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Descriptive Report

Addressing Social Determinants of Health in a Free Clinic Setting: A Student-Run Free Clinic and Community Resource Navigator Program

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Abstract

Background: Social determinants of health (SDOH) disproportionately affect medically underserved populations such as those cared for in student-run free clinics (SRFCs). Community resource programs which address SDOH play an important role in reducing health disparities. The Southside MEDiC Clinic (SMC), a SRFC at the University of Wisconsin School of Medicine and Public Health, partnered with the Community Resource Navigator Program (CRNP), a community resource program focused on addressing SDOH, to remove barriers that prevent positive health outcomes for SMC patients.
Aim: Our objective is to describe the partnership between the SMC and the CRNP. We hope this design may be used as a model for addressing SDOH in other SRFCs.
Discussion: Partnership goals include improved patient perception of health, increased communication between patients and the clinic, and enhanced opportunities for volunteer action-learning. Challenges discussed include adaptation to unique clinics. Future directions and potential advancements in this partnership are also addressed.

Introduction

As defined by the World Health Organization, social determinants of health (SDOH) refer to "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[1] Underserved patients, including undocumented immigrants, racial and ethnic minorities, homeless individuals, and other uninsured patients, are at increased risk of chronic health conditions due to the impacts of various SDOH.[2] Such determinants include poverty, food and housing insecurity, lack of access to healthcare and education, and marginalization.[3] It has been shown that addressing SDOH in a clinical setting can reduce health disparities, hospitalizations, and cumulative healthcare costs to individuals and society as a whole.[4-5]

Multiple needs assessments in free clinics have identified systems navigation and SDOH-related interventions as focus areas to address gaps in services and improve patient experience.[6-9] While screening for SDOH has been shown to increase referrals to community resources,[10] researchers have identified that free clinics must better design and integrate intervention strategies following screening.[11] One avenue for addressing SDOH in traditional clinics is through community resource programs that develop individualized plans to address social needs and remove barriers to care.[12] Community resource programs in traditional clinic settings have been shown to reduce unmet social needs and improve patient satisfaction, but more research is needed to assess the efficacy of such programs in free clinics.[13-14]

The University of Wisconsin (UW)-Madison Community Resource Navigator Program

(CRNP) was established in 2016 with the aim of identifying patients in the Madison, Wisconsin, community with SDOH needs and connecting them to resources. It was modeled after the Health Leads community resource program, which aims to connect communities to essential resources that dictate health and wellbeing like food, heat, and housing.[15] Similarly, the CRNP addresses social needs and improves patient satisfaction in traditional clinic settings. According to a recent study of patients enrolled in the CRNP, a majority of patients reported an improvement in their area of concern and overall perception of health, satisfaction with the co-location of services, and increased trust in providers, the clinic, and the healthcare system.[16]

In addition to benefiting patients, the CRNP provides educational benefits to student volunteers, most of whom intend to pursue health professions careers. Studies conducted at several medical schools found that student engagement with patient care in underserved areas increases empathy, knowledge, and intention of practicing in an underserved area.[17-19] In this way, benefits of a partnership between a free clinic and a resource navigation program may extend beyond individual experiences to affect the attitudes and decision making of future healthcare professionals. Considering the benefits provided by addressing SDOH for patients and students alike, we present a model for the integration of community resource programs into free clinics.

Partnership Formation

The CRNP is an outreach program of the UW Center for Patient Partnerships (CPP), an interdisciplinary patient advocacy organization based out of the UW-Madison Law School. Funding for the CRNP stems from grants and the CPP. The CRNP began operating within a Federally Qualified Health Center in Madison in 2016 and has since expanded to a Madison area primary care clinic and a student-run free clinic (SRFC). At all sites, the CRNP is staffed by undergraduate volunteers with oversight from an offsite team including a social worker, lawyer, and community health worker. All resource navigators complete a semester-long service-learning course at UW–Madison in which they learn about community resources and social systems.

