Global Jesuit Case Series
May 2018, Vol. 36, No. 3, p. 12-20
Special Issue of the *Journal of Case Studies*
ISSN 2162-3171
www.sfcrjcs.org

A Pro-Bono Therapy Clinic: Valuable and Viable?

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Introduction

John, a self-employed handyman, had surgery to repair a rotator cuff tear sustained while trimming trees and could not work. His doctor ordered immobilization and physical therapy (PT) or occupational therapy (OT) follow-up 2-3 times per week. However, he did not have insurance or the ability to pay for the necessary follow-up care. A friend suggested RockU CARES pro-bono PT and OT clinic. John's lack of income and intense pain influenced him to make an appointment where he met Sunni, an occupational therapist of over 25 years and Rockhurst University faculty mentor at the RockU CARES monthly pro-bono clinic located in Kansas City, Missouri. She was excited to evaluate John and others on the full schedule of patients needing rehabilitative services.

John was evaluated and began treatment for his shoulder during his first visit. He was scheduled for monthly follow-up appointments with the goal of returning to work. Sunni worked closely with his schedule to ensure he was able to receive the needed therapy. However, John did not return, and Sunni was frustrated. John was the tipping point which made Sunni question the value of the pro-bono clinic. About fifty percent of the scheduled patients did not show up for their scheduled appointments. She knew that patients seen at the clinic did not have the ability to pay for the necessary rehabilitative services. Also, she worried about her patients' welfare and their likelihood to fully return to work and daily life. Pro-bono clinics, such as RockU CARES, attempted to provide social justice by bringing patients from vulnerable situations together with health profession students and faculty. However, given the high no-show rate, what should Sunni and her team have done different to serve these patients' needs?

Mission and Values of Rockhurst University

Founded in 1910, Rockhurst University was a Jesuit institution in the Midwest with a mission "to transform lives by creating a learning community centered on excellence in undergraduate liberal education and graduate education" (Rockhurst University, 2017). Rockhurst University sought to be "involved in the life and growth of the city and the region, and committed to the service of the contemporary world" (Rockhurst University, 2017). The vision of the University was to make the world better through learning, leadership, service, and the pursuit of justice. Six core values guided the Rockhurst University culture, including "Finding God in All Things;" "Reflection and Discernment;" "Magis" or seeking to continuously better oneself, love more, and find more purposeful and effective actions; "Cura Personalis" or caring for the whole person; "Contemplation in Action" or seeking to be agents of transformation, especially in social justice and equality; and "Wisdom" or commitment to learning (Rockhurst University, 2017).

History of RockU CARES Clinic

RockU CARES, founded in 2000, consisted of a team of faculty and students from the physical and occupational therapy programs at Rockhurst University, who aimed to infuse Jesuit core values, such as social justice, when providing rehabilitation services at a local non-profit healthcare clinic, Kansas City (KC) Care Clinic. Since 1971, the non-profit KC CARE Clinic served the local, urban area and grown to become one of the largest community health clinics in the country, serving over 11,000 patients per year (KC Care Clinic Annual Report 2015-16, 2017). KC CARE Clinic, with a goal to provide high-quality care to those in the community that need it the most, provided patients with general health, prevention, dentistry, primary care, and other services through the help of its 115 full-time staff members and over 700 volunteers (KC Care Clinic Annual Report 2015-16, 2017). The clinic was located close to a major city intersection. The nearest bus stop to the clinic was about four blocks away.

RockU CARES provided the rehabilitation care at the KC CARE Clinic by offering pro-bono PT and OT to individuals who were uninsured or underinsured, allowing patients to receive services they may not have been able to routinely afford. Physical therapy and occupational therapy addressed the health of patients and overall quality of life. Physical therapy incorporated a theoretical approach to improve movement and mobility of patients, while occupational therapy focused on increased participation in meaningful daily activities. Many patients suffered injuries, received surgeries, or had pain and were not able to afford the follow-up rehabilitation services required. The lack of care prevented the patients from being able to fully live their lives. The RockU CARES team, mentored by PT and OT faculty, provided quality therapeutic services while empowering students to become strong leaders and resourceful clinicians through interprofessional collaborative experiences. The cross-sector partnership between KC CARE

Clinic and the RockU CARES team had a goal to enhance the quality of life for underserved citizens while helping Rockhurst University faculty and students to fulfill moral, social, and professional responsibilities as citizens of the community (Strengthening Nonprofits, n.d.). In addition, student participation in the clinic addressed national accreditation standards of social justice and clinical care for the PT and OT education programs (Accreditation Council for Occupational Therapy Education (ACOTE®), 2016; Commission on Accreditation in Physical Therapy Education (CAPTE), 2017).

