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Reopening a Student-Run Free Clinic During the COVID-19 Pandemic to Provide Care for People Experiencing Homelessness

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Data: Data presented in this article regarding number of televisits were collected for the internal telehealth grant. Data on numbers of volunteers and clinic volume were collected routinely for JeffHOPE quality improvement purposes.
Abstract

Problem

Student-run free clinics (SRFCs) provide health and outreach services to underserved populations while offering medical students opportunities for service and education. Many SRFCs were forced to suspend in-person operations in early 2020 due to the COVID-19 pandemic. Prior to March 2020, JeffHOPE, the SRFC at Sidney Kimmel Medical College at Thomas Jefferson University, operated an evening clinic at 5 locations throughout Philadelphia each week.

Approach

JeffHOPE’s response to challenges posed by COVID-19 focused on a redesign for a pilot clinic at a shelter site that expressed interest in resuming operations. The student leaders conducted a needs assessment with shelter stakeholders, including administrators and long-term residents, to identify service priorities. They also developed a list of key components for safe patient engagement and care delivery. A hybrid telehealth approach was developed to reduce in-person exposure for patients and volunteers and to involve preclinical medical students remotely. Three iPads were acquired via an internal grant.

Outcomes

The pilot clinic reopened in September 2020. Over the first 13 weeks of operation, 44 unique patients received care across 98 visits. Of these visits, 21 were in-person only with a clinical student and preceptor, while 77 also used the hybrid telehealth model to connect via iPad with a preclinical student. Patient visit volume was approximately 35-40% of the pre-COVID level. Of the 58 total volunteers, 11 were preclinical students who participated remotely.
Next Steps

Three additional JeffHOPE clinic sites have reopened since December 2020 using this hybrid telehealth model. Patient feedback, via surveys and interviews, will determine which components are retained. Other SRFCs should be encouraged to innovate and develop plans for safe resumption of services, with an appropriate approach and organizational support, despite the challenges posed by the pandemic.
Problem

Student-run free clinics (SRFCs) have historically provided underserved populations with health and outreach services while offering medical students opportunities for service and education.\textsuperscript{1} Research has shown that SRFCs can provide preventive care, diabetes management, and screening for infectious diseases.\textsuperscript{2,3,4} In March 2020, however, many SRFCs in the United States were forced to cease in-person operations due to the COVID-19 pandemic.

JeffHOPE, our SRFC, was established in 1991 through Sidney Kimmel Medical College at Thomas Jefferson University. JeffHOPE focuses on engaging homeless and underserved individuals and empowering them to navigate established health resources (e.g., housing, public benefits, job training, long-term medical care) while also providing them with acute medical care as needed. Prior to the pandemic, JeffHOPE operated an evening clinic at 5 different locations within Philadelphia each week.\textsuperscript{4,5} Four clinics operated within shelters, and one clinic operated at a nonprofit center promoting harm reduction among people with opioid use disorder and housing insecurity. Each clinic was led by a third- or fourth-year medical student and a physician preceptor and staffed by medical student, resident, and faculty physician volunteers. Fifty-six preclinical students volunteered weekly in trained roles, such as triage, education and counseling, sexually transmitted infection screening, and advocacy and resource navigation.\textsuperscript{4,5}

Given the projected disproportionate impact of COVID-19 on people experiencing homelessness\textsuperscript{6} and the lack of available personal protective equipment (PPE) for clinic volunteers, JeffHOPE leaders decided to suspend in-person services in early March 2020. This coincided with the suspension of on-site volunteer activities at our partner sites. In this Innovation Report, we outline the steps we took to develop and implement a pilot clinic to resume services safely 6 months later, despite the challenges posed by COVID-19.
**Approach**

During the initial months of the pandemic, one of JeffHOPE’s partner sites shifted from a short-term shelter to a long-term model and suspended daytime drop-in services to provide stability and safety to guests. In June 2020, the site leaders expressed interest in reopening the JeffHOPE clinic after receiving requests from guests and staff. Revisiting JeffHOPE’s mission—to improve access to health care for the homeless and underserved populations of Philadelphia, as well as to educate trainees and faculty about medical issues, homelessness, and poverty—motivated our student leadership team to prioritize shelter clinic re-opening. Over the next 3 months, JeffHOPE leaders focused on a redesign for a pilot clinic to provide clinical and health education support to individuals experiencing homelessness while addressing the safety concerns of the shelter leaders, student volunteers, and medical college and health system leaders.

Core to our reopening process was the needs assessment we conducted to identify the service priorities of the clinic given the gap caused by pandemic restrictions. Conversations during June and July with shelter stakeholders, including administrators and long-term residents, prioritized the following services: acute short-term medical care, smoking cessation, health education, advocacy services including connection to primary care, and hygiene supply distribution. In August, as part of our planning and creative collaboration, we developed a list of key components for safe patient engagement and care delivery at our SRFC during the pandemic. The components included: leadership; maintenance of community and organizational support; PPE needs and supply chain; volunteer screening; patient screening; clinic staffing; volunteer transportation; and clinic infrastructure.
Concurrently, in August, we developed a hybrid telehealth model to provide services in accordance with physical distancing guidelines to permit participation by preclinical student volunteers. Through an institutional grant, we acquired 3 iPads with secure wireless internet and a video platform (Zoom for Healthcare, Zoom Video Communications Inc., San Jose, California) compliant with the Health Insurance Portability and Accountability Act (HIPAA). In our hybrid model, clinical students were present on-site in full PPE to facilitate operations and disinfection of the iPads. Preclinical students participated in their trained roles remotely, which also reduced face-to-face exposure for patients and on-site volunteers.

