



**Operating a Student-Run Free Clinic with Direct Patient Care During a Pandemic**

Experiences, procedures, and resources outlined for the operation of a student run free clinic

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## **Overview of The JayDoc Free Clinic**

The JayDoc Free Clinic is a fully volunteer operated, student-run free clinic that provides quality healthcare to the underserved population within Greater Kansas City, while creating invaluable opportunities for students at the University of Kansas to enhance their education. Each Monday, Tuesday, and Wednesday evening, the student-run clinic provides non-emergency urgent and preventative care to over 1,000 patients every year. A cohesive unit of attending physicians, resident physicians, medical student physicians, pharmacy students, clinical lab scientist students, dietetic students, interpreters, and undergraduate interns, the JayDoc team works to create a tangible reduction in health inequities within Greater Kansas City.

The primary role of JayDoc is to provide acute care to our patients while connecting them with a long-term primary care provider (PCP). On general clinic nights, this most often includes treatment of upper respiratory infections, sexually transmitted infections (STIs), and hypertension. On acute specialty care clinics, patients are seen for Dermatology, Ophthalmology, Radiology, and Musculoskeletal care. JayDoc also provides medium-term and long-term care for select specialties. Those specialties include a medium-term women's health clinic, a long-term transgender clinic, and a long-term diabetes clinic. Notably, these services are provided to our patients free of charge, without the need for health insurance.

## **Closure of clinic due to COVID-19**

In early March of 2020, growing concerns about the COVID-19 pandemic caused many states to impose shelter-in-place orders to stop the spread of SARS-CoV-2. As they were considered essential, Health care workers and clinics were exempt from these orders. Although essential workers were not mandated to shelter-in-place, medical students at the University of Kansas were pulled out of clinical rotations to minimize the number of potential exposures and individuals needing Personal Protective Equipment (PPE). This called into question whether we could consider student volunteers exempt from the shelter-in-place order. Because medical students are vital in the operation of JayDoc, it would not be possible to continue clinic if they were unable to volunteer.

Following discussions with the JayDoc faculty advisors and the University of Kansas School of Medicine's Dean of Student Affairs, it was decided the restrictions on student involvement in the larger hospital system did apply to student involvement at JayDoc. As a result, on March 16th JayDoc announced that operations would be suspended for a two-week period. Unfortunately, this two-week closure continued through early June until medical students would be allowed back into clerkships.

When the clinic first closed to general night patients, the executive leadership took steps to ensure all administrative duties for the clinic were completed despite the cessation of weekly

operations. We believed keeping up these duties would allow us to support our patients and the clinic as much as possible during a strenuous time. Patient lines of communication were kept open via our medical assistant creating telephone encounters in our Electronic Medical Record (EMR) to notify executive leadership of patient inquiries or concerns. Executive directors readily checked these encounters and triaged them accordingly. All general night patients in need of a new prescription for chronic medications had their prescriptions refilled by an attending volunteer with access to the patients' information. Executive Directors also worked with volunteer physicians to solve any medical management concerns that arose during our closure. Additionally, Executive leadership developed a log of open Safety Net and Federally Qualified Health Center clinics in the Kansas City Area to disseminate to patients with higher acuity needs. Lastly, we utilized our online platforms (Facebook and Website), as well as our medical assistant to keep all our patients informed on both the timeline of our closure and any pertinent details about our reopening.

### **Plans to reopen clinic**

Although medical students would be allowed to volunteer at JayDoc again in early June, there were still many logistical concerns to be addressed before students would be welcomed back in the clinic. One major discussion was held on the types of chief complaints we would treat. Historically, a significant portion of JayDoc patients presented for upper respiratory issues, but due to a lack of access to rapid testing early in the pandemic, we would not have been able to differentiate between COVID-19 and the flu. As a result, we decided to refer all upper respiratory complications to other clinics in the area.

