



Clínica Comunitaria Esperanza Pediátrica: The Development and Early Outcomes of a Bilingual Medical Home for Uninsured Hispanic Children

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Abstract

The uninsured Hispanic pediatric population in the United States faces significant challenges in accessing medical care due to language barriers, citizenship status, and limited access to health insurance. Clínica Comunitaria Esperanza Pediátrica (CCE-P) is a bilingual student-run free clinic created to provide healthcare to the underserved population in southeastern Virginia. This study further details the creation, implementation, and early outcomes of CCE-P as well as barriers encountered throughout the process. It describes four critical steps in establishing CCE-P, including leveraging existing institutional partnerships, ensuring high standards of care, prioritizing community outreach, and implementing a quality improvement program. Study outcomes include a demographic characterization of the 46 pediatric patients served by CCE-P, a description of clinic services, and an analysis of gaps in care and strategies to provide more comprehensive health services. This publication serves as an outline to an adaptable model that other organizations may use to establish similar clinics in their own communities.

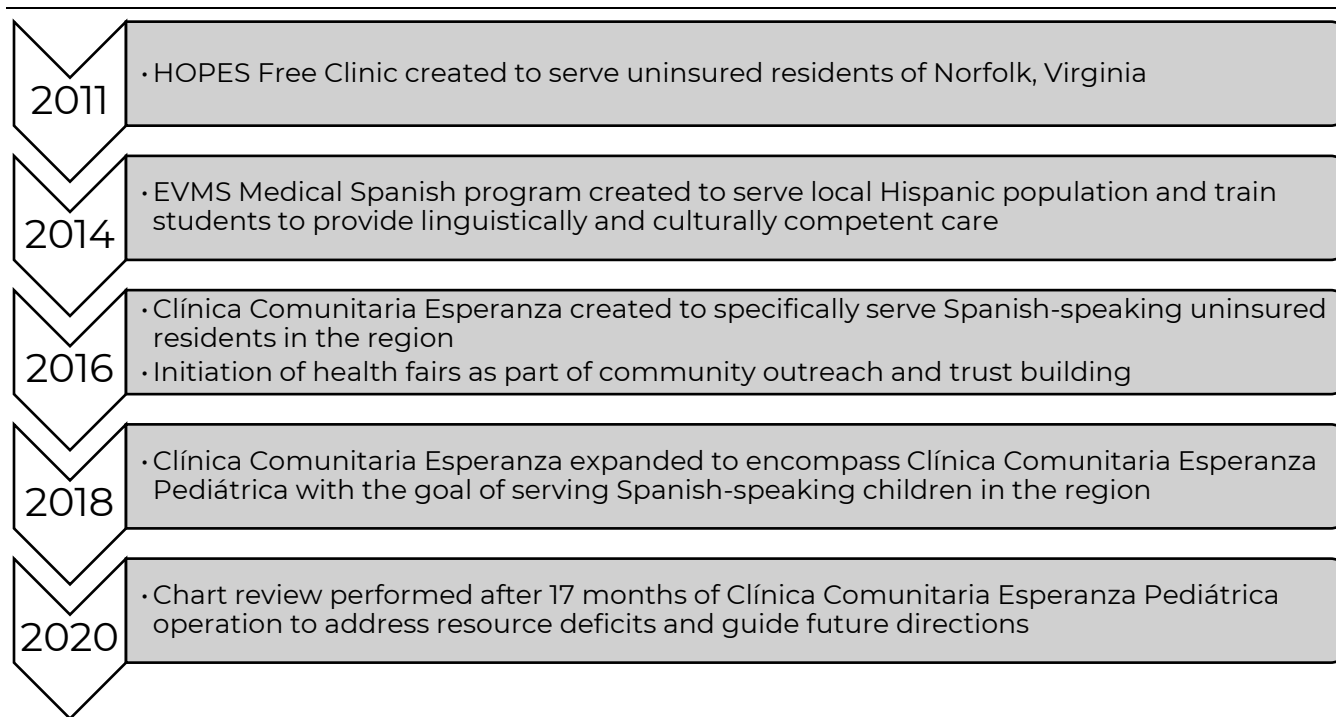
Background

The immigrant Hispanic population in the United States faces multiple barriers to obtaining healthcare. These include language obstacles, lower levels of health literacy, and limited understanding of the healthcare system.^{1,2} Recent policies implemented at the national level by the Trump Administration, such as the Priority Enforcement Program and Secure Communities Program, as well as several states' movement toward more restrictive immigration and enforcement related laws, have fortified these barriers for undocumented immigrants.³ In one example, the federal government's September 2018 announcement to identify immigrant families seeking government assistance as a "public charge" resulted in a decline in coverage of 260,000 children in Medicaid and other safety-net programs such as the Supplemental Nutrition Assistance

