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Descriptive Report

Model for Providing Wrap-Around Care for Patients with Substance Use Disorders at a Single-Site, Urban Student-Run Free Clinic

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Abstract

Patients with substance use disorders (SUDs) have low levels of care access and utilization, driven by factors such as medical provider stigma, disinterest and inadequate education. Student-run free-clinics (SRFCs) are uniquely positioned to begin addressing these interlocking problems, with impact possible both in the near and long-term - for example, the potential to increase access to care for patients with SUDs now while also preparing medical students to enter the workforce as physicians equipped to provide this population with stigma-free, evidence-based care in the future. However, few SRFC-based interventions aimed at caring for this patient population have been implemented or published in the literature. The authors aim to fill this gap by describing a pilot intervention that aspires to provide wrap-around services to patients with SUDs at the East Harlem Health Outreach Partnership (EHHOP), a single-site, urban SRFC. Prior to this intervention, EHHOP already had a strong groundwork in place to care for patients with SUDs, consisting of primary care integrated with opt-in mental health care, capable of providing both pharmacotherapy and psychotherapy. The pilot intervention described here aims to fill gaps in this groundwork, specifically (1) improved patient identification through universal patient screening and connection to immediate care through creation of a consult/liaison service, (2) increased student-provider education to address variable levels of prior experience, and (3) strengthened harm reduction infrastructure to offer both on-site education and resources, with seamless referrals to community organizations for services physically unavailable in the clinic. In describing this process of addressing gaps in effort to provide wrap-around services for EHHOP patients with SUDs, the authors aim to provide a scalable model for peer SRFCs to adapt to better their care for this patient population.

Introduction

Medical providers at academic medical centers (AMCs) often feel insufficiently prepared to care for patients with substance use disorders (SUDs). A nationwide survey of primary care physicians found just 15-20% felt “very prepared” to diagnose and care for patients with SUDs.[1] Similarly, a single-site survey of internal medicine residents found 25% felt unprepared to diagnose SUD, with 62% feeling unprepared to provide treatment.[2] Beyond this, providers can create a care environment rife with stigma toward this patient population.[3] Drivers of such stigma are multifactorial, including language

used to describe patients,[4] and persistent beliefs in scientifically disproven myths about addiction; for example, one qualitative study of internists found 31% thought SUD was a "choice."[5]

Taken together, provider stigma and lack of preparedness are often cited by patients with SUDs as reasons for not utilizing care,[4] and by providers as rationale for not implementing better care systems for this patient population.[6] Resultantly, patients with SUDs access care at unacceptably low rates; in 2018, just 8% of patients with SUDs sought any form of care.[7] Care utilization and access is particularly poor for historically marginalized patient populations due to the structural racism and classism that are foundational to the US health system.[8-10]

Numerous community-driven efforts have aimed to improve access and lessen the impact of these disparities. Efforts include street medicine initiatives that care for individuals experiencing homelessness with co-occurring SUDs, low-barrier interventions like overdose prevention centers and syringe exchanges housed within community-based organizations (CBOs), and increasing efforts to host intensive outpatient group-based sessions in Spanish.[11-15] Critically, these community interventions often do not require insurance or documentation status.[16,17]

However, improving care access for patients with SUDs by addressing insufficient provider education and provider-perpetuated stigma within AMCs are critical steps that must supplement these community-driven efforts. AMCs are uniquely positioned for this work because of their responsibility to educate medical students and residents,[18] and therefore have a role to play in building a future provider workforce that is interested in and equipped to provide humanistic care for patients with SUDs.

Within AMCs, student-run free-clinics (SRFCs) are one care site that can be better utilized to achieve these goals. In addition to playing a formative role in medical student education,[19-21] SRFCs often see uninsured and uninsurable patients, so are also uniquely positioned to improve access for historically underserved patients with SUDs. However, few SRFC-based clinical or educational interventions focused on care for this patient population have been implemented, and the literature yields only isolated examples—limited to patient screening, teaching motivational interviewing, co-housing a SRFC within a syringe exchange, offering naloxone training, and providing telemedicine-based pharmacotherapies during coronavirus disease 2019.[22-27] No published examples aim to provide wrap-around services for patients with SUDs at SRFCs.