Additionally, we wanted to ensure the safety of all volunteers prior to reopening our doors; this meant that we would need to exercise an abundance of caution until more information about the nature and spread of SARS-CoV-2 was discovered. To mitigate potential exposures, our advisors recommended that all our volunteers wear N95 masks to limit any potential exposures to COVID-19. At the time, access to N95s was extremely limited, so our supply had to be rationed among a very limited number of volunteers. We developed a proper donning and doffing protocol to train volunteers and a tracking system to keep masks organized at clinic. Although this prioritized the safety of our patients and volunteers, this required a small number of physicians, students, and interpreters to take on a significant burden of work that would not be sustainable long-term. As a result, JayDoc board members worked with the University of Kansas Medical School to identify an acceptable, safe reopening plan that would be sustainable for the duration of the pandemic. That reopening plan and considerations from those discussions are outlined in this document.

### **Specialty care telehealth model**

With many clinics shutdown to new patients in the area during the early months of the pandemic, we had a difficult time finding replacement care for our patients who required ongoing help. The directors of our Women's Health (WHIP) and Diabetes Night clinics made the decision to continue to provide care for the most critical patients through whatever means possible.

Providing comprehensive prenatal care to pregnant patients, WHIP night directors created a system of importance to determine which patients needed acute care. These directors then found a provider who was willing to see the most pertinent prenatal patients at their own facilities. Prioritized visits included third trimester appointments, Group B Strep swabs, and fetal ultrasounds. As we were unable to provide in person care for most, we focused our attention to the opportunity to provide telehealth abilities.

As the only true chronic care arm of JayDoc, the JayDoc Diabetes Night clinic provides comprehensive and multidisciplinary diabetic management of both newly diagnosed and established diabetics bimonthly. At this specialty clinic, patients are followed up in one, three, or six-month intervals for regular diabetic care dependent upon patient need and risk stratification. This care includes medication management, routine and special labs, nutrition consultation, and community resources consultations. The chronic nature of this specialty night is needed for the successful management of this patient population; however, it also made this specialty clinic and its patients uniquely vulnerable at the start of the pandemic.

### *Initial Telehealth Model*

After the closure of the clinic we decided, along with the JayDoc Diabetes night Directors, to pursue telehealth rather than refer our patients elsewhere. This decision to pursue telehealth was multifactorial taking into account the lower socioeconomic status of our patients, their ability to access free and quality medical care during a pandemic, and the chronic nature of our relationship with our patients. After critically appraising these aforementioned points, we felt telehealth was the best way to continue providing quality medical management to our diabetes night patients. Following approval for the use of our clinic space to conduct calls and complete patient charting, we opened on 3/24 for 12 telehealth visits with a protocol as follows:

1. *Medical liaison contacts patients to expect a phone call on either 3/24 or 3/25 between the hours of 5:30pm-9:00pm. Patients are expected to take inventory of medications and pertinent symptoms prior to appointment.*
2. *On the night of telehealth two Diabetes clinic directors, with an executive director for guidance, will utilize clinic space in order to gather information prior to and during the patient encounter.*
3. *Diabetes clinic directors will call patients and conduct a virtual patient visit, using a telephone interpreter as needed.*
4. *Diabetes clinic directors will then call a volunteer attending physician to present the patient and work together to create a care plan.*
5. *Diabetes clinic directors will call patients once more to inform them of any significant changes to their care.*
6. *Diabetes clinic directors will chart encounters into the clinic's EMR, aid in calling in scripts, and completing any other miscellaneous tasks needed for the patients.*

### *Areas for Improvements to Telehealth Model*

At the onset of the clinic's closure, we believed the need for telehealth appointments, just like the pandemic, to be transient. However, when the Kansas stay at home order was extended in April and medical students across the country were still barred from participating in clinical activities, we were forced to view the pandemic as a more pertinent entity to address. Thus, we

began to reassess the content of our protocol, allowing us to identify flaws in our process preventing optimal patient care.