Program.⁴

Immigrant Hispanic children residing in the United States have not been spared these challenges and are an often-overlooked patient population that lacks access to consistent, quality medical care. Only four states, not including Virginia, offer Medicaid/Children's Health Insurance coverage to pediatric patients without regard to their immigration status.⁵ Data from the 2019 American Community Survey reveals that in the Virginia Beach/Norfolk/Newport News metropolitan area, approximately eight percent of the Hispanic population under the age of 19 years is uninsured.⁶ This deficit in coverage prompted the 2018 creation of Clínica Comunitaria Esperanza Pediátrica (CCE-P), a bilingual student-run free clinic for uninsured Hispanic children in Norfolk, Virginia. This paper aims to critically evaluate the design, creation process, and early outcomes of CCE-P and to outline an adaptable model that

Figure 1. Evolution of CCE-P



CCE-P: Clínica Comunitaria Esperanza Pediátrica; HOPES: Health Outreach Partnership of EVMS Students; EVMS: Eastern Virginia Medical School

other interested organizations may utilize.

Clinic Implementation

The goal of CCE-P was to create a medical home that provides comprehensive health care to uninsured Hispanic children in their native language. The first priority in creating CCE-P was to foster local partnerships to leverage existing community resources. This was followed by efforts to ensure a high standard of care in CCE-P and to promote outreach to the community. Once the clinic was established, a focus was placed on providing accessible and comprehensive care through expanded appointment slots and a strong referral network for services not available in our clinic.

Step 1: Fostering Local Partnerships

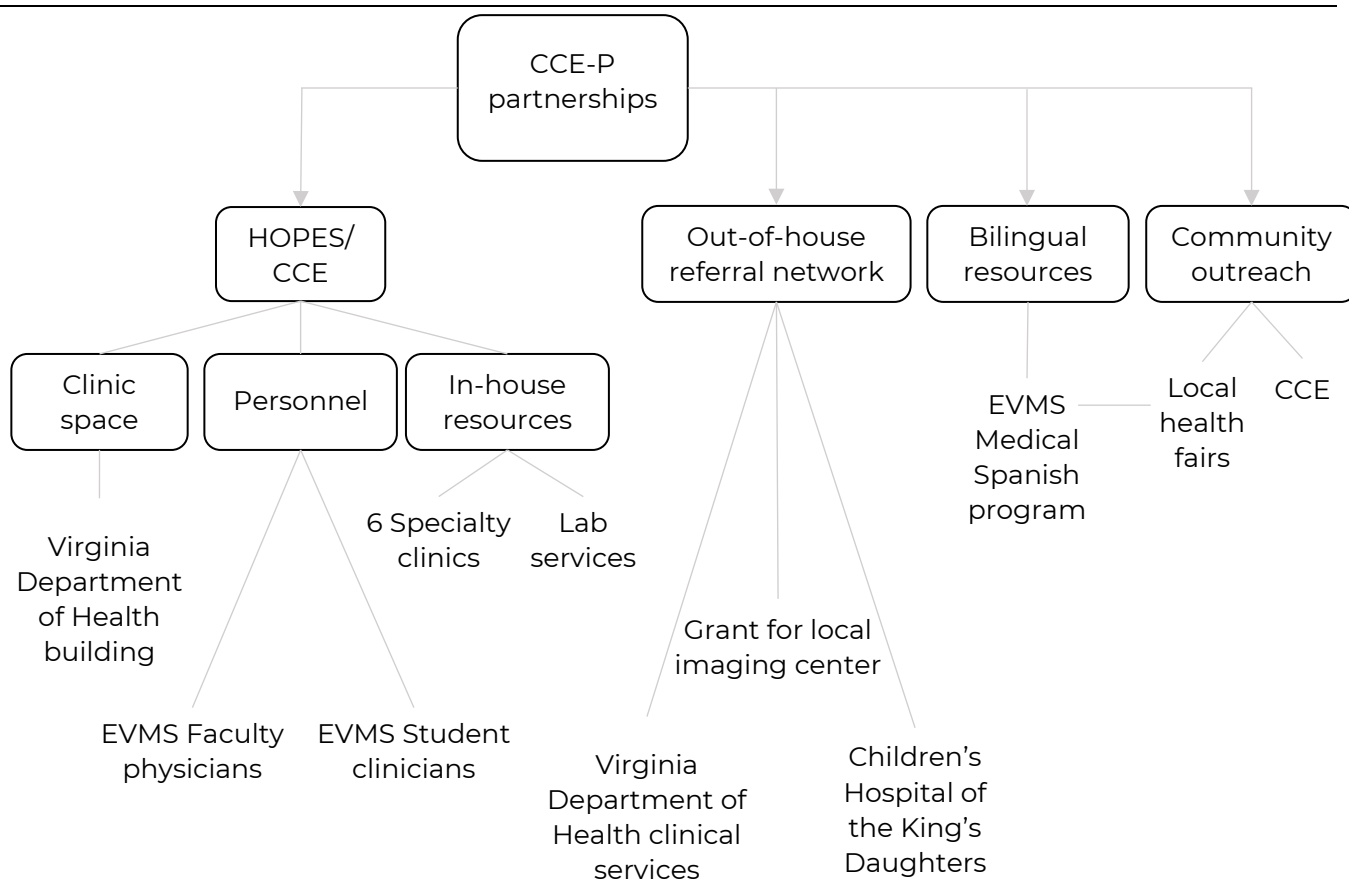
Pre-existing Infrastructure of EVMS Free Clinics

