Efficacy of a free clinic utilized as a transitional clinic for the uninsured:

Outcomes on chronic disease management and ED/hospital rates.

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Background

Data on methods for disease stabilization and the establishment of long-term care in a medical home for uninsured populations in the United States is scarce. Currently uninsured patients leaving the hospital are given a list of potential clinics to follow up at yet most fail to get the care due to barriers in cost, transportation, lack of available appointments, language/cultural differences and lack of understanding of the healthcare system. Uncontrolled chronic conditions predict greater risk of hospitalization and use of the Emergency Room. These costly visits could be prevented with a system to establish long-term care in vulnerable populations.[1,2]

Objective

To determine the effectiveness of a novel transitional care system in the uninsured population served by the Virginia G. Piper St. Vincent de Paul free clinic (SVdP) in Maricopa County.

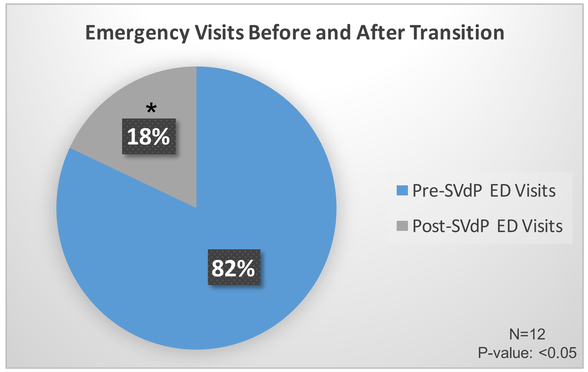
Methods

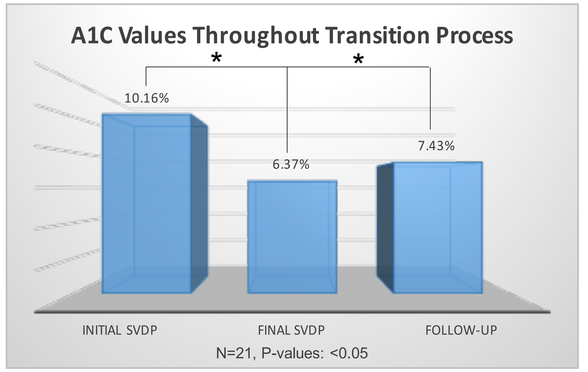
A retrospective review was performed of all diabetic patients controlled at an A1C of < 8.0 who were transitioned from St. Vincent de Paul to an FQHC between May 2017 and April 2018. Phone surveys using a Spanish interpreter were completed regarding their experience with the transition process. A1C values were tracked throughout their care.
Records from Health Current were reviewed for hospital or Emergency Department visits.
38 total patients responded to the survey when contacted. Of these 38 patients, 21 were able to provide current A1C values to assess Diabetes maintenance after transition.

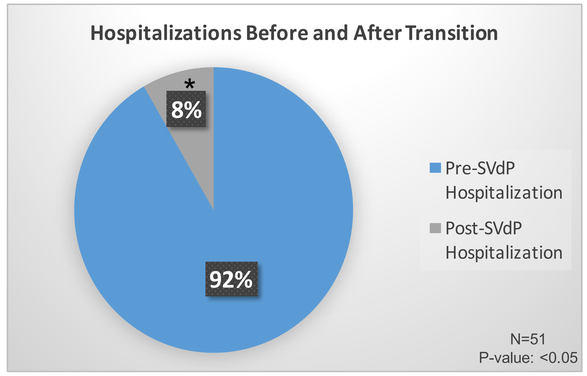
Demographics

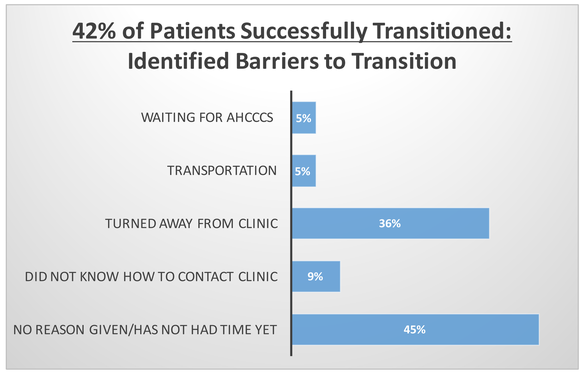
	Men	Women	All
# of Patients	14	24	38
Age	52	52	52
Transitioned	8	8	16
A1C (Initial SVdP)	9	9.8	9.5
A1C (Final SVdP)	6.3	6.5	6.4