1. *Timing of telehealth appointments:* Prior to the pandemic, our patients were familiar with the flow of in-person visits at the JayDoc clinic. Introducing telehealth introduced an entirely different format of visit for our patients that came along with its own struggles. As previously stated, our patients were told a 3.5-hour window of when they would be contacted for their appointment. This proved to be a barrier as a subset of our patients could not wait this long for their appointment. Furthermore, it took around 90-120 minutes to complete a virtual visit, meaning the patients would need to be free upwards of five hours. To reduce this burden, the patient list was split into four factions, with the patients being guaranteed to be called during a 90-minute evening time slot over the course of two designated days. However, we still did field occasional complaints from those called later in the night. Due to our status as students, it was harder to optimize this much further.
2. *Inability to Run Lab Tests or Provide Physical Examinations:* The largest barrier to continuing our model of telehealth indefinitely was access to labs. Typically, all patients receive an HbA1C during every visit with routine Basic Metabolic Panel, Micro Urinalysis and lipid level testing when needed. These lab results are not only used to trend diabetic control and overall patient health, but also provide integral information needed to make decisions on medical management of the patient's disease. Approximately one month into clinic closure our volunteer providers began to express concern over filling scripts without having the needed lab and physical exams to aid in decision making.
3. *Providing Medications:* Many of our patients relied upon the free insulin from our clinic given at their in-person visits. When we closed, they no longer had access to this; furthermore, as we were to have zero in-person patient contact we could not give the patient's their insulin ourselves. To ensure access to insulin, we created a system with Family Health Care (FHC), the clinic that houses JayDoc, where patients could pick up the insulin provided by JayDoc during their business hours. Additionally, during telehealth visits we began to call in the patients' scripts to their preferred pharmacy to avoid the need for the patient to come to our clinic in order to pick up their script. This was efficient unless the patient visit was concluded outside of the hours of the pharmacy's operations, causing a delay in obtaining medications in a small subset of patients. Lastly, some patients did not have a pharmacy home and needed a paper script, they, as well, obtained their script from the staff at Family Health Care during their business hours.
4. *Lapse in Spanish Speaking patients:* Typically, our patient population at the JayDoc Free Clinic is 50% Spanish speaking; this is also reflected in the population of Diabetes Specialty Clinic patients. During telehealth appointments, it was relayed to our Diabetes Clinic Directors that many patients within our Spanish speaking population did not feel comfortable sharing medical information over the phone and preferred an in-person appointment. To that end, we began to see a drop-off in our Spanish speaking population attending their Telehealth visits.
5. *Nutrition consultation:* During normal Diabetes specialty clinics our patients benefit from consistent consultations with a volunteer dietician. Including dietetic care into our

telehealth calls proved to be hard due to the circuitous nature of our protocol. To better integrate the Dietetic volunteers into our patient's telehealth appointment we developed an on-call system in which the volunteer dietician would contact any patient who expressed interest in a consultation during their normal telehealth appointment. Although this allowed any patient to access dietetic care, we did not believe this service was being utilized adequately by our patients in the way it would have been during in-person consultations.

After assessing both the successes and pitfalls of our telehealth appointments we felt continuing telehealth as our main source of patient care was unsustainable in the long run. We then turned our attention to creating the safest way to open our clinic for in-person specialty care.

## **Reopening phases**

A four-phase reopening approach was developed and presented to KU School of Medicine administration with the approval of United Government Public Health Officer as a plan of how JayDoc could operate in a COVID-19 era. Following initial telehealth appointments based on previous charting and lab values, it became apparent of the need for updated labs to continue providing quality care, and this become of the focus of the first phase of the protocol. As the COVID-19 restrictions continue to persist, the phase IV plan has been left out, as it is modeled after our pre-pandemic workflow. The objectives and reflections of the current phases are detailed below.