The first step in CCE-P creation was to work with the Health Outreach Partnership of EVMS Students (HOPES) and Clínica Comunitaria Esperanza (CCE). The HOPES clinic is a student-run,

free, primary care clinic founded in 2011 to serve uninsured residents in the region (Figure 1). CCE and CCE-P are subspecialized clinics within HOPES. Clinic sessions are held on alternating weeks and occur in four-hour evening sessions. Through this partnership, CCE-P operates simultaneously with the CCE clinic to utilize the same infrastructure and to integrate pediatric resources and services (Figure 2). Other specialty clinics available through HOPES include dermatology, mental health, ophthalmology, orthopedics, otolaryngology, and women's health. All clinics operate in a rent-free, fully equipped space provided through a partnership with the Norfolk City Department of Health (NDH).

The CCE-P staffing infrastructure was designed based on the existing CCE clinic framework. Teams of Eastern Virginia Medical School (EVMS) student volunteers and community physician volunteers evaluate and treat patients using the traditional academic model.⁷ In this model, students begin evaluating patients and starting treatment plans under the guidance of an experienced physician. Students are also responsible for administrative roles including

Figure 2. CCE-P Partnerships



CCE-P: Clínica Comunitaria Esperanza Pediátrica; HOPES: Health Outreach Partnership of EVMS Students; CCE: Clínica Comunitaria Esperanza; EVMS: Eastern Virginia Medical School

Table 1. Laboratory services available at EVMS free clinics

Lab and screening tests
HbA1c
Fingerstick blood glucose
Hemoglobin
Comprehensive metabolic panel
Lipid Panel
Thyroid stimulating hormone
Urinalysis
Microalbumin
B-hCG
Fecal occult blood test
EKG

EVMS: Eastern Virginia Medical School; HbA1c: hemoglobin A1c; B-hCG: Beta-human chorionic gonadotropin; EKG: electrocardiogram

volunteer recruitment, appointment scheduling and day-of reminders, and patient intake and charting. A student lab team is present to provide in-house tests (Table 1).

EVMS Medical Spanish Initiative

CCE-P is committed to ensuring all patient encounters are culturally appropriate and conducted in Spanish. As such, all students providing patient care are trained and recruited through the EVMS Medical Spanish initiative (Figure 1). Students entering the program are screened by a native Spanish speaker to identify their Spanish fluency as beginner, intermediate, or advanced. Each student is asked to take weekly Spanish classes and utilize supplementary online language resources. Community events also encourage students to engage with the local

community and hone their cultural humility and competency.

EVMS Physician Volunteer Force

Physician staffing is achieved by voluntary physicians who are either EVMS faculty or EVMS-affiliated pediatric and family medicine physicians, primarily through networking and word of mouth. All physicians are required to hold an affiliation with EVMS and be covered by EVMS liability insurance. Due to the shortage of local, fluent Spanish-speaking physicians, English-speaking physicians interested in serving the Hispanic immigrant community are also recruited and paired with a Spanish-speaking student clinician team.

Out-of-House Referrals

Clinic leaders also established referral partners for specialty services not readily available through the EVMS free clinic infrastructure. These include imaging studies, funded by a local grant; lead screening and immunizations, provided by the NDH; and subspecialty care, provided by the local Children’s Hospital of the King’s Daughters (CHKD). Following a referral by CCE-P leaders, bilingual CHKD Case Management specialists help patients navigate applications for the Financial Assistance Program which subsidizes care for low-income patients.

