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Experience and Attitudes Toward Telehealth in Student-Run Free Clinics (SRFC)

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Abstract

Introduction/Objectives: Telehealth services expanded during the coronavirus disease 2019 (COVID-19) pandemic. Student-run free clinics (SRFC) deliver important health care services to underserved populations, who may face barriers to telehealth use. This study characterizes telehealth usage, experiences, and attitudes among individuals working in SRFCs. **Methods:** In November 2021, a survey adapted from the COVID-19 Healthcare Coalition Telehealth Impact Physician Survey was sent to all registrants who identified themselves as students at the 2020 Society of Student-Run Free Clinics Annual Conference. **Results:** Thirty-eight individuals of 576 registrants (7%) representing 21 of 88 (24%) SRFCs completed the survey. Twenty-one (58%) individuals reported using telehealth in their clinic. Those that did not cited lack of infrastructure as a barrier (eg, broadband, Internet challenges, technology investments), were more likely to serve homeless ($P = .01$), and less likely to serve non-English speaking populations ($P = .02$). There were increases in telehealth and decreases in in-person visits after March 11, 2020 though changes did not reach statistical significance. At least 15 (68%) wanted to continue chronic disease management, preventative care, and mental/behavioral health via telehealth after COVID-19. Most felt that telehealth was easy to use and improved the health, safety, and timeliness of care of patients, but not work satisfaction or access to care. Difficulty accessing physical devices, Internet, and data was the most-cited barrier to maintaining and accessing telehealth. **Conclusions:** Nearly all participants cited significant benefits and barriers to telehealth that impacted perceived access to care and sustainability. SRFCs' experiences may be modulated by their underserved populations and role in student education. Addressing barriers, particularly patient- and clinic-level technology challenges, could work to improve inequities in telehealth uptake.

Keywords

student-run free clinics, SRFC, telehealth, COVID-19

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Introduction

The provision of telehealth services expanded rapidly at the onset of the coronavirus disease 2019 (COVID-19) pandemic as a safe way to provide access to medical care.[1] Considerable benefits for clinic staff and patients have been reported. Compared to in-person visits, telehealth is associated with reduced practice workload,[2] patient wait times,[3,4] and time off needed from work to seek care.[5] Providers report high levels of satisfaction and endorse the potential of high quality, virtual care.[6] Approximately one-third of visits to primary care practices are considered amenable to telehealth, including visits for depression,[7] hypertension, and diabetes management.[8]

However, less is known about the potential disparities that exist amidst telehealth's expansion. Student-run free clinics (SRFCs) are present in 75% of Association of American Medical Colleges (AAMC) member institutions[9] and collaborate via the Society of Student-Run Free Clinics (SSRFC)–a national network created in 2010 by a group of students gathered from several family medicine and healthcare justice conferences–to provide important health care to underserved populations. Primarily, this

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consists of preventive care and chronic disease management services[9] to those who are uninsured,[10] refugees,[11] or experiencing homelessness.[12]

The underserved populations who utilize these clinics may face barriers to telehealth use due to social risk factors, including unmet transportation needs, food insecurity, and housing instability. While telehealth may help overcome transportation barriers, other factors may impede telehealth use in at risk populations including patient poverty level, inadequate access to technology and high-speed internet, as well as limited clinic resources. The purpose of this study is to assess the prevalence of telehealth use in SRFCs prior to and during the COVID-19 pandemic as well as attitudes toward providing future telehealth services.

Methods

This is a cross-sectional survey study. Our online survey was adapted from the COVID-19 Healthcare Coalition Telehealth Impact Physician Survey and informed by prior surveys developed by the National Committee on Quality Assurance and the American Medical Association.[13] Two student leaders belonging to a local SRFC, 1 physician volunteer and faculty advisor of a SRFC, 1 national coordinator for the SSRFC, and 2 biostatisticians experienced in survey methodology pre-tested the survey for clarity, completeness, and functionality on the RedCap platform.

Registration information from the 2020 SSRFC Annual Conference was used to identify all students and SRFCs represented at the meeting. This included medical students and allied health (pharmacy, nursing, social work, physical therapy) students. The list was cross-referenced with information on each clinic's website to verify individuals' identities, their corresponding SRFC, and the accuracy of contact information. The survey link on RedCap was emailed to all identified subjects. Non-responders were tracked and sent reminders to complete the survey 2 and 4 weeks later. The survey was open from November 10 through December 28, 2021. All responses were confidential, collected electronically by statistician collaborators, and inaccessible to the authors.