The MEDiC clinic system consists of six SRFCs at the University of Wisconsin School of Medicine and Public Health, one of which is the MEDiC Southside Clinic (MSC). The MSC operates as a weekly acute care walk-in clinic, which prior to the COVID-19 pandemic served an average of 22 patients per week, 96% of whom were uninsured. In 2019, 78% of MSC patients identified as Hispanic or Latinx, and 87% of patients preferred to speak a language other than English, with over 40 languages represented (Table 1). MSC volunteers consist of a multidisciplinary group of medical, physician assistant, nursing, and pharmacy students overseen by licensed providers. In addition to the services provided in the clinic, MSC routinely makes referrals to area hospitals, outpatient clinics, and community programs that provide free or low-cost medical care in a variety of areas (Figure 1).

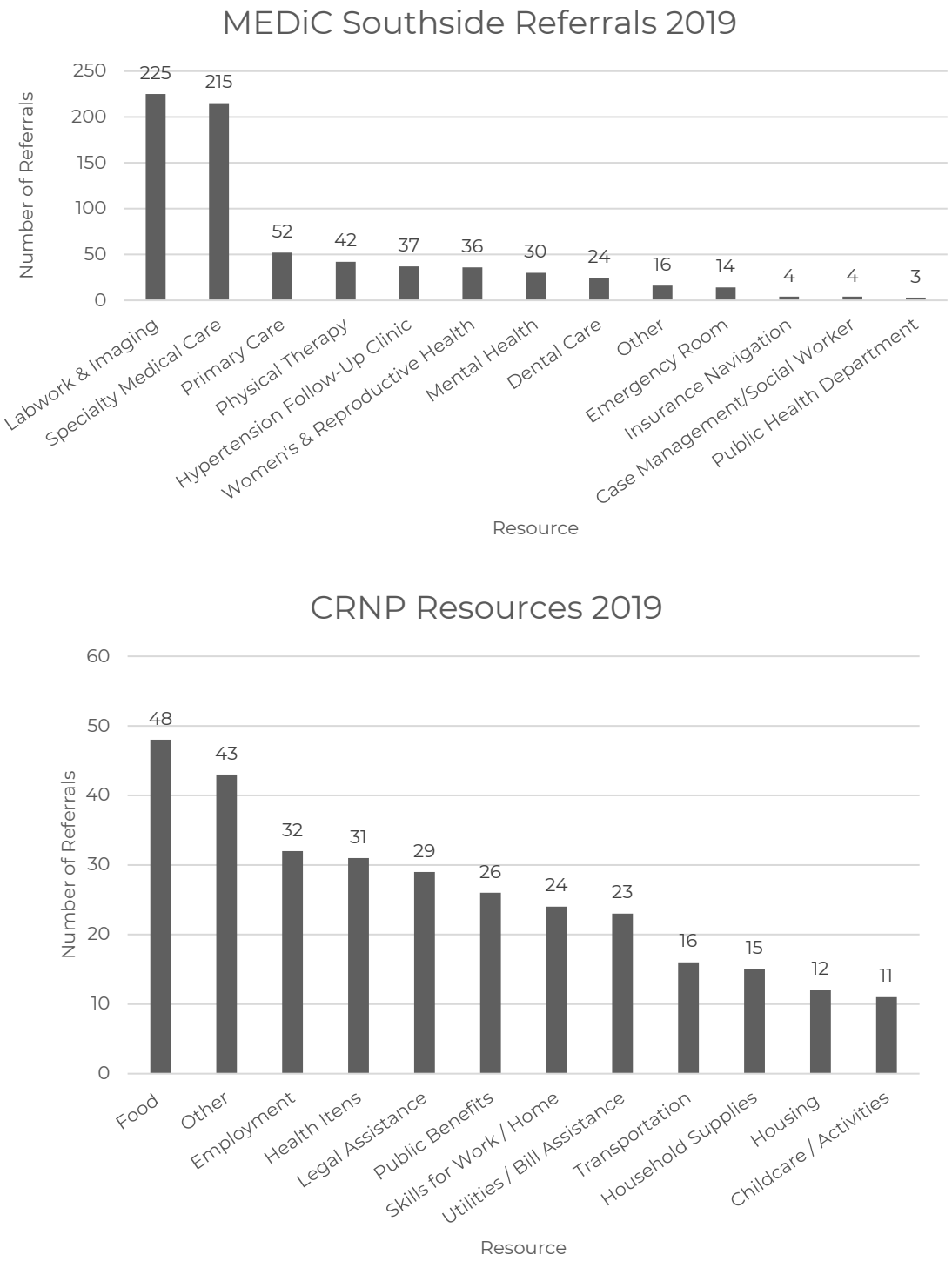
A partnership was formed between MSC and the CRNP in 2018. Creation of this partnership