We seek to fill this gap, both in the literature and in practice, by describing a pilot implementation aiming to provide wrap-around care for patients with SUDs at the East Harlem Health Outreach Partnership (EHHOP), a single-site, urban SRFC with an affiliated AMC. EHHOP is a primary care SRFC with 250-300 uninsurable, primarily Spanish-speaking, adult patients.[28-30] EHHOP co-houses numerous subspecialty clinics, namely an integrated Mental Health Clinic (MHC) capable of providing outpatient mental health care, including cognitive behavioral therapy (CBT), for patients with SUDs. Figure 1 features an organizational chart, outlining EHHOP structure, leadership positions and interventions relevant to this manuscript. Within EHHOP, the most common SUD is alcohol use disorder (AUD).[31-34] In documenting EHHOP's pilot implementation of wrap-around services for patients with SUDs, we hope to describe a replicable model for other SRFCs hoping to provide more comprehensive, humanistic care to this patient population.

Pilot Implementation Description

Prior to the described implementation, EHHOP already provided patients with SUDs both primary care and opt-in integrated mental health care, which includes both intensive outpatient psychotherapy such as CBT and limited pharmacotherapies - namely naltrexone and acamprosate. Integration of primary care with mental health care is the standard of care for this patient population and serves as the groundwork upon which the described pilot implementation was built.[35] However, numerous gaps in existing offerings were identified:

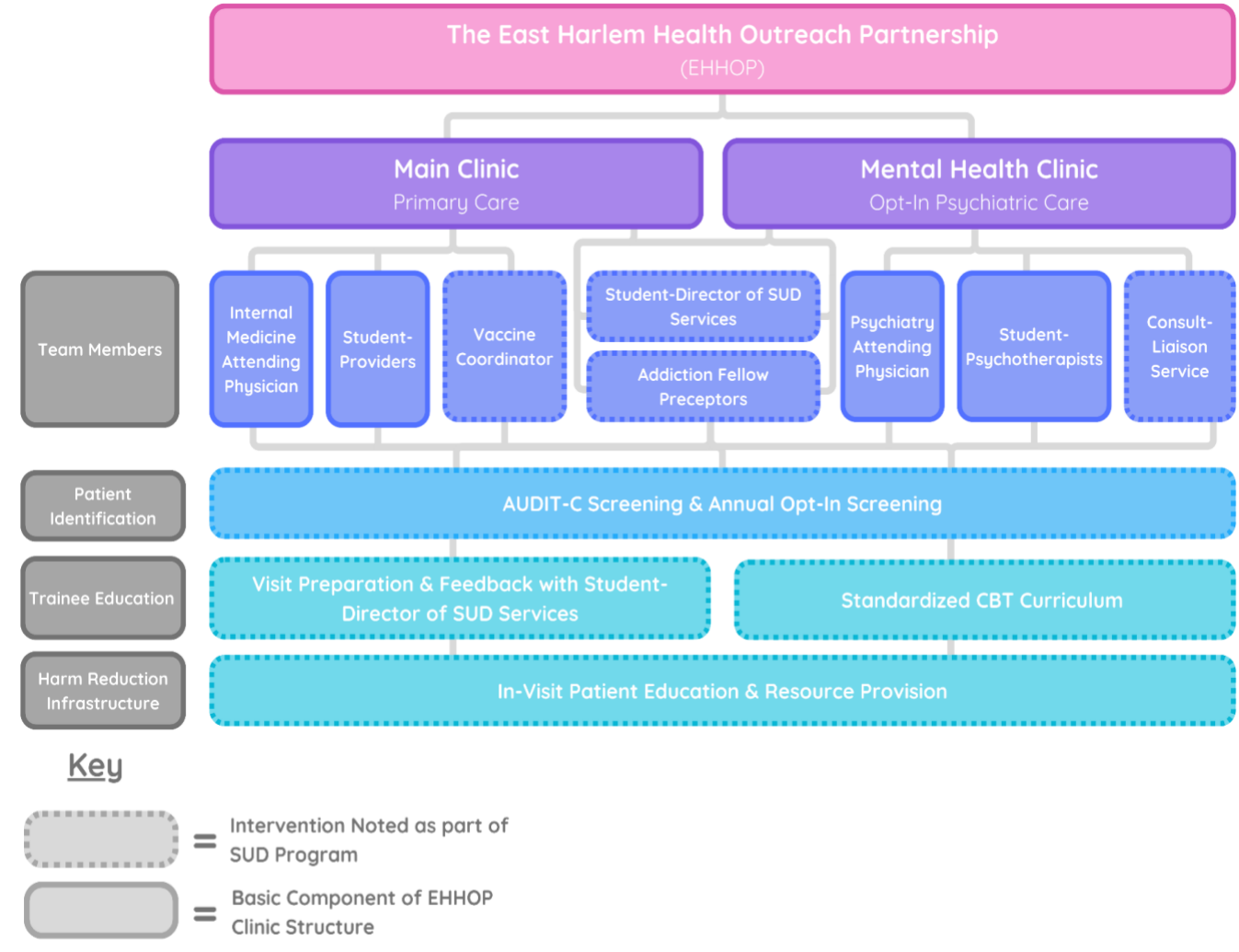
1. Patient identification: Lack of standardized methodology to screen for SUDs among all patients, and the inability to immediately connect identified patients with mental health services
2. Trainee education: Variable levels of exposure among student-providers to caring for patients with SUDs
3. Harm reduction infrastructure: Lack of standardized harm reduction patient education, supplies and interventions available on-site