### *Phase I – Clinic opened for lab draws only*

On May 18<sup>th</sup>, we were given confirmation from the school administration, FHC, and the Wyandotte County Health Department to participate in clinical activities in purely supportive roles. This led us to open a specialty night clinic in a very limited capacity on may19<sup>th</sup> for lab draws. Critical labs included HbA1c for Diabetes Night, and Group B Strep screen and Oral Glucose Tolerance Tests for WHIP Night. Prior to COVID-19, lab services were provided by our KUMC Clinical Lab Scientists in training (CLS) with oversight by our volunteer licensed laboratory scientists and phlebotomists. However, on our first reopening date the clinical lab scientist students were still unable to participate in clinically adjacent activities. Thus, we relied upon our volunteer clinical lab scientists to perform all necessary labs. This first reopening date became a target trial session to test out a new protocol of how we could operate a student-run clinic in a COVID-19 era. Only essential specialty night directors, one physician, two executive directors, two volunteer laboratory volunteers, and two interpreters were allowed in the clinic. Specialty nights were directed to select only critical need patients for their night. This was a total of 20 people in clinic, with 8 being patients.

Prior to their appointments, patients were called by our administrative assistant and screened for COVID-19 symptoms and exposures using the county's current COVID-19 triage call line questions. Patient arrival times for their appointments were also staggered to avoid any congestion in the waiting room. On arrival, patients were screened through a glass partition using the same aforementioned screening questions and, given no symptoms and a temperature below 100 F, were immediately escorted to their room. All volunteers were stationed at pre-designated base stations and we relied heavily on our newly developed clinic tracker to update patient status with each group. Spanish interpreters were given the option of phone or in-room interpreting,

although all of them chose to do in-room. Every volunteer was required to wear a mask and were also screened for symptoms and temperature before being allowed to volunteer.

For Women's Health, only Oral Glucose Tolerance Tests were performed. Any clinical management was completed over the phone following these encounters. For Diabetes care, clinic consisted of provider led patient encounters for five high acuity patients, with Diabetes clinic directors and the executive director acting as medical scribes, administrative assistants, and community resource liaisons. The five patients chosen for in-person visits were selected based on the criteria of having an HbA1C greater than 9%, Insulin use, or greater than 3+ years as a JayDoc Diabetes clinic patient with dependence upon the clinic for medications. All remaining patients scheduled were given a telehealth appointment. The inpatient appointments were able to be seen by a provider for a physical exam, as well as have their HbA1Cs drawn to monitor their disease control. In order to ensure that no students had any direct patient contact all rooms were stocked with any paperwork prior to the patient's appointment, and all patients were instructed to stay in their rooms unless otherwise told after checking in. Although extremely important to be open in any capacity, we felt it very important to begin to directly involve our student leaders within the JayDoc Free clinic in patient care.

#### *Phase II – Clinic opened with limited volunteers*

Following a successful experience with the Phase 1 reopening, the goal transitioned to Phase 2 implementation, with a goal date of June 8, 2020. A push to move forward within our phased structure occurred when the county health department began its Phase III protocol in response to decreasing COVID-19 cases within Kansas City. This lapsed some previous restrictions and opened more opportunity for us to be in clinic. The objectives of Phase 2 were to open for specialty nights, schedule general night patient encounters, to re-involve student physicians in patient care, and to establish a framework for transition into Phase 3 full reopening. Most importantly, we wanted to do this in a manner that prioritized safety for all parties.

Medical students received approval from the School of Medicine to reenter direct patient encounters beginning June 1, we implemented that within this phase after receiving approval from the county's Public Health Officer. Additionally, in order to see patients on a larger scale, we felt it was of the utmost importance to reincorporate our clinical lab student volunteers into Phase two. After detailing our protocol to the Program Director of the Clinical Laboratory Sciences program, CLS students were allowed back in clinic. However, similar to the medical student restrictions during phase one, CLS students were not able to provide phlebotomy as they could not have any direct patient contact but would be allowed in clinic to run laboratory tests. This gap in the ability of CLS students to directly interact with patients was filled by the development of a phlebotomy team formed by medical students and other trained phlebotomists to cover the clinic's needs. Once this approval was given and the phlebotomy team was created, we felt comfortable moving forward with Phase 2.