Table 1. Demographics of 2019 MSC patients

Demographic	Number of Patients (%)
Gender	
Female	580 (54%)
Male	492 (46%)
Primary Language	
Spanish	759 (72%)
English	141 (13%)
Mandinka	20 (2%)
French	11 (1%)
Hindi	11 (1%)
Other	110 (10%)
Ethnicity	
Hispanic/Latinx	776 (77%)
Not Hispanic/Latinx	214 (21%)
Unknown	13 (1%)
Race	
White	302 (45%)
Black	112 (17%)
Asian	59 (9%)
American Indian	27 (4%)
Unknown	168 (25%)

MSC: MEDiC Southside Clinic

Figure 1. Comparison of resources and referrals provided by MSC vs. the CRNP in 2019



MSC: MEDiC Southside Clinic; CRNP: Community Resource Navigator Program; Specific information regarding referrals can be found in Appendix A

was mutually beneficial, as it allowed the CRNP to extend its services beyond traditional clinic settings to work with uninsured patients and promoted MEDiC's desire to provide high-quality patient care that included addressing SDOH as part of the treatment plan. The programs' shared goal of improving health outcomes was foundational to successful partnership creation. The following year, 189 MSC patients were referred to the CRNP, which constituted the majority of MSC referrals related to social services (Figure 1).

Workflow

Intake and Medical Visit

Upon arrival, patients complete consent and privacy forms along with an optional SDOH screening tool. The screening tool, readily available in English and Spanish with options to translate to additional languages, explains the CRNP, collects contact information, and prompts patients to respond "yes" or "no" to statements regarding their need for community resources (Appendix B). The tool was developed to be inclusive of patients with a wide range of literacy levels by utilizing images and simple sentences; however, it can also be verbally read to patients, employing interpreter services as appropriate. Upon completion, a MSC intake volunteer collects the forms and obtains the patient's vitals and chief complaint.

Following MSC intake, a health professions student volunteer pair works with a provider to complete the medical visit— ordering labs, prescribing medications, and making specialist referrals as necessary.

Resource Navigator Visit

Throughout the day, the resource navigator collects patient screening tools from the intake volunteers, identifies patients who indicated a need for community resources, and informs the student pair that their patient wishes to work with the CRNP.

The resource navigator meets with any patient who screens positive for community resource needs and wishes to talk with a navigator. The resource navigator then completes an intake with the patient to assess the type and level of social needs as well as previous resources used. The intake can be completed in person directly following the medical visit or by phone at a later time, depending on patient preference. The resource navigator uses their experiential knowledge, a resource library,[20] and/or internet searches to identify appropriate social services for each patient. Information on these services is then distributed during the in-person meeting or mailed in the patient's preferred language. At the end of the intake meeting, the resource navigator inputs all relevant information into Research Electronic Data Capture (REDCap [School of Medicine and Public Health, University of Wisconsin-Madison, Version 12.5.8]), a secure, web-based software platform designed in collaboration with the CRNP to support data capture (Appendix C).[21-22] REDCap is used to document information about the patient and resources provided for purposes of follow-up and continued case management. The REDCap platform was chosen by CRNP leadership to centralize data collection despite partnering with clinics that use different electronic medical records.

