

2026 NHMA La Próxima Generación (The Next Generation) Scholarship

Title: Case Management to Address Comorbidities and Social Needs Among Adult Latine Patients in a Student-Run Free Clinic

Summary: Implement a case management program at a student-run free clinic to improve health outcomes for underinsured, low-income Latine patients with ≥ 1 chronic medical conditions and ≥ 1 social needs. Provide case management using undergraduate student case managers and interdisciplinary pods that include pharmacy and medical students. Services include care coordination, disease management, appointment follow-up, referrals to community resources, assistance with social needs, and longitudinal support. Interdisciplinary supervision meetings with clinical preceptors are held monthly for case discussion and care planning.

Statement of Need: Latines in the U.S. are more likely to be uninsured, have lower household income, and experience a disproportionate burden of chronic disease, with cancer, heart disease, strokes, and diabetes being the leading causes of death (U.S. Census Bureau, 2024). Comorbidities are costly, disabling, and associated with poorer health outcomes, which exacerbate existing inequities in Latine communities (Roth et al., 2022) and contribute to fragmented care, particularly in a safety-net setting. Case management programs may improve care coordination, disease management, and address both medical and social needs, yet evidence in student-run clinic settings remains limited.

Target Audience: Uninsured or underinsured, adult Latine patients at Clinica Tepati (Sacramento, CA) with ≥ 1 chronic medical condition and ≥ 1 identified social need (transportation insecurity, food insecurity, medication insecurity, etc.).

Program/Activities: The program is fully run by volunteer students and preceptors. Patients are referred to case management and then assigned a case manager (undergraduate student). Case managers are paired into pods with a medical student and/or pharmacy student who works with them to provide patients with care coordination, disease management, appointment follow-up, medication refills, referrals to community resources, assistance with social needs, and longitudinal support. Case managers contact patients at least once every three months, but typically more frequently, to check-in. Pods meet monthly for supervision from a medical doctor, mental health provider, and pharmacist. Each patient has an individualized care plan that is tailored to their medical conditions and includes recommendations from the U.S. Preventative Services Task Force (USPSTF) Grade A Recommendations and American Diabetes Association Standards of Care. There are protocols in place for frequency of patient contact and appropriate documentation of care. Patients are screened for social needs using the PRAPARE screening tool. Social needs are addressed on an individual basis and can include:

- Transportation insecurity: Ubers to and from clinic
- Medication insecurity: Dispensary of Hope enrollment for free medications distributed in-house, medication reimbursement for medications purchased at the pharmacy, and pay-ahead with delivery covered by clinic for patients with both transportation and medication insecurity

- Food insecurity: Local food bank resources are provided and Cal-Fresh enrollment for eligible patients
- Medical insecurity: Medi-Cal enrollment and support with applying for fee assistance programs.

While most case management can be done remotely, there is a representative from the case management team available on clinic days to support patients coming in for appointments, needing help with BenefitsCal enrollment, or needing in-person support.

Evaluation & Impact: The program will use process measures and clinical outcomes to assess for improvement in comorbid conditions and social needs. Patient goals are set based on guideline recommendations. For example, using ADA guidelines for outcome goal HbA1c.

- **Process Measures**, completion of guideline-based care, including:
 - **USPSTF Grade A Recommendations:** Cervical cancer screening, Breast cancer screening, Colorectal cancer screening, Statin therapy for Cardiovascular Disease prevention, Osteoporosis screening, and HIV screening
 - **Laboratory Monitoring (ADA Standards of Care):** Hemoglobin A1c (HbA1c), Urine albumin-to-creatinine ratio (UACR), Comprehensive metabolic panel (CMP), Lipid panel, and Complete blood count (CBC)
 - Additionally, Thyroid Stimulating Hormone (TSH) and Free T4 as indicated
 - **Specialty Referrals (ADA Standards of Care):** Ophthalmology, Retinal screening, Podiatry, and Dental
- **Clinical Outcomes:** Change in HbA1c, blood pressure, and PHQ-9 scores at 12 months.

Additionally, patient feedback surveys will be used to understand their experience participating in case management and to guide improvement.