A key contributor to the success of CCE-P was its ability to build upon existing resources and promote collaboration among local partners. This approach allowed CCE-P to optimize the care available to the underserved, Hispanic children of Hampton Roads within the constraints of a student-run free clinic.

Step 2: Ensuring Standards of Care

Clínica Comunitaria Esperanza Pediátrica was created to provide the same standard of care available to children in a typical pediatrician's office; therefore, clinic leaders sought expert advice from local pediatricians. As a result, comprehensive age-appropriate screening forms (Table 2), standardized age-specific well child visit templates, and anticipatory guidance recommendations have been implemented into CCE-P based on recommendations by the American Academy

Table 2. CCE-P screening forms

Screening form	Age distributed
Edinburgh Depression Score for postpartum mothers	At 2 weeks, 1 month, 2 months, and 4-month visits
Ages & Stages Questionnaire	At 9 months, 18 months, 24 months, and 30-month visits*
The Modified Checklist for Autism in Toddlers	At 19 months, 24 months, and 30 months*
Patient Health Questionnaire-9	Between 9-12 y.o. and 16-18 y.o.
Asthma Control Test Vanderbilt Score	Available as appropriate

*ASQ forms are available for other age marks due to the high no-show rates at some appointments.

CCE-P: Clínica Comunitaria Esperanza Pediátrica; y.o.: years old; ASQ: Ages & stages questionnaire

of Pediatrics.⁸

Families are also provided information packets incorporating guidance on local resources, such as information on immunizations at NDH, Women, Infants, and Children eligibility and benefits, and the HeadStart Program. Recognizing the importance of childhood literacy in reaching developmental milestones, CCE-P also worked with the Reading Enriches All Children program to provide free age-appropriate books in English and Spanish to all patients at the end of their visit.

Step 3: Community Outreach

Once CCE-P was established, clinic leaders focused on outreach in the Hispanic community to recruit patients, utilizing programs previously established through the EVMS Medical Spanish initiative (Figure 1). As part of these initiatives, students and faculty met with local Hispanic community leaders, such as pastors of congregations, to gain insight into the concerns and needs of the community. Meaningful channels of community engagement were established, including monthly health fairs advertised via word of mouth and through regional Spanish-language radio.⁹

Patients were recruited through three primary channels: a) families scheduling appointments directly during health fairs, b) adult CCE patients scheduling appointments for their children

following their own visit, or c) interested parties calling the CCE-P phone number to schedule appointments independently. Case Management specialists at CHKD and staff at local pediatric clinics shared flyers with interested patients, helping CCE-P to reach mixed citizenship households.

Step 4: Implementing a Clinic Quality Improvement Program

Clínica Comunitaria Esperanza Pediátrica was created with the mission to provide high-quality care to underserved, Hispanic children. To do so, implementation of quality improvement monitoring was considered a key part of CCE-P. The first iteration of this process included a chart review of all CCE-P patients seen during the first 17 months of operation. Data collected as part of the chart review included patient demographics, diagnoses, prescribed medications, and referrals. This data was used to identify clinic deficits and to evaluate the readiness of CCE-P to expand appointments based on adequate clinician staffing on clinic nights.

Outcomes

Patient Demographics and Diagnoses

A total of 46 patients were seen at CCE-P from the clinic's inception in August 2018 to January 2020 (Table 3). Of the 23 patients who reported their arrival date to the United States, 78.0% had arrived within two years of their first visit to the CCE-P clinic. A lack of adequate dental care was specifically noted in at least 44.0% of charts, likely an underestimation due to the significant need for dental services previously identified in this population.⁸

Clinic Growth and Referrals

Since the inception of CCE-P, there has been a continuous growth of patient volume, averaging three new patients per month. Collectively, there have been 32 clinic sessions, with three to four appointments during each clinic session. In its first 17 months, CCE-P treated 46 patients for a total of 83 completed visits. Eleven children were seen in specialty care inside the HOPES clinic framework, while six received care through the CHKD

Table 3. Patient demographics

Variable	Number (%)
Sex	46 (100.0)
Male	26 (57.0)
Female	20 (43.0)
Country of origin	46 (100.0)
Honduras	14 (58.0)
Colombia	4 (8.7)
Mexico	1 (2.1)
El Salvador	1 (2.1)
Missing	22 (47.8)
Age	46 (100.0)
0 to 2	4 (9.0)
3 to 5	6 (13.0)
6 to 12	19 (41.0)
13 to 18	17 (37.0)
Weight	32 (100.0)
Normal	13 (41.0)
Overweight	9 (28.0)
Obese	10 (31.0)

referral process. The attendance rate for CCE-P appointments was 72.0% (n = 83), with a no-show rate of 16.0% (n = 19) and a cancellation rate of 12.0% (n = 14). Collectively, this data provides a longitudinal overview of CCE-P's work toward providing sustainable, comprehensive care and justifies the recent expansion of the clinic's patient panel and clinic services.

