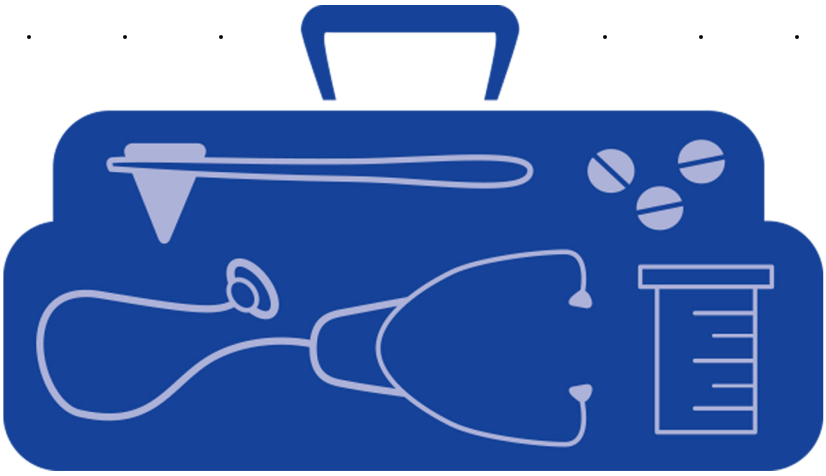
WFCC Q4 2019 NEWSLETTER

A DISPATCH OF THE WORCESTER FREE CLINIC COALITION



accessible healthcare for central Massachusetts

wfcc

MEMBER CLINICS

Epworth (Mon 6-8pm)
64 Salisbury St, Worcester

St. Anne's (Tues 6-8pm)
130 Boston Trnpk, Shrewsbury

Greenwood (Wed 6-8pm)
215 E. Mountain St, Worcester

India Society (Wed 6-8pm)
152 W. Main St, Shrewsbury

Akwaaba (Thurs 6-8pm)
67 Vernon St, Worcester

Islamic Center (Thurs 6-8pm)
248 E. Mountain St, Worcester

The Worcester Free Clinic Coalition is a group of free medical programs that provide health care services to uninsured or underinsured in the greater Worcester area.

All programs welcome anyone in need of services.

Letter from the Editor

One of the primary reasons for creating the task force and this newsletter was to promote collaboration between the clinics and bring the right people to the table for discussion and community engagement. After regular task force meetings and deliberation, a number of diverse issues have come to light. The task force has allowed the clinics to work together to begin addressing these matters.

We wanted to highlight some of the projects that the Coalition members are working on to solve these issues, including:
- the standardization of intake forms across all clinics,
- a proposal to form the Coalition into a 501(c)(3) non-profit organization, and
- communication methods to allow for seamless referrals between institutions (including from clinic to clinic, primary care facilities, specialists, etc.).

As the clinics continue to expand their services, coordinating their schedules so that patients can be referred from one clinic to another becomes increasingly frequent and difficult. In concert, unpredictable schedules of volunteers can change the availability of services, which is especially true of specialists who come in once or twice a month to provide specific services, such as cardiology and dental care. During the peak school physical season, many patients wait in line for a full two and a half hours to be seen. Patients not seen are given a signed form that explains the situation to the school nurse, allowing them to continue school. Effective communication may help reduce patient wait times.

Debate regarding the 501(c)(3) organization required that a subcommittee of representatives from each clinic be formed and meet for discussions. A finalized proposal for the formation of such an organization was made for early 2020, and highlights are listed in the Minutes from the Meetings section. Forming such an organization will allow the Coalition access to many more opportunities that will better serve the uninsured and underinsured population.

Finally, the second annual symposium of the Worcester Free Clinic Coalition is being planned for Spring 2020. While the specific date has not yet been finalized, as additional information becomes available, it will be published through email, social media, and through the clinics themselves. We encourage everyone to attend to learn about and contribute to the Coalition.

Thank you for supporting this critical mission,
Sahil

SAHIL A. NAWAB
Media Coordinator, WFCC

FILIA VAN DESSEL
Co-President, WFCC

JOHN ROMANO
Co-President, WFCC

Minutes from the Meetings

Discussion: Creation of a 501(c)(3) non-profit organization

One topic that has been brought up at the WFCC Task Force, created after the first annual Symposium last January, was whether a 501(c)(3) non-profit umbrella organization would strengthen the six individual clinics. From the large group, a small subcommittee with two representatives from each clinic and two representatives from the medical student WFCC organization (Table 1) was created to investigate the formation of a 501(c)(3). On November 10th, this subcommittee met to discuss the pros and cons of such an organization (Table 2).