RockU CARES Clinic Operations

RockU CARES provided pro-bono rehabilitation services once per month on a Friday for four hours. Under the RockU CARES model, experienced faculty mentors facilitated students to provide care, including conducting interviews with patients, completing tests, developing a plan of care, and providing interventions that helped patients meet their goals. The pro-bono clinic fostered an educational environment where PT and OT students developed the most effective rehabilitation plan of care for patients. The services offered include: screening, evaluation, exercises, fabrication and application of some orthotic devices, education and wellness (health promotion and injury prevention). Common reasons patients sought services were occupational, musculoskeletal, neuromuscular, perceptual, and/or cardiopulmonary disorders with symptoms or needs such as: weakness, pain, decreased endurance, decreased ability to care for family, sensation deficits, low vision, decreased functional/community mobility, impaired self-care skills (grooming, dressing, bathing, toileting), and need for diagnosis-related education (diabetes, ergonomics, etc.). At least 75% of patients seen for the initial visit required follow-up therapeutic care to help the patients' goals be achieved. The staff at the KC CARE Clinic scheduled these follow-up appointments for patients.

During the clinic time, KC CARE Clinic allowed the RockU CARES team use of a shared waiting room, two rooms with medical exam tables, and a documentation system. Rockhurst University physical and occupational therapy departments paid for adjunct faculty to consistently help cover the clinic and for some supplies and equipment, such as exercise bands and goniometers.

Administration of RockU CARES Clinic

Rockhurst University negotiated a yearly contract with the KC CARE Clinic to provide the PT/OT services by the RockU CARES team of students and faculty. The University paid additional liability insurance required for students and faculty to practice at the facility. RockU CARES was operated by three senior and one junior physical therapy (PT) and occupational therapy (OT) student administrators who managed teams of student, clinician and faculty

volunteers. PT and OT students routinely had Fridays off from class to allow them to help with the clinic. The student administrators were selected through an application process by faculty mentors. The chosen administrators were paid through the Rockhurst University work-study program and PT and OT department funds. On average, student administrators each worked 5 hours per month. The student administrators of the clinic routinely changed due to the student schedules and clinical rotations that required students to work on Fridays or be out of town. During half of the academic year, the administrator team consisted of three OT student senior administrators and one PT student junior administrator, while the other half of the academic year, the administrator team was made up of three PT student senior administrators and one OT student junior administrator. The senior administrators were in charge of operations, communication and data collection. Additionally, the senior administrators mentored the junior administrator who eventually took on the senior role when a new team of administrators began their work on the team. Outside of the student administrators, students who volunteered at the pro-bono clinic were not paid.

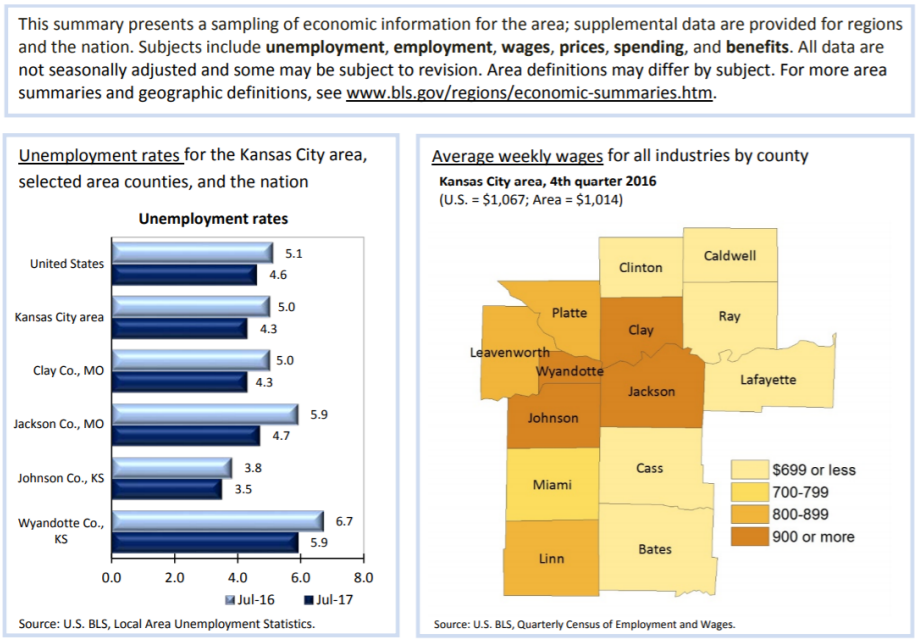
PT and OT student volunteers participated in groups of three, which included two senior students, one from each program, and one junior student from either program. For each patient interaction, the student volunteers worked together interprofessionally to learn about the patient and the symptoms the patient was experiencing. During the evaluation portion of the patient interaction, the students had the opportunity to interact with their PT and OT faculty mentor outside of the patient room to discuss findings and the patient's plan of care. The faculty mentor provided students with feedback on their communication, decision making and critical thinking skills. The treatment part of the patient interaction involved generating an individualized home exercise program that addressed any physical limitations, such as working, sleeping, or self-care, the patient experienced.