Initial data analysis shows that among 12 patients enrolled in case management for at least one year, the cohort had a mean age of 54, and demonstrated substantial clinical complexity, with a mean of five chronic diagnoses and seven medications per patient. All patients had type 2 diabetes, with hypertension and hyperlipidemia as frequent comorbid conditions. Nearly half of patients experienced one or more diabetes-related complications, including nephropathy, retinopathy, or neuropathy. Patients had substantial social needs, including lack of insurance and medication insecurity. Process measures demonstrated high completion of recommended care, with an average of 81% of referrals, 68% of USPSTF Grade A recommendations, and 93% of recommended laboratory tests completed. Though screening for colorectal cancer and HIV remained areas for improvement. Clinical outcomes showed improvement across multiple domains, including a mean reduction in hemoglobin A1c of 1.46%, with greater reductions observed among patients with higher baseline values. Blood pressure improved by at least 5 mmHg, or was maintained in all patients, and all patients with elevated baseline PHQ-9 scores experienced reductions in depressive symptoms.

Implementation of a case management program in a student-run free clinic was associated with improvements in care coordination, disease management, and social determinants of health among underinsured, low-income Latine patients. These findings support the role of case management as a scalable strategy to address complex patient needs in resource-limited clinical settings.

Sustainability and Growth: The case management program at Clinica Tepati came from a desire to provide better and more consistent care to patients who often fell through the cracks and did not have the health literacy to navigate the healthcare system on their own. Through much hard work and dedication, we were able to formalize the case management program as a permanent clinic committee to ensure continual support and resource allocation, specifically personnel allocation. Case management is now in its second year and we have been able to grow from a handful of students and patients to over 50 student volunteers (undergraduate and professional) and over 30 patients.

Through sharing our protocols, trainings, and resources, the case management program created at Clinica Tepati is currently being replicated at a sister student-run clinic, Knights Landing, with the goal to continue to share out our successes so that other student-run clinics can implement their own case management program.



Case Management to Address Comorbidities and Social Needs Among Latine Patients in a Student-Run Free Clinic: A Quality Improvement Study

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Background

Latines in the U.S. are more likely to be uninsured, have lower household income, and experience a disproportionate burden of chronic disease, with cancer, heart disease, strokes, and diabetes being the leading causes of death (U.S. Census Bureau, 2024). Comorbidities are costly, disabling, and associated with poorer health outcomes, which exacerbate existing inequities in Latine communities (Roth et al., 2022) and contribute to fragmented care, particularly in a safety-net setting. Case management programs may improve care coordination, disease management, and address both medical and social needs, yet evidence in student-run clinic settings remains limited.

Objective

The objective is to evaluate the effectiveness of a case management program in addressing comorbid conditions and social needs among uninsured or underinsured, low-income adult Latine patients at a student-run free clinic.

Methodology

Design: Pre-post observational quality improvement study comparing baseline to 12-month outcomes after enrollment in case management.

Population: Uninsured or underinsured, adult Latine patients with ≥ 1 chronic condition and ≥ 1 identified social need.

Social Needs Assessment: Social needs were assessed using the PRAPARE® (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) screening tool.

Process Measures: Completion of guideline-based care, including:

• **U.S. Preventive Services Task Force (USPSTF) Grade A Recommendations:**

- Cervical cancer screening
- Breast cancer screening
- Colorectal cancer screening
- Statin therapy for Cardiovascular Disease prevention
- Osteoporosis screening
- HIV screening

• **Laboratory Monitoring (ADA Standards of Care):**

- Hemoglobin A1c (HbA1c)
- Urine albumin-to-creatinine ratio (UACR)
- Comprehensive metabolic panel (CMP)
- Lipid panel
- Complete blood count (CBC)

• **Specialty Referrals (ADA Standards of Care):**

- Ophthalmology
- Retinal screening
- Podiatry

Clinical Outcomes: Change in HbA1c, blood pressure, and PHQ-9 scores at 12 months.

Case Management Operations: Case management is delivered by undergraduate students functioning as case managers and organized into interdisciplinary pods that include relevant members of the patient care team, such as pharmacy and medical students.

Services include care coordination, disease management, appointment follow-up, referrals to community resources, assistance with social needs, and longitudinal patient support.

Interdisciplinary supervision meetings with clinical preceptors are held monthly for case discussion and care planning.