Our pilot program aims to fill these gaps (Figure 2).

Patient Identification

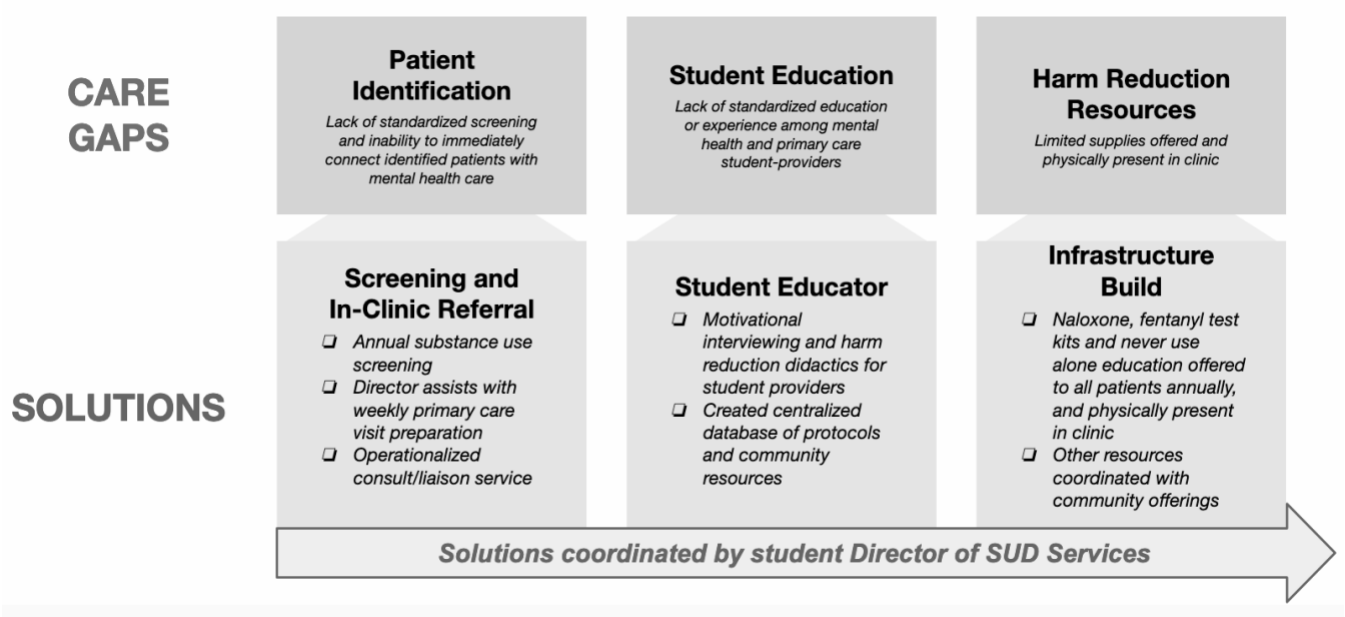
A cross-sectional screening of all patients in the clinic's primary care setting was administered in the waiting room before visits. Screening was completed using AUDIT-C due to its brevity and sensitivity for identifying patients with harmful alcohol use.[36] Forms were provided in both English and Spanish; patients who could not complete the form independently due to literacy, vision or other limitations were assisted by student-clinic managers with interpreters. Student primary care providers would subsequently record scores in a database that flagged patients with positive results,

Figure 1. EHHOP organizational structure, leadership positions and interventions



SUD: substance use disorder; AUDIT-C: Alcohol Use Disorders Identification Test-Concise; CBT: cognitive behavioral therapy

Figure 2. Overview of care gaps identified and solutions piloted



defined as AUDIT-C scores of 4+ for males or 3+ for females. These patients were then asked in detail about their substance use during their primary care visit, and referred to MHC on an opt-in basis.