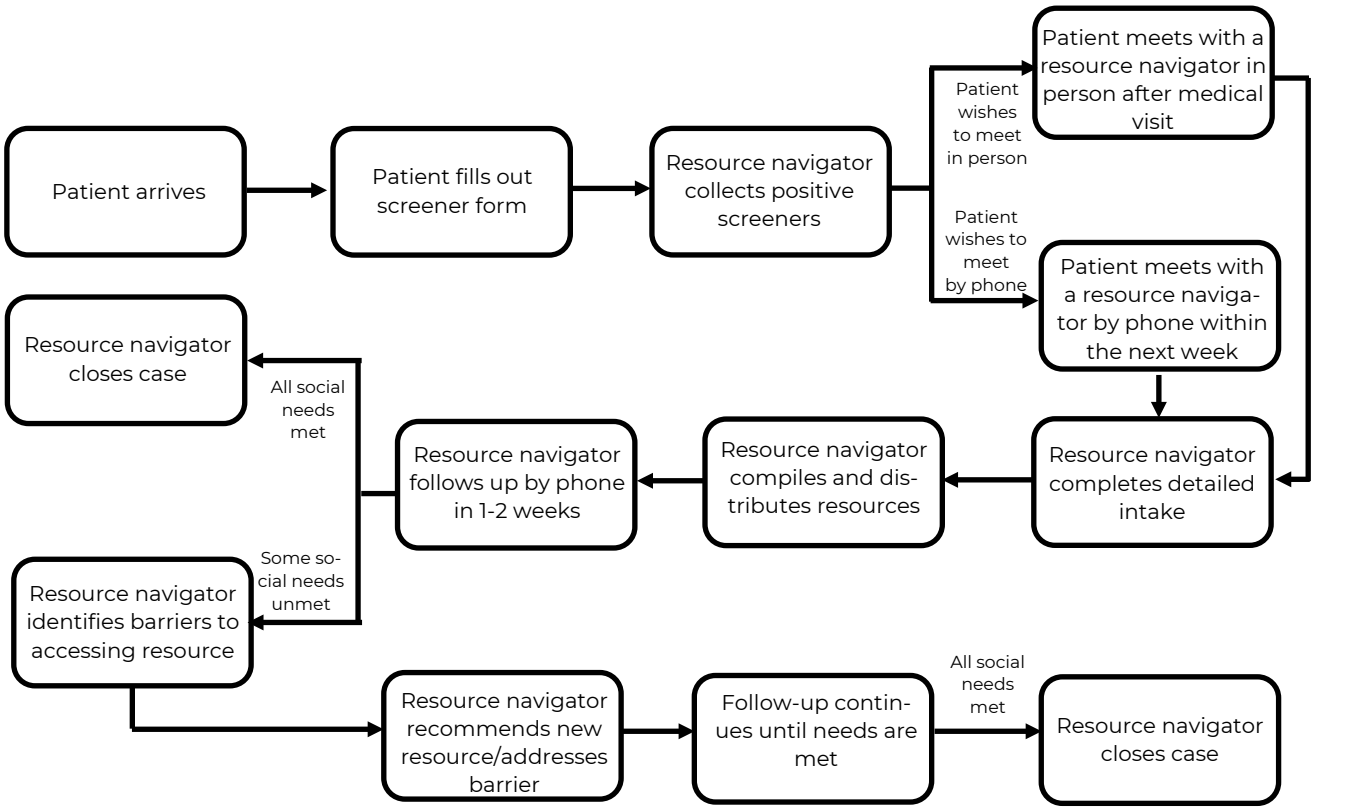
Debrief Meeting

At the end of each shift, health professions students, resource navigators, and providers participate in a debrief meeting, which allows members of the team to reflect on their experiences, identify themes seen across multiple patients, and share important information. This time could be utilized, for example, for the resource navigator team to share with the health professions students what social needs have been most prevalent in the community to better direct patient care. This time of reflection is critical to the interdisciplinary action learning process, as medical volunteers and resource navigators share their unique perspectives on the social and medical factors that affect patients' health.