Results



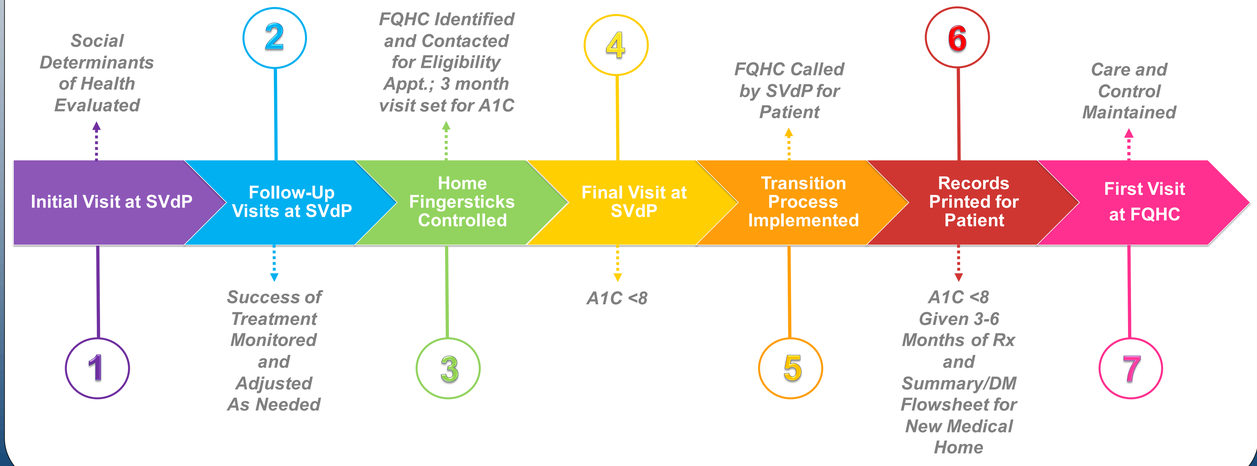






* = statistically significant

St. Vincent de Paul Transition Process

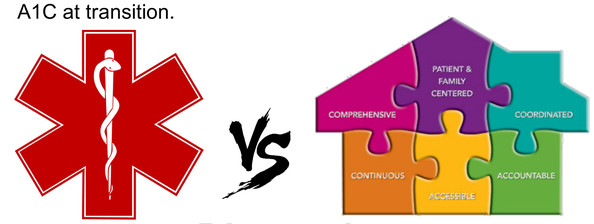


Conclusion

Follow up was achieved in 42% of the 38 patients surveyed at their assigned FQHC to establish care, representing an increase of 26% compared to a previous study using a hospital to home model in an insured population.[3] The 58% that were not able to follow-up using the system as designed quoted multiple reasons including: clinic inaccessibility (appointments, location, etc.), being told they did not qualify for the sliding fee scale, or being told they were missing the proper paperwork to qualify for the clinic.

Emergency Department visits and hospitalizations after transition demonstrated decreases of 79% and 91% respectively for all patients surveyed, compared to 24% and 29% decreases in previous studies of insured patients who were previously homeless.[4]

The average follow-up A1C was 7.4, a decrease of 2.8 from the initial SVdP A1C of 10.2 and an increase of 1 from the A1C at transition.



Discussion

The results of this study suggest that having a medical home, even if temporary, has major impacts on complex chronic diseases like diabetes, utilization of emergency services and financial burdens of the healthcare system.

Over the last 3 years SVdP has been addressing perceived barriers to transition. The clinic has streamlined the process and walks the patient's through all the steps except for their first in-person visit at the FQHC.

The barriers identified to successful transition unmasked a number of causes that can be categorized as patient's not accepting ownership in their own health and/or FQHCs not accepting their responsibilities as a key component of the federally subsidized safety net.

Future process improvement will have to keep in mind these barriers and the clinic will have to work with both the patients and FQHCs to ensure the patients do not get lost to follow up.

References

1. Williams G, Akroyd K, Burke L. Evaluation of the transitional care model in chronic heart failure. British Journal Of Nursing [serial online]. December 9, 2010;19(22):1402-1407. Available from: CINAHL Plus with Full Text, Ipswich, MA.
2. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults. Ann Intern Med. 2008;149:170–176. doi: 10.7326/0003-4819-149-3-200808050-00006.
3. Watkins L, Hall C, Kring D. Hospital to home: A transition program for frail older adults. Prof Case Manag. 2012;17(3):5. doi: 10.1097/NCM.0b013e318243d6a7 [doi].
4. Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. JAMA. 2009;301(17):1771-1778. doi: 10.1001/jama.2009.561 [doi].

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