In August 2022, MHC piloted a consult/liaison (CL) service to better integrate mental health care with primary care visits at EHHOP. This established an on-call student-mental health provider physically present in primary care clinic to triage mental health or substance use concerns identified via questionnaires or primary care visits. This student-provider precepts each CL visit with a psychiatry resident physician, under the supervision of the MHC physician medical directors. When indicated, the CL student-provider can immediately provide counseling or medication in the same visit. Through the CL program, patients seeking care for SUDs can choose to enroll in MHC's treatment program with monthly visits, or receive follow-up less frequently with the CL student-provider during their next primary care appointment—thereby allowing patients to self-select what they believe to be the most appropriate level of support.

Concurrently, EHHOP piloted a student Vaccine Coordinator position, which indirectly aided in patient identification efforts. This coordinator tracks the vaccination status of all patients. Eligibility for some vaccines varies by immune status, and patients who chronically use alcohol and other substances in excess are considered immunocompromised. Accordingly, the Vaccine Coordinator was able to both re-identify patients whose alcohol and substance use had been previously documented but not followed up on, while ensuring standards of care regarding vaccine eligibility are met. The CL and Vaccine Coordinator are both featured in the EHHOP organizational chart in Figure 1.

Trainee Education

Given student-providers across primary care and MHC have variable experience levels caring for patients with SUDs, provision of student education was important to ensure high quality care. First, a SUD-focused page was created on EHHOP's centralized, internal resource and protocol database to promote standards of care, available as Appendix A. On this page, students can find care protocols, harm reduction resources, prior didactic materials and community-based resources.

Both primary care and MHC student-providers have the opportunity to precept with addiction fellows in clinic during visits, to ensure application of fellow's expertise to patient care and for student education. Fellows precept approximately quarterly, with exact frequency pending their availability.

Each week, primary care student-providers are also offered ad hoc education from the student-Director of SUD Services, a clinic leadership position staffed by a senior-level medical student with expertise in harm reduction and addiction medicine. This position supports student-providers in preparing for appointments with patients with SUDs, including providing feedback on visit plans and role-playing care modalities like harm reduction and motivational interviewing. The student-Director of SUD Services is featured in the EHHOP organizational chart in Figure 1.

Within MHC, CBT student-psychotherapists receive a standardized eight session curriculum, of which one is dedicated to AUD.[37] Additionally, the student-Director of SUD Services co-facilitates three interactive didactic sessions annually, with expert guest speakers focusing on implementing harm reduction and motivational interviewing care modalities in clinic. In the first year implemented (2022), these didactics reached approximately 50 students-volunteers.

Harm Reduction Infrastructure

Primary and mental health care settings provide ideal opportunities to offer patients integrated harm reduction services—including both patient education and supply offering.[38-40] Frequently published harm reduction supplies and services include naloxone, supply testing, "never use alone" education, syringe exchange and injection or smoking education to lower infection risk, and overdose prevention centers.[41-43] When resources are constrained, the offering of these services can be prioritized for higher-risk patients, which include patients with chronic pain on prescription opioid agonist therapy, patients with diagnosed opioid or stimulant use disorder, or patients who use any non-alcohol or cannabis substance recreationally.[44-46] However, these services should ideally be offered to all patients, with the goal of increasing broader community literacy.[47, 48]

In accordance with this ideal, EHHOP now offers opt-in harm reduction education and supply provision to all patients annually. All patients are sent a standardized HIPAA-compliant text message in English and Spanish, asking them to reply to express interest in receiving harm reduction education and supplies; the text message is available as Appendix B. Patients who opt-in are offered naloxone and fentanyl test kit training and supply distribution by telephone, with additional harm reduction education provided as needed. The conversational script is provided in English and Spanish in Appendix C. This phone call is led by a medical student who received special training from the New York City Department of Health and Mental Hygiene to provide naloxone and fentanyl test kit education through a "train the trainer" model.[49-51] In its first year implemented (2022), five patients opted-into receiving education by telephone.

