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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Introduction

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. Historical data has shown that uncontrolled chronic conditions predict greater risk of hospitalization and use of the Emergency Department. These costly visits could be prevented with a system to establish long-term care in vulnerable populations.1,2 Patients 45 and older with diabetes made 12 million visits to the ED in 2015, accounting for 25% of all ED visits for that age group. They were 183% more likely to require a hospitalization compared to those without diabetes.3 These statistics indicate in the community.

Research Question

To determine the effectiveness of decreasing return Emergency Department visits in patients with diabetes utilizing 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.

Materials and 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.

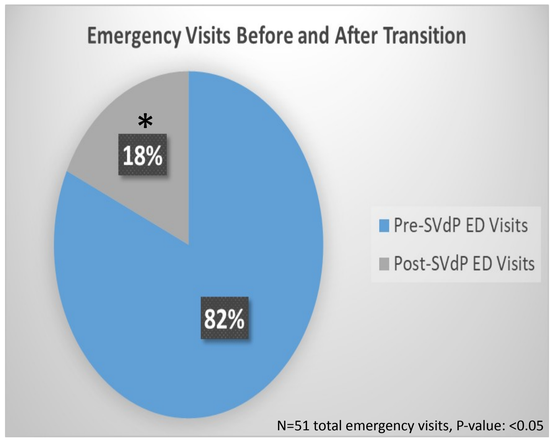
38 total patients responded to the survey when contacted. Of these 38 patients, 21 were able to provide current A1C values to assess Diabetes maintenance after

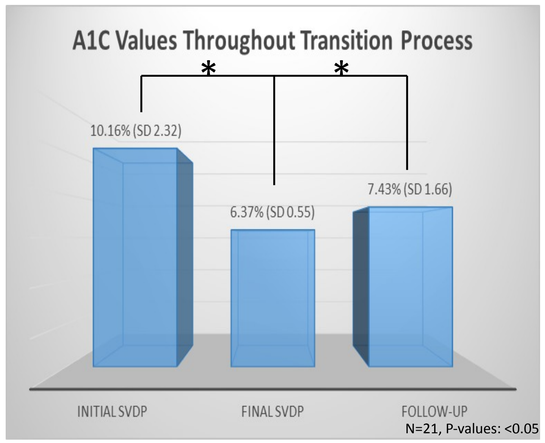
Demographics

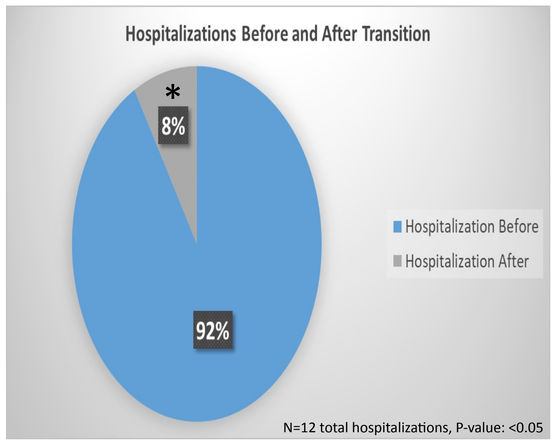
	Men	Women	All
# of Patients	14	24	38
Average Age	52	52	52
Transitioned	8	8	16
A1C (First at SVdP)	9 (1.9)	9.8 (2.3)	9.5 (2.2)
A1C (Last at SVdP)	6.3 (0.42)	6.5 (0.56)	6.4 (0.51)

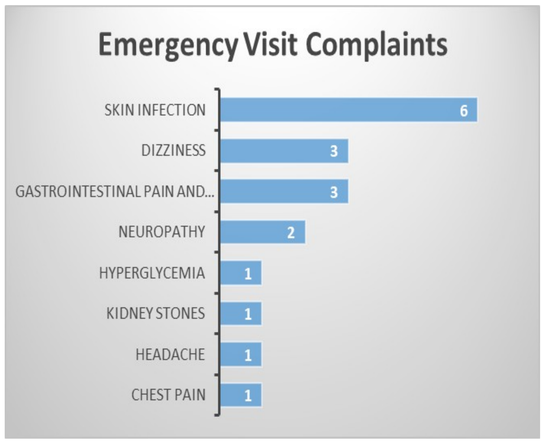
Results

Before transition is defined as 12 months prior. After transition is defined as 5-14 months post-transition.
A1C Values include 21 individuals: 10 did not complete step 7 of the transition process & 11 fully transitioned.

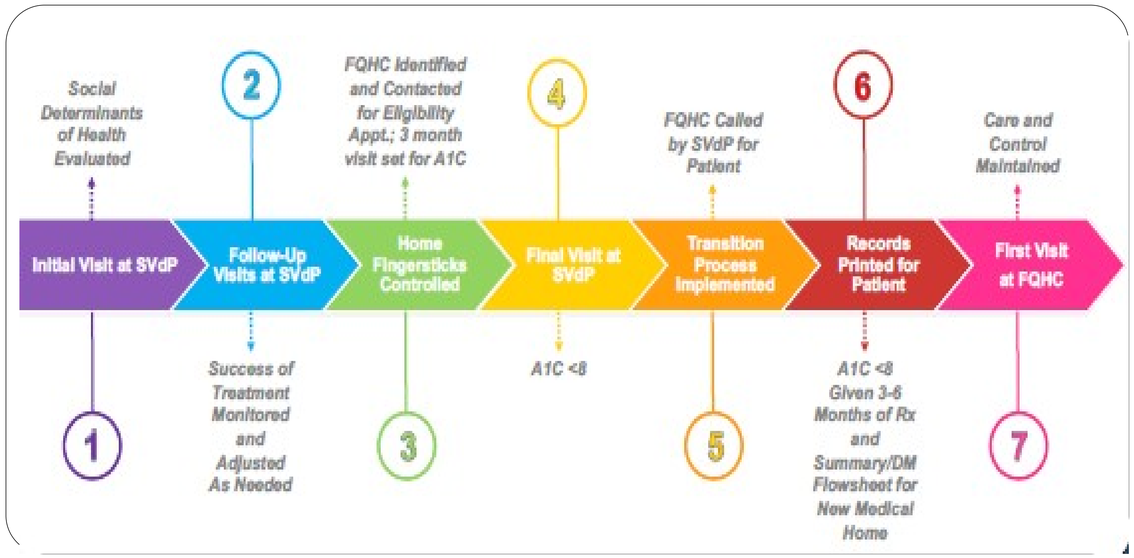








* = statistically significant



Conclusion

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. Overall, this was a significant change that indicated greatly improved control of chronic diabetes that was previously uncontrolled.

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.5 The 58% that were not able to follow-up using the system as designed

Summary

inaccessibility.

Having a medical home, even if temporary, has major impacts on chronic disease management, utilization of emergency services and financial burdens of the healthcare system.

Barriers to successful transition utilizing processes, such as the system at SVdP, have been identified that require modifications to increase success, including patient ownership of health and FQHC's accepting responsibilities for patient care.

Improved coordination and communication between FQHC's and patients will allow for the burden of vulnerable patient care to be taken off of emergency departments and for patients with chronic disease to have a higher quality of life.

Acknowledgments and References

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