Changes to the foundation that was laid in Phase 1 came in volunteer numbers, protection, and type of patient seen. With the expansion of the services offered, we made the decision to do a trial of student-physician interactions in our clinic nights using only our most informed members, being the JayDoc Executive Board Members and all Specialty Night Directors. Through this cohort of volunteers, we felt we could work out any issues with the operational flow prior to expanding our volunteer opportunities to the larger medical student pool.

For this phase, we required all volunteers that had longer than ten-minute interactions with patients to wear N-95 masks and eye protection or face shields. In practice, the proper use and wear of the PPE was difficult to maintain as many people found the use of N-95s uncomfortable to breathe through. While our volunteers complied with the rules of their use, it was vocalized that many volunteers would support the discontinuation of their use when possible.

A limit of no more than 14 patients per night, regardless of number of specialties, was set for all clinic nights. While initially we began scheduling patients in ten-minute interval arrival times, we found this actually contributed to waiting room crowding as many patients still arrived at the same time. Later, we implemented block scheduling with half the patients at 5:30 PM and the other half at 7:00 PM. This helped keep congestion in our waiting area low while allowing us to know how many patients were expected to arrive. After trialing this phase in motion, we found that JayDoc could reasonably accept 8-10 patients every general night, with a cap of 10 for each specialty night. Scheduling via email and phone was overall successful, although we noticed an initial change in our patient population. While previously we had seen roughly 40% Spanish-speakers, through most of our initial reopening months, we would have a paucity of Spanish-speaking patients. This raised a lot of questions within our board of how we were effectively communicating with our community about our reopening and whether we were reaching all underserved populations.

### *Phase III –Clinic opened with wide pool of volunteers*

In Phase 2, we learned a lot about the efficiency of our clinic flow and our abilities to provide care to patients. Throughout the weeks we were in this protocol, we relied heavily on our most involved members of JayDoc, our Executive Board and Specialty Directors, to maintain their leadership role as well as fulfill duties as student-physicians in clinic. For some board members, their increased commitment to the clinic during this time became too much when considering outside duties. This allowed us to realize we needed to expand our pool of volunteers to continue to operate the clinic efficiently, leading us to push forward with our Phase 3 protocol. On July 6, 2020 we were approved by our medical advisors and the School of Medicine to begin this phase. The objectives for this phase were to open for scheduled general night patient encounters, to expand our student physician volunteer capacity, and to re-introduce community resource and administrative interns into clinic workflow, all in a manner that prioritized safety.

The widening of our volunteer slots to our student-physicians as well as the remaining adjunct groups was important for us to implement at this time in order to both have enough volunteers for efficient clinic operation, and to begin training the newest class of medical students who would be eligible to volunteer and eventually taking over roles in JayDoc leadership. We allowed four student physicians spots per night, with one executive board member filling a final student physician role.

We also prioritized the reintegration of our adjunct volunteer groups in this phase, including pharmacy, dietetics, and community resources. As the organizational structure of the clinic was much different than before the pandemic, we felt it imperative to create an effective way to communicate all of the changes we had made during our reopening process to the volunteers prior to their return to the clinic. To this end, we developed a “Return to Clinic”

training model with an accompanying multiple-choice quiz that all volunteers were required to complete before returning to clinic. We believe this helped curb a lot of basic questions about new rules while effectively retraining our volunteers on clinic basics.

Following the addition of all volunteers, we became concerned about adequate distancing within clinic. Even though all volunteer roles were limited to the minimum number needed per night, it became apparent that alternative mechanisms of enacting social distancing within the clinic structure would be imperative. We decided to pre-assign working location and computer use to student physicians ahead of time, using desktop and laptops previously unused in various rooms in the clinic. We also incorporated the use of the second-floor conference rooms as home bases for adjunct groups like interpreters and community resource interns. Splitting people up in differing corners of the clinic, while requiring us to walk more, was overall effective strategy to give enough distance between people.