Clinic	Representatives
Epworth	Dr. James Ledwith, Brenton Faber
St. Anne's	Dr. Jane Lochrie, John Smithhisler
India Society of Worcester (ISW)	Dr. Sahdev Passey, Carolyn Passey
Greenwood	Dr. Eric Matthews, Sarah Strozina
Akwaaba	Dr. Karen Peterson, Jason Lui
Worcester Islamic Center Social Services (WICSS)	Dr. Sadia Chaghtai, Shahida Balaparya
Student representatives	John Romano, Filia Van Dessel

Table 1. Two representatives from each clinic and student organization on the WFCC Umbrella Organization Subcommittee.

Pros	Cons
Financial • Access to larger grants and greater fundraising & donation power • Potential support from UMMS • Negotiation of purchase of items as a group (strength in numbers and decreased competition), such as lab services & malpractice insurance coverage • Greater financial support is needed at certain clinics that struggle with funding • With greater funding, potential of expansion of services that are offered **While not explicitly requiring 501(c)(3) status, a more formal organization may bring added benefits:** • Improved collaboration and empowerment of a larger group • Sharing of resources like volunteer pool • Standardization of data collection between clinics • Greater advocacy with the local government and other organizations by having a unified voice	**Administrative Overhead** • Grants have limits and/or cannot pay for administrative salaries • Staffing requirements for filing taxes, audits, etc. **Clinic Autonomy** • Will clinics be able to maintain their autonomy with an umbrella organization?

Table 2. Pros and cons of creation of a 501(c)(3) umbrella organization.

Following a round table discussion of these pros and cons, Dr. Sahdev Passey, the medical director of the India Society of Worcester (ISW), brought us back to the origin of this idea: students at the University of Massachusetts Medical School (UMMS). Each of the six clinics were created as individual entities as early as 1996 with the founding of St. Anne's by Dr. Harvey Clermont and Epworth by Dr. Paul Hart. These clinics began and continue as charitable services provided by religious organizations to fill a special niche and need within the community, namely providing free health care to those with limited access. UMMS students became involved within the clinics and sought to coordinate volunteer services amongst themselves, creating the Worcester Free Clinic Coalition (WFCC). Students soon became the connecting force between clinics and as volunteers within all the clinics saw potential for what the coalition could become.

As a student organization without non-profit status, this limited what the WFCC could accomplish—mostly regarding financial capacity. Dr. Passey reminded the subcommittee that this is where the idea of the 501(c)(3) began, where students with plenty of ideas and the motivation to improve the coalition were limited by their capacity to find money to support their ideas.

One of the major concerns brought to the table was that the administrative overhead and burdens would outweigh the potential financial benefits. The solution proposed to this concern was that this non-profit would start out small, it would target smaller grants and open the possibility for fundraisers and donations from larger organizations, but contain itself to limit the administrative burdens. Keeping the non-profit to a manageable size would allow for the potential of accessing these funding opportunities. If the non-profit grew to become larger years later, we would again weigh whether the administrative burdens are worth it. Another concern was whether individual clinics would lose their autonomy with the introduction of an umbrella organization. It was discussed unanimously that the creation of this organization would not take away from the autonomy and culture of individual clinics. Ways to mitigate this concern include giving clinics veto ability to opt our of any decisions or projects that were not a priority for them, to have representatives on the board, and to have financial freedom to fundraise on their own.

Ultimately, the subcommittee came to vote in favor of proceeding with an umbrella 501(c)(3) organization (Greenwood did not have a representative present, but will vote at the next meeting). The vision for this organization was to start small, to build a board with representatives from each clinic and students, and to have a student executive board responsible for planning and executing projects. Next steps include discussion of the structure of the board at the next subcommittee meetings. If you have suggestions or comments, please contact your clinic's representatives (Table 1) or email Filia.VanDessel@umassmed.edu.

- Is forming a 501(c)3 non-profit umbrella organization beneficial for the six individual clinics?
- Non-profit would enable greater access to grants, fundraisers, and donations.
- Non-profit may come with increased administrative burden or loss of autonomy of individual clinics.
- Five of the six clinic voted to join a non-profit umbrella organization that focused on starting small, keep clinic autonomy, and have a board with representatives from each clinic and an executive committee with students.
- Next steps are to flush out the structure of the board and executive committee & begin discussing 501(c)3 bylaws.
- The second annual WFCC Symposium is being planned for March 2020.

