service points and patient-professional relationships. However, insurance status often limits a patient's ability to maintain continuity of care. Student-run free clinics aim to address this gap, initially focusing on primary care service lines and now diversifying into multidisciplinary operations. Ongoing evaluation and new collaborations and resources likely will be necessary for student-run free clinics to manage the growing magnitude and breadth of patient needs.
Purpose: To apply the insights shared at the Society of Student-Run Free Clinics 2023 Annual Meeting's Bridge-the-Gap session, which aims to address challenges in patient continuity of care, toward synthesizing generalizable strategies. These strategies will help student-run free clinics develop actionable approaches to strengthen patient continuity of care.
Summary: Three themes emerged over the course of multi-disciplinary discussion: 1) consistency of healthcare services, 2) breadth of healthcare service lines, and 3) mobility and portability of healthcare resources. Additional research toward developing programs and resources to strengthen patient continuity of care should be conducted to enable student-run free clinics to provide their patients with world-class care and a medical home. This editorial explores areas where student-run clinics can improve patient care via increasing opportunities for continuity of care.

Introduction

Patient outcomes are impacted by patient access to continuity of care.[1,2] The American Academy of Family Physicians describes continuity of care as "quality of care over time" and "the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care."[3] The concept has also been extensively discussed in the literature.[4-6] Data further suggest that patient confidence in and their relationship with healthcare professionals are critical to improving outcomes.[7-9]

Unfortunately, patient access to care services is heavily influenced by health insurance status. In 2023, roughly 7.7% of the United States (U.S.) population was uninsured and 30% of individuals resided in areas without access to a primary care physician.[10,11] Even amongst insured individuals, 51% of those in private industry carried high-deductible plans with median deductible of $2500.[12] This highlights continued opportunities for aligning patient needs with available resources, including those that can be offered through

student-run free clinics (SRFC).[13,14] A network of over 200 SRFCs across the United States works to address the healthcare needs of underserved and uninsured individuals, functions as a pressure-release valve for the modern healthcare system, and serves as important social justice and advocacy initiatives.[15-20] Many SRFCs now provide patients access to multidisciplinary care, and data suggest that SRFCs perform comparably to traditional healthcare settings in certain domains.[21-23] As a result, SRFCs are increasingly representing the face of healthcare services for vulnerable patient populations.[24,25]

Facilitating continuity of care in the SRFC setting can be particularly challenging.[26,27] Patients seeking care at SRFCs tend to possess a host of socioeconomic hardships such as variable living, transportation, and occupational circumstances, all of which serve as barriers to consistent care.[28,29] They also tend to present with more advanced or poorly-controlled disease states, likely secondary to previous lack of or inability to access care.[30,31] Furthermore, patient mistrust and/or lack of confidence in SRFCs and/or the healthcare system in general to care for them in a competent, respectful, and dignified manner remains a noteworthy challenge.[32] This is particularly significant given the healthcare system's history with patients from minority backgrounds and ongoing need for healing historic wounds.[33]

The persistence of these and other challenges ultimately gave rise to the Society of Student-Run Free Clinics' (SSRFC) Bridging the Gap program. With principles of hackathons and kaizens at the core of its design, the program was successfully piloted at the SSRFC 2018 Annual Meeting as an opportunity for interdisciplinary collaboration to synthesize solutions for critical SRFC challenges, and it remains an integral part of SSRFC programming.

In this editorial, we attempt to synthesize discussions that emerged from the 2023 Annual Meeting's Bridging the Gap session, and propose actionable strategies SRFCs may employ to improve patient experience, optimize care delivery, and ultimately strengthen SRFC capacity for providing patients with a medical home. Additionally, these strategies can serve as a guide for SRFC leadership when discussing quality improvement initiatives, scholarly activities, and resource allocations for their respective clinics.

Consistency

Why is this important?

SRFC patients are typically underserved and uninsured individuals, with a host of socioeconomic needs and vulnerabilities. Providing these patients with readily-available access to essential care services mitigates delays in timely evaluation for and treatment of indolent health conditions before they evolve into complications.[34] Minimizing disruptions to a patient's membership within their medical homes similarly translates to reductions in unscheduled healthcare resource usage.[35] Therefore, it is reasonable to assume that without consistent operations, some patients might struggle to access care altogether.