Descriptive statistics were performed for the results of all survey items. Likert scale responses were grouped into 2 categories to facilitate clarity in reporting: 1. Strongly Agree, Agree, 2. Neutral, Disagree, Strongly Disagree. Fisher's Exact Test for Count Data was used to assess differences in clinic characteristics between telehealth and non-telehealth respondents. Bowker's exact symmetry test was used to assess differences in visits by time period. A P-value $\leq .05$ was considered statistically significant. Analysis was performed using R version 4.1.2 (R Core Team, Vienna, Austria). The Mayo Clinic Institutional Review Board deemed the study exempt.

COVID-19 Healthcare Coalition Telehealth Impact Physician Survey

This questionnaire was created by members of the American Medical Association, American Telemedicine Association, Digital Medical Society, Massachusetts Health Quality Partners, MassChallenge HealthTech, Mayo Clinic, and MITRE Corporation and initiated in summer 2020. Its goal was to characterize the experience and attitudes of physicians and other frontline clinicians during the COVID-19 pandemic.[13]

Our survey contained a total of 38 multiple choice and Likert scale questions. Its content was composed of respondents' use or non-use of telehealth; telehealth modalities and training on telehealth use; impact of COVID-19 on visit numbers; and attitudes toward telehealth, including barriers, potential benefits, and future implementation.

The following changes were made to the original COVID-19 Healthcare Coalition Telehealth Impact Physician Survey that pertained to SRFCs: addition of questions on characteristics of SRFCs and populations served, addition of language and student barriers toward telehealth, and inquiry on additional aspects of health care disparities.

Results

The SSRFC Annual Conference participant list included 88 SRFCs from 74 AAMC member institutions. Nationwide, there are a total of 208 SRFCs from 106 AAMC member institutions.[9] Thirty-eight individuals of 576 registrants (7%) representing 21 of the 88 (24%) SRFCs completed the survey. Of the 38 respondents, 28 (74%) were medical students and 10 (26%) were allied health students.

Respondents were from clinics distributed across the United States; 14 (37%) were located in the Midwest, 10 (26%) were in the South, 8 (21%) were in the West, and 6 (16%) were in the Northeast. Most representation came from California and Pennsylvania, which comprised 16% (n = 6) and 13% (n = 5) of all locations, respectively. Twenty-one (55%) individuals belonged to clinics located in large cities and nearly all served uninsured adults. A large proportion of respondents served homeless (n = 26, 68%) and non-English-speaking populations (n = 29, 76%) in their SRFC.

Twenty-two (58%) respondents reported using telehealth in their clinic. Sixteen (42%) reported not using telehealth in their clinic, most commonly citing lack of infrastructure (eg, broadband, Internet challenges, technology investments) as a barrier to implementation. Compared to respondents offering telehealth, these respondents were more likely to serve homeless ($P = .01$) and less likely to serve non-English speaking populations ($P = .02$). Thirteen (81%) non-telehealth users and 21 (96%) telehealth users reported receiving at least some training in telehealth.

Table 1. Sentiments from those Working in SRFCs on Telehealth.

	Likert scale responses, n (%)	
	Strongly disagree, disagree, neutral	Agree, strongly agree
"I am personally motivated to increase use of telehealth in my SRFC."	8 (38%)	13 (62%)
"It has been easy for me to use telehealth in my SRFC."	6 (29%)	15 (71%)
"Patients in my SRFC have reacted favorably to leveraging telehealth for clinical care."	9 (43%)	12 (57%)
"By offering telehealth, my SRFC has increased the socioeconomic diversity of my patient population."	14 (70%)	6 (30%)
"By offering telehealth, my SRFC has helped reduce health care disparities."	6 (30%)	14 (70%)
"The use of telehealth in my SRFC has helped our patients overcome transportation barriers."	5 (24%)	16 (76%)
"Our patients have had better access to care since my SRFC began using telehealth."	11 (52%)	10 (48%)

Total visit volume did not change after March 11, 2020 when the World Health Organization declared the COVID-19 outbreak a pandemic, though there were increases in large quantities of telehealth visits (6-20+) and small numbers of in-person visits (0-5). Eleven (50%) respondents reported an increase in telehealth visits, and 8 (36%) reported a decrease in in-person visits. The primary means of delivering telehealth was through Zoom (n = 19, 86%) followed by audio-only telephone calls (n = 7, 32%).