Volunteer Highlights

Beth Mena, RN, Immunization Nurse

"I joined the St. Anne's Free Medical Program staff 21 years ago and haven't missed many Tuesdays since. It is an amazing and inspirational experience to work with all of the volunteer staff on a weekly basis. The founder, Dr. Harvey Clermont has become a good friend and role model who has shown me a passion for caring and dedication that goes beyond words. Although I have experienced a rich and fulfilling professional working career, it has not compared to the personal rewards of volunteerism in this environment, where everyone gathers to work hard for a unified goal on a weekly basis, year after year. It is an awesome feeling. I have come to know so many high school kids that have helped out in the "shot room" that have gone on to become nurses and doctors. Over the years so many fabulous nurses, students, and other professionals have assisted in making our immunization program a successful and a well praised component of the overall program. Several of the staff are now my best friends. We work hard together and we play hard too!

This January the immunization staff made a bold and courageous step towards best practice by learning, implementing, and converting our paper record practice into the web-based Massachusetts system called MIIS. It was really frightening! I wasn't totally convinced we had the manpower to make it successful, but many came to our aid. We did it! Now we are even a tighter group and can laugh about our strengths and weaknesses without ever being afraid to say, "How do you do that?" This is a family of volunteers who look forward to seeing our volunteer friends on a weekly basis while serving some of the medical needs of the greater community."

St. Anne's Immunization Team

Elizaveta Reznichenko, UMass Medical Student

"St. Anne's is what I would call the Utopia of the medical care system. While this statement might seem confusing at first, in my opinion, a healthcare setting which provides the best possible care for patients is one in which all members of the care team have seamless collaboration and communication without intervening hierarchical power structures, and one in which the patient is listened to at each step. This rarely occurs these days, in part due to the immense time constraints placed on primary care physicians. St. Anne's is the one place where I have witnessed attendings, residents, PAs, NPs, medical students, nurses, EMTs, and other healthcare professionals all working together outside of the power dynamic that is commonly present between different "tiers" of medicine. As a medical student, it is very easy to get lost in studying, forgetting what brought you to medical school in the first place. St. Anne's has been my weekly reminder, that has grounded me, and allowed me to pursue my medical studies in the context of compassionate patient care. Furthermore, the physicians, nurses and other medical professionals who tirelessly have shown up week after week, after having worked long hours at their own practices, have further reinforced my belief that medicine is not simply a profession, but rather a life-long calling that does not adhere to the 5 day/ 9-5 work schedule."

For additional information about volunteering at the free clinics, please visit:
worcesterfreeclinics.org/volunteer.html or send an email to worcesterfreeclinics@gmail.com

Featurette: Prescriptions and Policy in the Free Clinics

By Sahil Nawab

Part of human nature is to make assumptions about others. This cognitive heuristic, while somewhat valuable in the past, now simply perpetuates ideals that are no longer relevant to modern society. When analyzed from the collective perspective, that is, by looking at systematic prejudices in institutions and professions, we can begin to tease out the less visible, but often more subversive prejudices that impact people at the population scale. This is particularly true in medicine, where the impacts of these institutional assumptions disproportionately harm those who we seek to help in the free clinics.

In this piece, I want to examine the prescription policies in place at the free clinics and invite discussion about the various factors in play. With that said, this is only a first step in addressing this complex issue rife with nuance. No amount of standardization can remove the necessary professional judgement of physicians and healthcare providers, but this may be an area where healthcare policy can make a tangible impact in patient care for the uninsured patient population in greater Worcester area.

The standard protocol encourages providers to prescribe the minimum necessary amount of medication. In practice, this often results in common chronic disease prescriptions being written for 30 days during the first visit, bumped up to 60 days on a following visit, and a maximum of 90 days on all subsequent visits. This procedure is grounded in real concerns - most prominently the potential for prescription abuse. However, it leaves the most vulnerable patients in limbo.

Uninsured or underinsured patients suffering from chronic diseases, such as diabetes or hypertension, are often the ones that have the most challenges associated with physically accessing prescriptions. Lack of transportation and difficulty taking time off from work during working hours are primary contributors to patients skipping their medications, along with insufficient funds to cover the prescriptions. These diverse issues cannot be solved without a large scale political effort and potentially restructuring the entire employment scheme. Regardless, being aware

of these fundamental issues is vital to effective policy proposals on the part of the Coalition and the individual clinics.

Providers are rightly concerned that patients can game the system, traveling from clinic to clinic to obtain duplicate prescriptions, especially in light of the opioid epidemic. Despite this, a more benign, yet potentially even more subversive justification for the policy is the idea that the clinics are simply stop-gap measures rather than primary care facilities and provide care to any person without question.