Throughout the clinic operations, patients were asked to provide feedback on their clinic visit(s). Verbal feedback from patient surveys was positive. Completion of written feedback was affected by limited health literacy. There was a lack of ability to obtain feedback from patients that did not attend follow-up visits. Over the years, the RockU CARES team made changes to the clinic hours, clinic space, frequency of appointment reminder calls, and the documentation system (paper to electronic) in response to student and patient feedback, healthcare trends, and patient attendance rates.

Patient Demographics

Based on demographic data taken from 2013-2015, the average age of patients seen at RockU CARES clinic was 51 years old. Female patients made up 46% of the patients. Additionally, 45% of the patients were Caucasian, 45% identified as African-American and 10% identified as Latino, European descent or Persian descent. Patients came to the clinic with musculoskeletal complaints including loss of movement and/or pain within the following areas: neck, back, shoulder, hip, knee, elbow and hand. Back pain was the most common complaint, made by 34% of the patients. Many patients did not speak English as a primary language. In general, 83% of the patients in the KC CARE Clinic system were uninsured, 75% lived below the federal poverty level, and over 60% of patients were diagnosed with one or more chronic conditions (KC Care Clinic Annual Report 2015-16, 2017). This population routinely faced the difficult decision of pursuing medical care for their conditions or paying rent. The economic climate for Kansas City metro area, particularly in Jackson County, where KC CARE Clinic is located, showed higher rates of unemployment and lower weekly wages compared to other US locations in Figure 1 (US Labor of Bureau Statistics, 2017).

Figure 1: Summary of Economic Information for Kansas City



US Labor of Bureau Statistics, 2017

As a whole, most of the patients seen at the RockU CARES pro-bono clinic were from vulnerable populations, meaning that they either did not have health insurance or had very limited benefits associated with their health insurance that did not include physical and occupational therapy services. Generally, patients from vulnerable populations tended to possess the characteristics of low economic status, compromised health, functional or developmental status, decreased ability to communicate/advocate for health needs (Dong et al., 2014) and inadequate health literacy (Dewalt, Berkman, Sheridan, Lohr, & Pignone, 2004). Health literacy is a collaborative exchange between the patient and provider (Paasche-Orlow & Wolf, 2007). Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (Centers for Disease Control and Prevention, 2017). Deficient health literacy has been more prevalent among vulnerable populations, such as the elderly, minorities, persons with lower education, and persons with chronic diseases (Dewalt et al., 2004; Health Literacy: A Prescription to End Confusion, 2004).

Barriers

The connection of vulnerable populations to pro-bono healthcare proved to be challenging for several reasons based on the characteristics of the patients, the feasibility of clinic services and lack of funding to grow rehabilitative care for patients. Patients from vulnerable populations struggled with time off from work to attend the clinic and reliable transportation to get to the clinic. The unpredictability of vulnerable patients attending their scheduled appointment times demonstrated a lack of ability to consistently attend the clinic within the clinic offerings. The pro-bono clinic offered one hour time slots on one Friday once per month. The team of volunteers scheduled 100% of patient slots and 50% of patients kept their appointments for their evaluation. Further, approximately 50% of patients evaluated at RockU CARES clinic returned for a scheduled follow-up therapy visit, with the patient return rate drastically reduced after one follow- up visit.

Based on the knowledge about persons from vulnerable populations, it was known that the predictability of transportation and food security was not stable (Shi & Stevens, 2005; Syed, Gerber, & Sharp, 2013). The closest bus stop to the clinic was 4 blocks away, which hindered patients with mobility deficits from being able to get to the clinic. A majority of patients used the public bus to get to medical appointments, as they could not financially afford cab fares or other options. Further, one in seven individuals in the community, which surrounded the pro-bono clinic, was impacted by food insecurity, or the lack of affordable fresh food (Brown, 2017). Without access to adequate nutrition, patients were at greater risk for chronic diseases and mobility deficits (Brown, 2017).