All respondents using telehealth wanted to continue it after COVID-19 for some type of care. Most agreed that telehealth allows their SRFC to provide quality care for mental/behavioral health (n = 14, 88%), chronic disease management (n = 13, 72%), and preventative care (n = 12, 71%) and favored its continued use for these visit types. Six (55%) did not believe that quality follow-up after hospital or emergency department (ED) admissions could be provided via telehealth, and 7 (32%) intended to offer specialty care and hospital or ED follow-up care virtually in the future.

Fifteen (71%) reported that telehealth has been easy to use and improved the efficiency of their clinic. Fourteen (67%) reported that telehealth has improved the health and safety of patients, and 13 (62%) reported that telehealth has improved the timeliness of care. In addition, telehealth helped reduce patient health care disparities and transportation barriers but did not increase volunteer work satisfaction, socioeconomic diversity, or overall access to care at individuals' SRFCs (Table 1). Thirteen (62%) wanted to increase future use of telehealth in their clinic.

Each participant cited multiple challenges related to telehealth. Among patient-level barriers impairing access to telehealth, 16 of 22 (73%) respondents perceived a lack of access to technology (computer, smartphone) and broadband/internet, 15 of 22 (68%) perceived patients had greater preference for in-person visits, and 13 of 22 (59%) perceived a lack of digital literacy among patients. Specific clinic barriers toward maintaining telehealth after COVID-19 were technology challenges (n = 17, 77%), language barriers (n = 13, 59%), and low patient engagement (n = 11, 50%).

Discussion

Several key results of the current study agreed with those of the original COVID-19 Healthcare Coalition Telehealth Impact Physician Survey. Individuals from SRFCs and physicians working in teaching hospitals and solo or group specialty practices favored telehealth use for chronic disease management, preventive care, and outpatient medicine.[13] Additionally, both groups reported that telehealth use improved patient health, timeliness of care, and transportation barriers.[13] Similar proportions–13 (62%) students in SRFCs and 1024 (68%) physicians[13]–were motivated to integrate telehealth moving forward.

However, there were differences between those in SRFCs and physicians nationwide regarding perceptions on patient access to care, barriers to telehealth, and work satisfaction. First, unlike nationally surveyed physicians, of which 830 (55%) experienced improved work satisfaction due to telehealth,[13] only 8 (38%) individuals in SRFCs reported the same sentiment, and 8 (36%) regarded student dissatisfaction as a barrier to sustainability. Second, those working in SRFCs appear to be more ambivalent regarding telehealth's effect on access to care; 10 (48%) agreed that telehealth has improved access to care in comparison to 1027 (68%) physicians elsewhere.[13] Third, the most-cited barriers to telehealth within SRFCs were technology challenges (n = 16, 73%), language barriers (n = 13, 59%), and student dissatisfaction (n = 8, 36%) versus low or no reimbursement (n = 1166, 73%), technology challenges (n = 1022, 64%), and liability (n = 529, 33%) for physicians in other settings.[13]

A potential reason for students' relative dissatisfaction with telehealth is the dual purpose of SRFCs as patient care facilities and education venues. Students compose much of

the leadership, staff, and care teams within SRFCs,[9] and performing common administrative and medical tasks is central to their educational experience. It is commonplace in SRFCs for students to practice history-taking and physical exam skills, present to attending physicians, collaborate across disciplines (eg, nursing, pharmacy, social work), develop leadership skills, and engage with patient populations they may not otherwise encounter in their clinical rotations.[14] Several of these opportunities may be unavailable or suboptimal in a virtual setting. These include managing volunteers or medical inventory, performing physical exams, and coordinating with interdisciplinary personnel to address psychosocial needs. Annual student turnover could be an additional impediment to effectively implementing telehealth within SRFCs. For these reasons, if students of SRFCs are lukewarm or dissatisfied with telehealth, its use may not be expanded despite the potential patient-oriented benefits.