In September 2020, one week prior to reopening, we conducted a shelter site visit to measure the clinical space and map out a safe flow for patients and volunteers. Safety protocols for on-site volunteers were modeled on those established by Thomas Jefferson University for students in clinical settings and closely mirrored those of the Department of Family and Community Medicine, our sponsoring department. Before each week’s clinic session, clinical students completed a symptom questionnaire and attested that (1) they had not had a known COVID exposure and (2) they had not violated physical distancing protocols in the prior 2 weeks.

Students were permitted to not participate in a session if they did not feel they were fit for duty. Resident and faculty volunteers also completed COVID-19 symptom and exposure questionnaires before volunteering at the clinic each week.

Patients were required by shelter staff to sign up in advance for each weekly clinic session. Prior to clinic entry, patient body temperature and symptom screening (similar to the screening used at the university’s medical practices) was performed by a student in full PPE. Patients who failed the screening had their clinic visits deferred and were assessed for need for urgent medical attention by the on-site physician preceptor. Per an algorithm developed with shelter leaders,
patients without emergent medical need were quarantined and referred urgently to a shelter-designated site for testing.

**Outcomes**

**Patient and volunteer data**

The JeffHOPE pilot clinic reopened at the shelter in early September 2020. In the course of the first 13 weekly clinic sessions (September 2020–December 2020), 98 patient visits occurred among 44 unique patients. Of these 98 visits, 21 were in-person only with a clinical student and preceptor, while 77 also used the hybrid telehealth model to connect via iPad with a preclinical student. In our previous model, approximately 20 unique patient visits occurred per session, and none utilized telehealth. Of the 58 volunteers who participated in the pilot clinic remotely or in person, 11 were preclinical students who participated weekly via telehealth. Two patients were sent to the emergency department for COVID-19 testing due to symptoms revealed during preclinic screening and physician triage. No students tested positive for COVID-19 after volunteering on-site, and no patients tested positive for COVID-19 after visiting the clinic. Data on volume and utilization were collected by JeffHOPE’s research committee for the purpose of quality improvement.

**Challenges**

One of the challenges of the redesign was the negative impact on patient volume and throughput. The extra attention to preclinic screening, fewer volunteers on-site, fewer guests in the shelter, physical distancing requirements in the clinic space, limited number of iPads, and cleaning of the workstations resulted in a patient volume that was approximately 35–40% of the pre-COVID level.
While we anticipate that volume may increase as more guests are allowed to stay in the shelter and our processes become more streamlined, the initial lower volume allowed us to focus on refining our new processes and to debrief in real time. Our primary objectives of safely piloting clinic operations in the shelter, engaging preclinical and clinical students, and providing JeffHOPE services to individuals experiencing homelessness were met.

**Next Steps**

Motivated by our mission to serve people experiencing homelessness in Philadelphia, the JeffHOPE student organization has reflected, strategized, innovated, and adapted during the pandemic. At the time of writing in September 2021, continuous quality improvement initiatives are ongoing. Since the pilot clinic’s reopening in September 2020, weekly updates have been discussed with the JeffHOPE faculty advisor (R.M.) and summaries have been forwarded to the associate dean of the medical college for review and comment. Twice-monthly meetings with JeffHOPE student leaders and the faculty advisor have identified improvements or refinements needed in clinic operations. Current challenges include volunteer continuity, clinic flow, and patients who score indeterminately on the preclinic screening questionnaire.

Formal evaluation of the effectiveness of the JeffHOPE services provided via telehealth is needed, but we are encouraged that the pilot data show we are safely engaging patients in the shelter setting while accommodating physical distancing and involving students and clinicians. Since December 2020, three additional JeffHOPE clinic sites have reopened using the pilot clinic’s hybrid telehealth model and additional iPads that we acquired. This model allows flexibility and safety in providing services in each clinical space, but patient feedback, via surveys and interviews, will determine which components are retained.
Our pilot reopening would not have been successful without support and encouragement from our larger organization. Our existing collaboration with the Department of Family and Community Medicine gave us access to physician staffing, PPE purchasing channels, and approved symptom screeners that were developed by health system leaders and legal representatives. The associate dean of our medical college was willing to review our weekly update summaries and identify facilitators and barriers. Collaborating with university faculty connected us to an internal telehealth grant and helped us build the infrastructure to support our virtual operations.

Although the specific details of our pilot clinic reopening are not likely to be fully generalizable to other SRFCs, we believe our cycle of innovation is replicable. We encourage other SRFC leaders to study their local landscape and engage their members, their community partners, and their institutions’ administrative leaders in forward-thinking discussions to innovate and develop appropriate approaches to re-engage patients and resume services safely, despite the challenges posted by the pandemic.
References