Potential focus areas

First, many SRFC patients tend to value their care experience over the content of the care visit itself. These patients may have various concerns, ranging from distances they must travel to appointments, to potential angst about whether they will be properly cared for at an SRFC, to how they might be perceived by staff and volunteers when they present for their appointments.[36] In 2020, the American College of Physicians issued a position paper emphasizing elements such as race and ethnicity, location, language and citizen status as key areas for eliminating barriers to patient care.[37] Thus, pursuing implementation of programs that provide SRFC patients with solutions such as telehealth and patient portals can be critical steps forward in proactively breaking down patient barriers to care.

Consistent and available services provided can be critical for patients returning to SRFCs for their health needs. If SRFCs are repeatedly unable to provide patients with the care services they need or the care experiences they desire, patients will stop sharing their concerns and their needs will likely go unaddressed.[38] The Oakland University William Beaumont School of Medicine's SRFC operational structure mitigates this by integrating with existing community healthcare infrastructure. In partnering with the Gary Burnstein Community Health Clinic (GBCHC), the SRFC initially

offered monthly Family Medicine clinic sessions and referred patients to other GBCHC healthcare team members. Following the loss of women's health professional volunteers at the height of the Coronavirus-2019 pandemic and increasing burden on remaining GBCHC service lines, a monthly Gynecology SRFC was established. This restored patient access to short-interval follow-up, ensured continued forward momentum in their individual care experiences, and demonstrated the value of ensuring consistency amongst core health services.

Additionally, robust patient scheduling and communication infrastructure are indispensable. Currently, there is significant variation in how SRFCs operate, including how many patients are seen at each clinic session and whether walk-ins are allowed. As a result, wait times for referrals and follow-up appointments can be unpredictable. This leads to uncertainty in patient lives which could adversely impact whether they choose to follow-up, and employed patients working long and unpredictable hours are at risk of lower levels of continuity-of-care.[39,40] For highly vulnerable populations, it is critical that SRFCs minimize time intervals between available appointments. One SRFC described a workaround by offering patients telehealth options, which improved safety and timeliness of a patient's care. However, ensuring patients have the necessary hardware for engaging in telehealth remains a challenge.[36] Thus, it may be advantageous to investigate opportunities for re-structuring scheduling such that same-day referrals can be seen, especially if SRFCs have more than one discipline operating at a time.

Furthermore, SRFCs should retain an emphasis on advancing equity in care given their diverse patient populations. One feature known to impact care of non-English-speaking patients is communication in their primary or preferred language.[41-43] Providing these patients with a certified medical interpreter is an ethical and legal requirement, contributes to better patient outcomes, and improves patient care satisfaction.[44,45] Unfortunately, SRFCs may not have consistent, if any, access to certified medical interpreters, and thus may rely on other translation resources with varying means of quality assurance.[46-49] Similarly important is the use of language easily understood by patients in any verbal or written materials provided. While most U.S. adults read between an 8th to 9th grade level, SRFC patients on average likely possess lower literacy levels.[50] Thus, developing a SRFC central repository of evidence-based informational materials for common health conditions written in and validated across various languages may offer lasting benefits across the SRFC landscape.

Breadth

Why is this important?

SRFC patients frequently present with concerns spanning various disciplines across healthcare. Tasking single-discipline SRFCs with addressing these needs can consume significant portions of a patient visit and generate inefficiencies in care. These pain points may be further exacerbated through a lack of robust referral systems, inadequate healthcare team staffing, and health system challenges in completing follow-up on outstanding patient needs.

Potential focus areas

Many SRFCs are connected with academic institutions that maintain relationships with healthcare facilities, community organizations, and programs for navigating care and social resource networks. Even so, they may still struggle with helping patients access indicated care.[51] One example includes scenarios where imaging or procedures function as gold standards of disease detection.[52] These challenges can put healthcare professionals in difficult situations where they find themselves obligated to counsel patients about issues they may not be able to act upon.[53] Thus, SRFCs should feel empowered to explore and maximize their professional and community relationships to develop quality pathways to indicated care interventions.

Ensuring expedient access to referral bases can also mitigate patient risk profiles, especially in patients with chronic conditions.[53] For instance, private practice physicians have previously opted to see uninsured patients under a charity care system.[54] These physicians may also donate their referral services to SRFCs, either occasionally or on a limited basis. However, their

magnitude of care for the uninsured is closely tied to infrastructure at their respective institutions and the reimbursement models they operate under.[55,56] As a result, leveraging faculty and administrative resources may help streamline these referral processes.[57]