Less individuals in SRFCs than physicians elsewhere felt that telehealth increased access to care for patients, which may be a reflection of persistent inequities between those who have and do not have ready access to digital technology. SRFCs primarily serve racial minorities, individuals with incomes below the federal poverty line, and immigrant communities who speak English as a second language.[14] Fewer non-English speaking patients have been seen via telehealth than in-person clinic visits, and lower proportions of minority patients were seen via telehealth across all adult specialties.[5] Those of high Social Vulnerability Index, as characterized by the Centers for Disease Control and Prevention, have faced more patient-related barriers, including lack of reliable Internet or appropriate devices, patient discomfort with technology, and language barriers.[15] Considering broad agreement on telehealth benefits along with widespread expectation and motivation for its continued use,[13] if access is impaired in SRFCs and other clinics serving the underserved, the populations most at risk stand to miss out on a beneficial service. In contrast, those with access would have the opportunity to unlock better and better health outcomes thereby widening health disparities.[16]

With thought toward patients' preferences and available resources, telehealth can bridge this divide. While students did not think telehealth increased access to care, visit volumes in SRFCs did not decline during the pandemic as numbers of telehealth visits rose—potentially providing stability in access. Within federally qualified health centers, there was a 63% decline in in-person visits accompanied by a 3405% increase in virtual visits between February 3 and May 17, 2020.[17] This mirrors larger trends nationally, in which there was a 766% increase found in telemedicine encounters among 36 million individuals with private insurance claims.[18] Doximity, an online medical networking service that includes 1.8 million physicians (approximately 80% of the physician workforce in the U.S.) estimated that 20% of all U.S. health care visits were conducted virtually in 2020.[18] Furthermore, preliminary results from several novel programs have shown improved patient satisfaction and access to care,[19,20] even in underserved patient populations.[21]

In order to further the value of telemedicine and equity in access, it is critical to address identified barriers related to technology and patient comfort. Approximately 24 million people in the United States live in "digital deserts."[22] Expanding Wi-Fi hot spots and affordability programs that provide subsidies to eligible low-income households for Internet and telephone services, such as the federal Lifeline program,[23] could be valuable. Hardware loan programs, in which smartphones or other devices are mailed to patients before their telehealth appointments, are another consideration that have already demonstrated some success for Department of Veterans Affairs hospitals in the U.S.[24] Also, students in SRFCs could initiate digital literacy workshops and host virtual dry runs with patients prior to their scheduled appointments.

Leveraging different forms of telehealth and tackling financial constraints are other angles to advance telehealth uptake. Nineteen (86%) respondents in our study used Zoom as opposed to audio-only telephone calls, which have composed more telemedicine visits throughout the pandemic.[15] Audio-only visits afford greater privacy, feasibility, and ease of use, especially for older patients, those with lower digital literacy, and those with high social risk.[25] They are preferred by patients,[15,26] yet providers drive more video usage.[27] Since changes in telehealth reimbursement have promoted the widespread expansion of telemedicine services,[28] equivalent audio-only and video reimbursement rates coupled with efforts to expand Internet and electronic device access, could improve telehealth amenability for providers and patients. In the context of SRFCs, in which 35 (92%) respondents served uninsured patients and 77 (93%) medical schools with SRFCs provide care free-of-charge,[9] proactive adoption of audio-only options may be required. Ameliorating issues related to funding sources (eg, grants tailored to telehealth initiatives)[29] and the uptake of telehealth in SRFCs' sponsoring institutions would be important routes to explore.

Our study had limitations. The SSRFC Annual Conference is a strong location for recruiting participants because the conference attracts a large portion of the SRFCs actively operating in the United States. However, our survey response rate was low, and not all respondents answered all questions in the survey nor belonged to different clinics. Therefore, this data may not be representative of all SRFCs in the United States. However, survey respondents did not demonstrate heavy geographic preponderance, and all regions (Midwest, Northwest, South, and West) were similarly represented between respondents and nonrespondents. Additionally, we surveyed students to report perceptions of

patient barriers and did not measure these barriers directly. Although this conferred unique insight, this approach did not provide patients' perspectives firsthand on barriers and telehealth use in SRFCs.

Conclusions

To our knowledge, this is the first study to examine experiences and attitudes toward telehealth, as well as the impact of the COVID-19 pandemic, among individuals within SRFCs, which represent a rapidly growing means of delivering health care to underserved areas and providing valuable learning opportunities for medical trainees. Bolstered by the pandemic, many SRFCs have adopted telehealth. It has helped deliver quality care for chronic disease management, preventive care, and mental health services and has the potential to improve health equity. Proactive, intentional targeting of patient- and clinic-level technology challenges are critical to increase telehealth access.

Authors' Note

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All authors listed have read and approved this manuscript for submission, and all contributed to the project to be included as authors.

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