Clinic Deficits Identified and Addressed

Clinic resource deficits were also identified. Of recorded BMI data, 31.0% of patients were identified as obese, and a lack of adequate dental care was noted in at least 44.0% of charts (Table 3). Several projects have been implemented to address these priority health issues. In response to the high rate of obesity, students pioneered a family nutrition program involving individual diet counseling in the clinic waiting room. Lack of adequate dental care documented in the chart review prompted leaders to implement a fluoride varnish application protocol as part of routine pediatric visits. CCE-P then worked with the local Old Dominion University School of Dental Hygiene to coordinate free dental appointments, including oral prophylaxis, cleanings, sealant application, and x-rays free of charge. In January 2019,

clinic leaders held a free flu shot drive at the NDH to provide vaccinations to pediatric patients. Leaders of CCE-P are also undergoing discussion of how to incorporate routine vaccinations into visits which has been logistically challenging to incorporate in the first year of clinic operation. In particular, two challenges impede our ability to incorporate routine vaccinations. First, our limited number of patients and HOPES' limited resources currently make it difficult to justify allocating resources to maintaining the storage of the vaccines in a refrigerator. In particular, the bulk of vaccinations in pediatric care is administered to patients under the age of four which makes up a very small proportion of the CCE-P patient panel. Additionally, because our clinic relies on student volunteers, we do not have the properly trained staff to administer these vaccines. At present, it makes more logistical sense to refer our patients to the Department of Health.

Limitations of CCE-P

Like many outpatient offices, the EVMS student-run free clinics all transitioned to telehealth in March 2020 due to the COVID-19 pandemic. While telehealth visits proved successful for many adult patients needing follow-up care and medication refills, it was a suboptimal platform for routine pediatric visits requiring weight and growth checks, physical exams, and developmental evaluations, resulting in a decline in visits until the reopening of in-person appointments in September 2020.

Even in non-pandemic times, the nature of CCE-P as a student-run free clinic without employed staff does not allow for vast scale-up. Clínica Comunitaria Esperanza Pediátrica is able to provide comprehensive care to patients currently seen in the clinic but does not have the capacity to provide care to all uninsured Spanish-speaking pediatric patients in the area. Data from 2019 shows that the number of uninsured Hispanic or Latinx residents in the Hampton Roads area under age 19 was approximately 3000 children.⁶ Although this study concluded that CCE-P has the capacity for growth, the need for improved healthcare access in this population far outweighs the capacity of CCE-P.

This critical limitation in access has become apparent in the more established adult CCE,

where the number of patients seeking care has superseded the capacity of the clinic. These discrepancies highlight the importance of implementing more community models to address the healthcare needs of the uninsured pediatric population and this paper may provide a template for interested parties aiming to provide such services within their own local uninsured communities. Nonetheless, the authors acknowledge that broader structural change at the federal and state level is needed to improve the health of our most vulnerable immigrant community members on a large scale, such as expanding Medicaid to include undocumented immigrant children.

Clínica Comunitaria Esperanza Pediátrica strives to be a comprehensive medical home for the uninsured, pediatric population of Hampton Roads. Leadership has focused on working with pre-existing local safety-net programs, providing a high quality of care, emphasizing strong partnerships with the local community, and embracing quality improvement. As a result, CCE-P seeks to serve both the primary healthcare needs and subspecialty needs of all patients in the clinic. Furthermore, as a medical home for both the local adult and pediatric Latinx populations, CCE and CCE-P serve as the foundation to sustainably address healthcare inequities unique to this population.

This paper serves as a template for parties interested in creating similar clinics for their own local uninsured communities. While the establishment and growth of CCE-P were expedited by pre-existing infrastructure, the authors of this paper acknowledge the wide discrepancies of available resources and partnerships at other communities and institutions. In terms of infrastructure and clinic space, clinic leaders should consider partnering with local churches. As mentioned briefly in our paper, CCE-P originally developed from health fairs held at local churches. Thus, leveraging partnerships with the local faith-based community may be a prudent strategy to obtain clinic space and recruit patients. In addition, staffing the clinic with student volunteers may potentially be an obstacle. Incorporating required clinic shifts into the medical school curriculum is a potential avenue to ensure consistent attendance by student clinicians.

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Disclosures

The authors have no conflicts of interest to disclose.

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