Resource Navigator Follow-Up

Resource navigators work in shifts throughout the following week to complete follow-up independent of the medical team. They contact patients to assess the efficacy of recommended community resources, identify and address barriers to accessing resources, and provide additional information in response to new concerns Resource navigators consult the CRNP social.

Figure 2. Workflow of the CRNP in MSC



CRNP: Community Resource Navigator Program; MSC: MEDiC Southdale Clinic

worker, lawyer, or community health worker when appropriate. The resource navigator documents the topics discussed and resources mailed in a REDCap contact summary (Appendix D). The patient and resource navigator identify a follow-up date at the end of each contact based on the patient's availability and ongoing needs. Due to the regularity of follow-up and the volunteers' consistent weekly schedules, patients and resource navigators can develop strong, trusting relationships. Follow up continues until the patient determines his/her social needs have been met and/or wishes to close his/her case (Figure 2).

Discussion

Challenges in Adapting the Model to Other Clinics

One challenge free clinics may face in implementing resource navigation programs is the absence of an established resource navigator program in their community. However, implementation of SDOH-focused resource navigation in a free clinic could take many forms and need not rely on partnership with an existing program. The components needed to adapt this model to any free clinic are: 1) comprehensive SDOH screening for all patients, 2) identification of specific social needs among patients who screen positive, 3) timely delivery of community resource referrals, and 4) continued follow-up to ensure successful utilization of resources. These tasks may be completed by students or staff of many educational backgrounds as long as they understand the community resources available, receive training addressing the systems of power and privilege that shape patients' interactions with the healthcare system, and practice cultural humility. Finally, consistent funding is needed to ensure long-term success of resource navigation programs in free clinic settings. When considering feasibility of funding sources, clinics should prioritize sustainability—continuation funding grant programs may be preferable to non-

renewable funding sources.

While a variety of SDOH interventional strategies may be successful, utilizing a partnership approach when feasible can solve additional challenges faced by free clinics. For example, a lack of volunteers with adequate knowledge of community resources may limit clinics' capacity to address SDOH. Utilizing trained undergraduate students expanded MSC's volunteer pool, and employing leadership from the CRNP's social worker and community health worker ensured expertise in recommending community resources. A partnership approach may also overcome funding-related barriers. The CRNP's distinct funding source allowed MSC to focus resources on purchasing medications and supplies. Therefore, while creation of a resource navigation program staffed by health professional students is possible, a partnership approach has been highly successful in our clinic and should be considered when possible.

Future Directions

Future goals for the CRNP-MSC partnership include further integration of the CRNP into patient care at MSC, integration of CRNP into additional MEDiC clinics, and formal evaluation of the partnership. Regarding further integration, resource navigators have little role in medical referrals in the current format; however, it is clear that there is also a role for resource navigators to provide medical navigation assistance including accompanying patients to appointments, helping patients fill out financial assistance applications, and facilitating better communication between patients and providers. In addition, although the other five MEDiC clinics serve a smaller number of patients and in some cases already have access to other unique resources, there may be a role for integration of CRNP into additional clinics. In the future, a needs assessment could help identify the potential utility of partnership between the CRNP and these clinics. Finally, we were not able to follow specific patient outcomes during this study, which was one limitation of the present work. Thus, a longitudinal program evaluation of the CRNP and MSC partnership should be completed to assess patient satisfaction and outcomes in the unique setting of a free clinic.

Conclusion

Because SDOH disproportionately affect the health outcomes of populations served in free clinics, a partnership aimed at addressing these barriers is a compelling strategy to improve health outcomes. The program design outlined here, which includes use of a SDOH screening tool, patient interviewing, and diligent follow-up, can be used as a model for implementation of such a program. Programs that incorporate SDOH screening and resource navigation, compared to clinics without these resources, provide wrap-around services and meet patient needs. This more holistic approach builds trust and improves patient health and well-being. This partnership model is adaptable to various communities and clinic settings, serves an important role in the education of future healthcare providers, and is a promising tool in advancing health equity.

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Disclosures

The authors have no conflicts of interest to disclose.

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