At this point in time, the difficulties surrounding obtaining enough PPE, specifically N-95 masks, for all volunteers came to a head. There was also a discrepancy among recommendations for their use in our clinic as local clinics, including FHC and the outpatient clinics at our affiliated University hospital, were only required to wear surgical masks and face shields. Further, a group of our physician volunteers felt uncomfortable volunteering with us when our PPE protocols for students did not align with that of our School of Medicine's guidelines. Once this concern was brought to us, we successfully petitioned the Public Health Officer for our county, our medical advisors, and school administration for permission to change needed PPE to a surgical mask and face shield operations. We still allowed the use of N-95s for our volunteers who felt more comfortable with it. Additionally, we were able to get a donation of 2000+ masks from a local supporter, further allowing us to feel confident opening to all volunteers. Overall, the use of surgical masks and eye protection has become the standard at all times in clinic.

## **Discussion**

### Challenges

#### *Communication*

Throughout our reopening, we faced many obstacles in effective communication as we learned how to best manage operations in a pandemic. In order to receive approval for reopening, extensive changes had to be detailed about our new operating structure; thus, necessitating the need for frequent and transparent communication. Additionally, most communication with our executive team had previously taken place in person, whereas with social distancing restrictions, we had to learn to communicate completely online. All of these factors lead to an obvious strain in our leadership communication style. At the peak of COVID-19 restrictions, with the county government rapidly changing restriction guidelines that had to be immediately reflected in our clinic operations, we found that we were not always transparent with our executive board about the changes that needed to be implemented. This left both the board and our volunteers confused about overall clinic operational structure.

To improve communication, we scheduled frequent meetings with our board and set an expectation of complete transparency in all of our operations. We put an emphasis on sharing all progress updates related to every position at our structured meetings. Additionally, before any

operational changes were made, all board members must have expressed their written approval. As the rate of changes made decreased and the strains in our protocol were worked out, we were able to better manage these problems and emphasize the importance of communication for future issues.

### *Meals in Clinic for Volunteers*

Prior to Covid-19 we supplied food every night for all volunteers. Typically, the food would be set up "family-style" in our main workroom with communal serving utensils. Although providing food was not necessary to clinic operations, we believed doing so had a positive impact on moral and volunteer rates. However, during the process of reopening the clinic we were forced to examine the true utility of providing food. As we wanted to mitigate all unnecessary exposures, we had to ask ourselves, given the state of the pandemic during summer 2020, if the benefit of providing meals to our volunteers was worth any additional risk. After this appraisal we decided it did make sense to continue to offer food nightly, but we knew the accessibility of the food had to be optimized. At the onset of our reopening, we provided individually packaged meals to all of our volunteers. Unfortunately, the additional cost associated with the increased packaging became too much to incur. We then returned to "family-style" packaged food but moved the eating location from the more trafficked provider workroom to a larger space dedicated solely for eating. Additionally, all volunteers were required to utilize their personal single-use utensils to serve themselves as we deemed communal serving utensils as an unnecessary risk. We also staggered the times in which our volunteers had access to the food such that no more than half of the group ate at one time. Social distancing was heavily enforced during the eating process and volunteers were required to wear masks whenever they were not actively in the process of eating. This was our working food protocol from summer to fall of 2020. However, as the cases of COVID-19 continued to hit peak numbers, we decided, once more, to assess the risk of providing food to volunteers. During this process we also received word that our university affiliated health system had begun to recommend that all staff and faculty eat their meals in their cars or personal offices. Due to the rising COVID-19 numbers along with the policy from our university's health system, we decided that providing food had become too great of a risk to continue. This decision, although unfortunate, was received well by all our volunteers. In hindsight, we believe this decision should have been made earlier in order to best protect our volunteers.