Similarly critical in maximizing patient retention is providing diversity in healthcare disciplines. The role of multi-disciplinary care has already been demonstrated in traditional care settings.[58,59] However, for single-discipline SRFCs looking to expand, there is limited guidance on which disciplines (e.g. dentistry, optometry, behavioral health, etc.) would be most beneficial to establish first.[60-62] The magnitude of need for specific specialties likely differ depending on a given SRFCs patient population and location.[63-65] Similarly, SRFCs should consider the practicalities and ethics of establishing subspecialty clinics that may only be able to offer patients a limited range of services that overlap with the scope of practice of core service lines versus maximizing the scope and reach of core service lines.[66] As a result, SRFCs must balance the costs of establishing new specialty clinics with the benefits of being able to offer patients in-house subspecialist referrals.[67,68]

Investing in the integration of Graduate Medical Education and similar advanced trainees into the SRFC setting can benefit these programs as they may gain valuable relationships with SRFCs while caring for their patient populations.[67,69,70] This can be particularly helpful for training programs with health tracks including rural medicine or health equity with requirements that could be fulfilled through their involvement.[71,72] Other reasons to bring in these individuals include potentially alleviating volunteer physician shortages and augmenting SRFC patient load capacity. Their participation may also expand educational opportunities for students, other advanced trainees, and patients.[73] Additionally, they may increase potential for completing and disseminating SRFC research which provides an additional avenue for advancing interdisciplinary education. Finally, it provides junior faculty with an accessible resource to develop their professional profiles with.

SRFCs should further examine opportunities for integrating their work into the health policy interests and initiatives of health professional organizations guiding the practices of represented disciplines.[14] SRFCs are uniquely positioned to witness, hear, and lend voice to patient concerns that span beyond the immediate perimeter of healthcare.[74] While it is understandable that SRFCs might not offer all the same care options available in traditional care setting, they should still should endeavor to close these gaps in care.

Mobility

Why is this important?

A number of SRFCs have dedicated themselves to bringing care services to where patients are rather than expecting patients to come find them. This initially meant bringing care to patients, often in a what-is-available when-it-is-available fashion. However, the evolving landscape of care for underserved and vulnerable patients across communities commanded SRFCs to evolve. Providing these services helped fixate a lens on day-to-day challenges of SRFC patients and efforts to address ongoing challenges.[75-77]

Potential focus areas

First, achieving clinic health record interoperability is critical to delivering quality patient care. Similar to traditional care environments, SRFCs vary considerably in the electronic healthcare platforms (EHR) they utilize, if any at all.[78,79] There also remains no guidance on which particular EHR platform would best suit the needs of SRFCs across disciplines, locations, and operational models. SRFCs have an opportunity to set an example for all of healthcare through endeavors to identify a singular EHR model that meets the needs of SRFCs across the country.

Next, developing a national database resembling those of government or private insurance entities of most-commonly utilized diagnosis codes for SRFC patients in each discipline would be invaluable. Magnitude and breadth of diagnosis codes function as a reflection of outstanding care needs across our communities. Unfortunately, it is well-known that even seasoned health professionals can struggle with documentation, and it is likely that their learners will struggle even more. There may be opportunities for SRFCs to intervene through integration elements of

training and quality assurance within their institutions' training curricula.[51,80]

Furthermore, while certain directory resources exist to help patients locate free clinics in their areas, there is no similar national directory specifically for SRFCs.[81,82] This can be particularly troublesome for certain SRFC patient groups, such as migrant farmers who face limited access to healthcare and often have to repeatedly explain their medical history to new healthcare teams.[83] For example, one clinic in Michigan described how their patients typically followed seasonal routes: the Great Plains area in the Spring, the Midwest in the Summer, the Carolinas and Georgia areas in the Fall, and the Florida area in the Winter.[84] Each of these likely bring unique limitations in healthcare delivery and opportunities for expanding health education and interventions.[85,86] A national SRFC directory would enable warm hand-offs and referrals to other SRFCs when these patients move from one area to another. It may also facilitate a greater sense of belonging amongst patients when they are given access to an array of SRFC network healthcare service points. Furthermore, this may ensure that patients can follow-up on services they previously utilized such as contraception when they move to a new area.[85,86]

Conclusion

SRFCs are poised at the perfect junction to address inequities and deficits within our society's current healthcare infrastructure. While they have demonstrated significant strides forward in meeting the ever-evolving landscape of patient needs, continued reassessment and growth in domains including but not limited to service breadth, mobility, and consistency are integral to SRFC operations staying relevant within their communities. Achieving these likely will require concerted efforts across SRFCs and their partner organizations. Ultimately, our SRFCs should be empowered to embrace leadership roles in their communities, to provide a platform for lending voice to their patients, and to advocate for needed changes.

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