During regularly-scheduled visits in clinic, patients considered by their student-provider to be higher-risk, including those who did not opt-into annual education, can also be offered naloxone, fentanyl test kit training and supply distribution, and other flexible harm reduction education. These supplies are physically available for distribution to patients through partnership with Mount Sinai's REACH Clinic, a harm reduction-focused primary care clinic housed within our affiliated AMC.[52]

In addition to supply offerings, EHHOP also provides patient education related to community offerings when appropriate:

1. Never use alone education: patients comfortable using drugs in the company of others are encouraged to do so; patients who express preference to use independently can be provided information about telephone or chat-based never use alone services that trigger emergency services if a patient stops responding.[53]
2. Syringe exchange: EHHOP is unable to offer syringe exchanges at this time due to New York State policy restrictions on becoming first- and second-tier syringe exchanges.[54] As a work-around, student-clinicians can provide interested patients with a publicly available list of syringe exchanges in the surrounding community.[15]
3. Overdose prevention centers: patients can be provided information about two currently open overdose prevention centers, and are encouraged to use in these spaces when possible to reduce their risk of fatal overdose.[55]

To account for varying levels of student-provider familiarity with these community-based offerings, information about these services is accessible, as previously mentioned, in Appendix A.

Discussion

In this review, we describe a pilot implementation aiming to provide wrap-around care for uninsured and uninsurable patients with SUDs at a single-site, urban SRFC. The goal of this intervention is to be one of many required steps that ultimately contributes toward lessening the disparity in access to SUD-focused care faced by non-majority populations in the US. Given SRFC's positioning as a key touchpoint between historically underserved patient populations and the US health system, these clinics have a critical role to play in lessening this disparity by identifying patients in need, providing direct and indirect patient services, and developing the workforce of the future equipped to care for patients with SUDs.

In describing this implementation, we hope to outline a model that other SRFCs can adapt at their own sites. When possible, numerous features of our model should be prioritized in other SRFC adaptations. First, the wrap-around services described are built on an already existing model of opt-in mental health care integrated with primary care, which is the standard of care.[35] Beyond this groundwork, patient identification using standardized forms with non-judgmental language should regularly assess all patients for SUDs—and this should be supplemented by a system capable of providing rapid, on-site assessment and care by a mental health provider when indicated. Harm reduction education and supplies should be available on-site, and offered to all patients, rather than just those who self-identify, is critical to minimize the stigma and self-reporting bias perpetuated by opt-in only models of care.

Importantly, our model of wrap-around care is supplemented by community-based services we cannot provide in clinic, including never use alone hotlines, syringe exchange services and overdose prevention centers. Humbly recognizing the limitations of SRFC offerings, fostering mutually beneficial relationships with CBOs, and publicizing the availability of these CBOs to providers and patients are critical steps to ensure clinic and community services are integrated.

Lastly, our model aims to have impact beyond our clinic walls through medical student education. Provider-level stigma can be taught and reinforced by our medical education system; for example, few institutions have explicit curriculum focused on harm reduction or destigmatizing language around SUD.[56-60] Prior literature hypothesizes experiential learning in which medical students work closely with patients with SUDs can reduce stigma and increase likelihood a student will care for patients with SUDs throughout their career.[51,61] Accordingly, implementations like that described here can have long lasting impacts by developing a provider-pool for the future that is both interested and appropriately trained in providing humanistic care to patients with SUDs.

Going forward, we aim to evaluate this pilot implementation, including quantitative assessments of care engagement, the CL service, patient adherence and outcomes, and qualitative assessments of student attitudes, perceived competency, and future intent to work with this patient population.

The pilot implementation described has several limitations. This pilot was made possible due to the availability of robust CBOs and professional expertise. This may reduce applicability to peer SRFCs, particularly those in rural areas or those without an affiliated AMC. Additionally, the impact of SRFC-based implementations is limited by federal and state policy. For example, provision of wrap-around care at a SRFC for patients with SUDs is necessitated by federal and state policy failures - including the failure to apply public insurance coverage to undocumented patients, and the failure to make harm reduction resources such as supply testing, syringe exchange and overdose prevention centers widely accessible. As such, implementations at a single-site SRFC must be supplemented by broader advocacy for policy and systems change to maximize impact.

In sum, SRFCs are well-positioned to train the next generation of physicians to provide high-quality SUD care while also contributing in the present moment to lessening disparities in care access faced by uninsured patients with SUDs. Our goal is to describe an aspirationally comprehensive model for SUD care in SRFCs, to enable the adoption of similar models by other clinics to provide the standard of care for patients with SUDs in their catchment areas.

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Disclosures

The authors have no conflicts of interest to disclose.

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