### *Successes*

#### *No Know COVID-19 Transmissions*

After operating for approximately nine months during the pandemic there have been no know transmissions COVID-19 acquired at the JayDoc Free Clinic. We believe this was due to our strict protocols and procedures outlined in this document. For instance, patients who had any COVID-19 symptoms were turned away until those symptoms resolved, and any volunteer or member of the student leadership team was required to complete a 14 day quarantine post COVID-19 exposure or infection. This was an important measure that contributed to lowering the risk of exposure in clinic. Additionally, with the masking and physical distancing requirements listed above, any further potential spread of disease was minimized.

### *Pre-Scheduled vs Walk-in Appointments*

JayDoc Free Clinic had relied on being a walk-in clinic model on general nights for the years leading up to the closure from the COVID-19 pandemic. Our administrators and advisors voiced concerns about increased COVID-19 risk associated with this model. Specifically, we were apprehensive about crowded waiting rooms where we could not control exposures to patients who possibly had upper respiratory symptoms and had not yet been triaged. To address this problem, we cautiously decided to adapt our model to a by-appointment only structure. This allowed us to control the types of chief complaints accepted, screen patients for symptoms via phone before the appointment, and control for spacing by having appointment maxes. Ultimately, this proposal allowed us to get approval by the administration to reopen.

We have always used a by-appointment model during our specialty nights; however, we worried about the ability to reach our population due to technological and transportation barriers if we switched to this during our general nights. In practice, we were surprised how well this worked for us. For many patients, the ability to have an appointment allowed them to be able to plan for transportation or other barriers that they may face in getting to an appointment. Our efficiency in wait or down time in the clinic greatly improved. Patient wait times were also significantly decreased by implementing block scheduling as previously our patients would sometimes have to wait for 2+ hours before being seen. Additionally, knowing the patient's chief complaints ahead of time helped us better schedule our physician volunteers. Our appointment slots often become full weeks out from the current date, letting us know that patients knew we were open and how to contact us. While we were initially hesitant to implement an appointment-type of system due to concerns of patient reach barriers, ultimately, we found block scheduling a success.

### **Conclusion**

Although there are differing clinical models among student run free clinics across the country, many of the materials and experiences outlined in this document are translatable to clinics other than the JayDoc Free Clinic. As a result, a major motivation in publishing this packet is to share the materials and experiences that arose from the operation of a student run free clinic during a pandemic.

### **Acknowledgment**

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**Description of resources**

- **Clinic COVID-19 Safety Training Module**  
A training module for safe practices in clinic during a pandemic.
- **N-95 Training module**  
A training module for safe and effective donning and doffing protocol of N-95 respirators.
- **Reopening protocols**  
A condensed reopening protocol used for each phase of reopening.
- **Needs Assessment Survey**  
A community resources tool to assess a patient’s basic needs apart from general health care.
- **Clinic Tracker**

A programable google sheet-based clinic progress tracker and communication tool. The clinic tracker in this packet functions similarly to an emergency room flow tracker, in that it lists patient progress throughout their time in clinic. For instance, volunteers can tell when their patient has been checked-in by looking at their assigned row in the tracker as illustrated in the figure below. Currently, the clinic tracker is set up to outline the flow of JayDoc Free Clinic, but the top column in the attached spreadsheet can easily be modified to track the progress of another clinic

Room Number	Chief Complaint	SP	Physician	Patient Language	Patient Checked in	Request Interpreter	Ready to Present	Doc Ready
1	Complaint 1	Medical Student 1	Doctor 1	English	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Complaint 2	Medical Student 2	Doctor 2	Spanish	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

At JayDoc, we set up eight iPads throughout clinic workstations all displaying this same google sheet with the Clinic Tracker. Each medical student periodically updates their progress so that clinic flow stays organized. Importantly, this centralized Clinic Tracker allows us to keep different groups of volunteers separate to maximize physical distancing during the COVID-19 pandemic. For instance, the interpreters can be at a different workstation than the medical students, and when requested on the Clinic Tracker, can meet the medical student at the patient room.

*This sheet is provided as a Microsoft excel file and will need to be uploaded to Google Drive as a Google Sheet to maintain full functionality.*