ADA: American Diabetes Association

Demographics

Characteristic	Category	Total (N=12)
Age (years)	Mean (\pm SD)	54 (\pm7.7)
Sex	Female, n (%)	4 (33%)
	Male, n (%)	8 (67%)
Race/Ethnicity	Hispanic/Latine, n (%)	12 (100%)
Insurance	Medi-Cal, n (%)	2 (17%)
	Uninsured, n (%)	10 (83%)
Social Needs	Transportation Insecure, n (%)	3 (25%)
	Food Insecure, n (%)	2 (17%)
	Medication Insecure, n (%)	11 (92%)
Diagnosis	Diabetes	12 (100%)
Comorbidities	Hypertension	10 (83%)
	Hyperlipidemia	8 (67%)
	Complications of Diabetes	Diabetic Neuropathy
	Diabetic Retinopathy	4 (33%)
	Diabetic Nephropathy	3 (25%)
Medications	Mean (\pm SD)	7 (\pm2.3)

Results

Figure 1: Average Completion of Process Outcomes Over 12 Months



Figure 2: Individual HbA1c Trends Over 12 Months

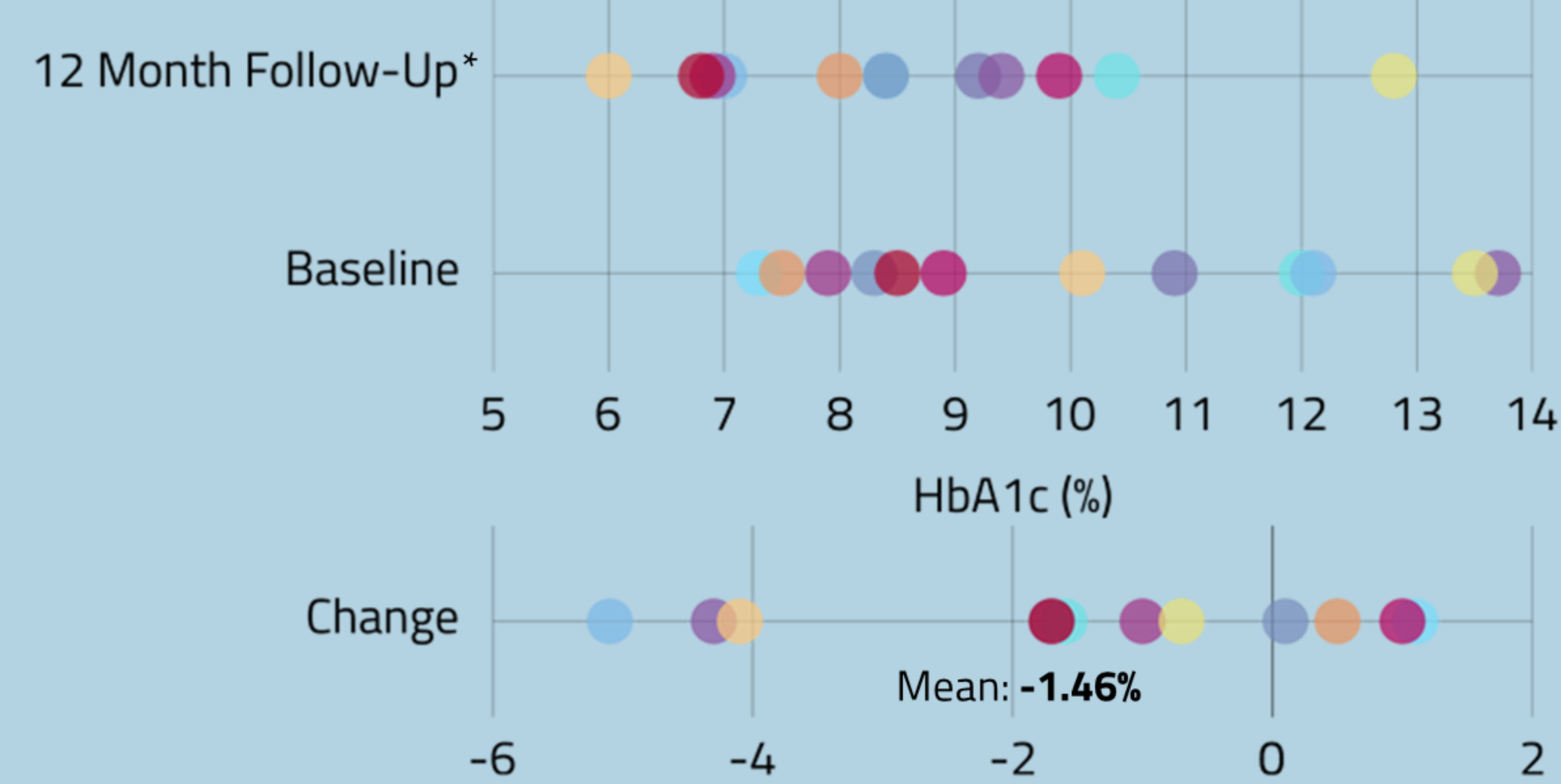
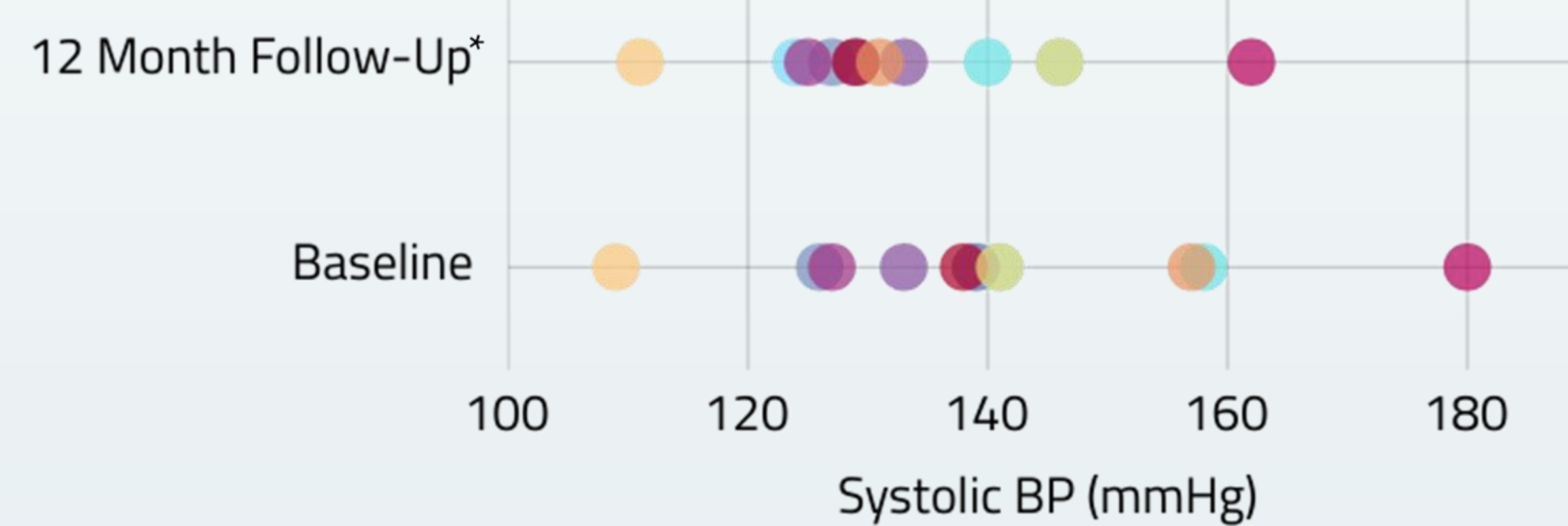