On the face of it, the answer is simple: the clinics are not, in fact, primary care facilities. A better analogy might be that of urgent care centers, but even this falls apart because the clinics do not have the staff, equipment, or funding to address more serious illnesses. The clinics are simply not equipped to provide the long term, personal care that is required of a primary care facility, nor are they equipped to provide immediate care for the types of injuries and illnesses that urgent care centers treat. Patients inevitably still end up using the clinics for both primary care and urgent care.

Keeping in mind these conflicting messages, that the clinics provide care to anyone without question, and that they are neither primary nor urgent care facilities, updates to the standard operating procedures

Featurette: Prescriptions and Policy in the Free Clinics (continued)

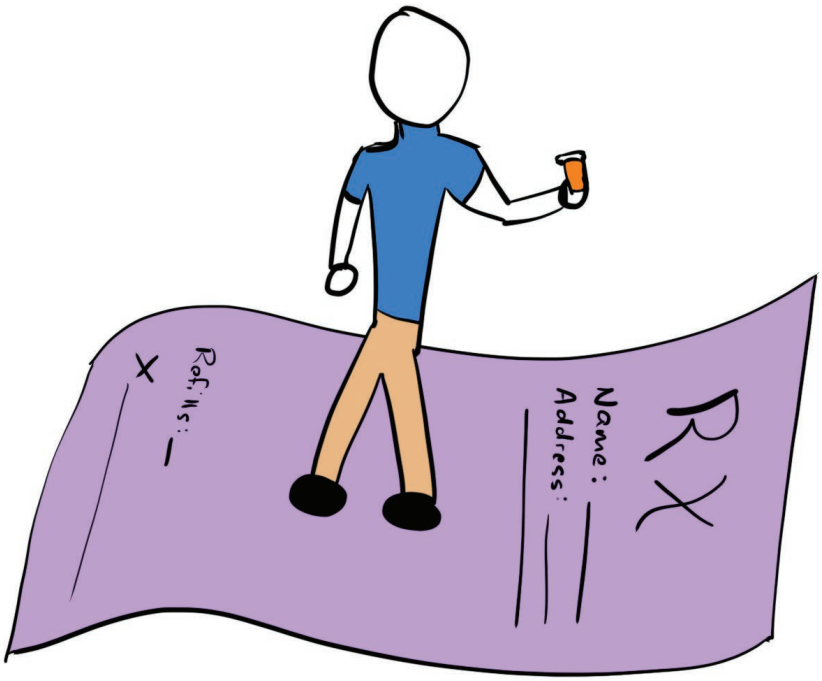
need to be made to better address the dichotomy. Without these changes, patients will remain in limbo, especially those looking for long term prescriptions for chronic illnesses.

Currently, 28.2% of patient encounters at Epworth result in the patient receiving one or more written prescriptions. A full 10.1% of patients arrive at Epworth seeking prescription refills. Providing prescriptions that take into account patient transportation challenges may be addressed by, for example, encouraging prescribing physicians to ask patients about the accessibility of prescriptions.

Another suggestion might include updating the standard operating procedures at the clinics to enable cross referencing of prescriptions, especially for some medications that are more prone to abuse. This does not reduce the importance of professional judgement, but rather reduces biases and provides objective measures that can ultimately lead to better patient care. An even more ambitious solution, but one that might address a larger range of the issues that the uninsured and underinsured population faces, is creating a mobile pharmacy that travels to each of the clinics. Patients can pick up their subsidized prescriptions immediately, while they are already at the clinic without need of further coordination. Even just having pharmacists available to discuss prescriptions during sign out may be immensely helpful to get patients to understand complex medications, their side effects, the proper timeframe to take them, and answer any lingering questions.

Coordinating between the multiple bastions of healthcare falls more and more on the patient. Rather than institutions playing this vital role, increasingly patients are responsible for making the phone calls to get prescriptions, understand the side effects, and ensure that they can afford the medication.

This makes a strong case for increased collaboration between the clinics, especially for prescriptions that have higher potential for abuse. Yet while the proposal for a system-wide EMR has yet to gain the full support of the Coalition for a variety of reasons, significant strides have been made thus far in bringing the individual clinics together. Careful policy that balances these multiple factors, on the part of the WFCC and individual clinics, can help defray the costs associated with being uninsured or underinsured in the greater Worcester area.



Dossier

"Unpaid, stressed, and confused: patients are the health care system's free labor," by Sarah Kliff, June 1, 2016. https://www.vox.com/2016/6/1/11712776/health-care-footprint

This article describes "the considerable burden our fragmented system puts on patients to coordinate their own care," and how the challenges associated with dealing with multiple systems in person and over the phone to get prescriptions can be akin to a part-time job.