In addition, the pro-bono clinic posed possible barriers to potential patients' attendance. These factors included limited clinic space and lack of consistent marketing about the clinic to the community or potential referral sources. The limited marketing that existed was delivered primarily written in English. Most of the patients that attended the clinic came from referrals from the KC CARE Clinic or word of mouth. As a result, many potential patients did not know of the presence of the RockU CARES clinic.

Lastly, RockU CARES did not receive any substantial, direct funds from Rockhurst University or other entities, thus operating on a very minimal, non-consistent budget. Rockhurst faculty mentors attempted to obtain a grant to help increase the pro-bono clinic time from monthly to weekly and increase support staff and equipment. However, funding was not found. Seeking donors and equipment was challenging due to the limited time of the clinic and other commitments of faculty and students.

Conclusion

Sunni, along with the PT and OT students, spent countless hours preparing for the RockU CARES Clinic in hopes to deliver needed care to vulnerable patients. However, despite their attempts to improve clinic operations, which affected the delivery of services, the lack of consistent patient attendance continued to spiral downward, which frustrated Sunni. This was the case for John, who despite needing therapeutic care for his shoulder, did not return to the clinic. The RockU CARES team felt they tried to accommodate specific needs of patients within the existing framework of the community partnership and pro-bono care, but they felt their social justice impact was significantly limited. What could Sunni have done to facilitate clinic sustainability and improved therapy outcomes for John and other patients?

References

Accreditation Council for Occupational Therapy Education (ACOTE®). (2016). *Standards and Interpretive Guide.* Retrieved from https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/Standards/2011-Standards-and-Interpretive-Guide.pdf

Brown, E. (2017, October 12). Advocates gather to address food insecurity. Retrieved December 16, 2017, from https://hcfgkc.org/advocates-gather-address-food-insecurity/

Centers for Disease Control and Prevention. (2017, May 3). What is Health Literacy? Retrieved December 16, 2017, from https://www.cdc.gov/healthliteracy/learn/index.html

Commission on Accreditation in Physical Therapy Education (CAPTE). (2017). Standards and Required Elements for Accreditation of Physical Therapist Programs. Retrieved September 5, 2017, from http://www.capteonline.org/home.aspx

Dewalt, D. A., Berkman, N. D., Sheridan, S., Lohr, K. N., & Pignone, M. P. (2004). Literacy and health outcomes: a systematic review of the literature. *Journal of General Internal Medicine*, *19*(12), 1228–1239. https://doi.org/10.1111/j.1525-1497.2004.40153.x

Dong, X., Liu, L., Cao, S., Yang, H., Song, F., Yang, C., … Lu, Z. (2014). Focus on vulnerable populations and promoting equity in health service utilization--an analysis of visitor characteristics and service utilization of the Chinese community health service. *BMC Public Health*, *14*, 503. https://doi.org/10.1186/1471-2458-14-503

Health Literacy: A Prescription to End Confusion. (2004). [ebook] Washington D.C.: National Academies Press. Available at: https://www.ncbi.nlm.nih.gov/books/NBK216032/pdf/Bookshelf_NBK216032.pdf

KC Care Clinic Annual Report 2015-16. (2017) (pp. 1-8). Kansas City. Retrieved from http://www.kccareclinic.org/Media/Default/AnnualReports/2015-16%20Annual%20Report%2010-27-16%20Reduced%20Size%20for%20Web.pdf

Paasche-Orlow, M., & Wolf, M. (2007). The Causal Pathways Linking Health Literacy to Health Outcomes. *American Journal of Health Behavior*, *31*(1), 19-26. http://dx.doi.org/10.5993/ajhb.31.s1.4

Rockhurst University. (2017). Rockhurst University Mission and Core Values. Retrieved September 5, 2017, from https://ww2.rockhurst.edu/college-health-human-services/mission-core-values

Shi, L., & Stevens, G. D. (2005). Vulnerability and unmet health care needs. The influence of multiple risk factors. *Journal of General Internal Medicine*, *20*(2), 148–154. https://doi.org/10.1111/j.1525-1497.2005.40136.x

Strengthening Nonprofits. (n.d.). Types of Partnerships. Retrieved December 16, 2017, from http://www.strengtheningnonprofits.org/resources/e-learning/online/partnerships/default.aspx?chp=2

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health*, *38*(5), 976–993. https://doi.org/10.1007/s10900-013-9681-1

US Labor of Bureau Statistics. (2017, August 30). *Kansas City Area Economic Survey.* Retrieved from https://www.bls.gov/regions/mountain-plains/summary/blssummary_kansascity.pdf