Figure 3: Individual Systolic BP Trends Over 12 Months

50% of patients had an improvement in systolic BP of at least 5 mmHg



Discussion

Overall, process measures demonstrated high rates of completion, though screening for colorectal cancer and HIV remained areas for improvement. Clinical outcomes showed improvement across multiple domains, including a mean reduction in HbA1c of 1.46%, with greater reductions observed among patients with higher baseline values. Blood pressure improved or was maintained in all patients, and all patients with elevated baseline PHQ-9 scores experienced reductions in depressive symptoms. However, there are opportunities to increase referrals to mental health services given that there is a known association between having multiple comorbidities and mental health.

Limitations

- Limitations include the small sample size and the pre-post design, which may limit the generalizability of the findings and the ability to establish causal relationships.
- Diagnosis lists may not fully capture a patient's complete medical profiles, potentially leading to underrepresentation of certain chronic conditions (e.g., obesity).

Conclusion

Implementation of a case management program in a student-run free clinic was associated with improvements in care coordination, disease management, and social determinants of health among underinsured, low-income Latine patients. These findings support the role of case management as a scalable strategy to address complex patient needs in resource-limited clinical settings. Through inter-clinic collaboration and dissemination of standardized protocols and training materials, case management is currently being implemented at Knights Landing One Health Center, a sister student-run free clinic, with the goal of promoting sustainability and scalability across similar safety-net settings.

Recommendations:

- Encourage the adoption of student-led case management programs in other student-run free clinics serving underserved and uninsured communities.
- Continue enhancing data collection to evaluate long-term impact and inform ongoing program improvement.

Acknowledgements

We would like to thank Dra. Joni Borbon, Dr. Lase Ajayi, and other physician mentors of Clinica Tepati for their guidance and commitment to patient care. We are especially grateful to the Case Management team for their dedication and care to improving health equity within our community.

References:

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*12 Months +/- 2 weeks