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Patient transition from a free clinic to a medical home

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Abstract

ECHO is a student-run free clinic in the Bronx, NY. To address issues in continuity, ECHO transitioned in 2009 from indefinite care to providing patients with only two visits before transferring them to a traditional primary care facility. Diabetic patients who visited ECHO between 7/1/2009 and 6/30/2011 (n=25) were compared to a control group seen between 1/1/2007 and 12/31/2008 (n=25). We studied the transition's effect on the establishment of a stable medical home by measuring percent of patients making follow-up visits according to guidelines. Patients who successfully transferred to a stable medical home were significantly older (56 vs. 46, $p=0.0068$). The transition policy made no significant difference on successful transfers ($p=0.3705$), but there was a trend toward increased delay of subsequent visits ($p=0.0810$). Further evaluation with a larger sample will help to clarify whether the new policy is detrimental to the establishment of a stable medical home, and why.

Introduction

Student-run free clinics (SRCs) comprise a small, but integral, part of the healthcare safety net for nearly 50 million uninsured Americans.^{1,2,3} SRCs struggle with continuity of care due to turnover of student and physician volunteers, infrequent clinic hours, and limited patient capacity. Einstein Community Health Outreach (ECHO) is an SRC associated with Albert Einstein College of Medicine and the Institute for Family Health (IFH), a federally qualified health center network, in the Bronx, NY. To address continuity issues aligned with funder stipulations, ECHO transitioned in 2009 from providing indefinite care to transferring patients to an IFH primary care site following two free clinic visits. A retrospective chart review of ECHO's diabetic patients seen before and after implementation of the two-visit limit evaluated how the new policy affected linkage to and continuity of care.

Methods

Diabetic patients visiting ECHO between 7/1/2009 and 6/30/2011 (n=25) were compared to a control group seen between 1/1/2007 and 12/31/2008 (n=25). All visits to ECHO and IFH sites were recorded. Linkage effectiveness was calculated as the proportion of patients

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Conflict of interest notification page

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attending at least one IFH visit following an ECHO visit. Based on current diabetes management guidelines, visit gaps of greater than 90 days were defined as detrimental to continuity.⁴ Patient continuity was approximated in each group by the average proportion of visit gaps less than 91 days in length.

Results

Patient characteristics were similar between the control group and the two-visit group, but successfully linked patients were significantly older than those lost to follow-up (56 vs. 46, $p=0.0068$). Compared to the control group, the two-visit group was not significantly different in linkage effectiveness ($p=0.3705$), but trended toward fewer total patient visits (2.96 vs. 4.44, $p=0.1181$) and worse continuity (73% vs. 93% of visit gaps shorter than 91 days, $p=0.0810$).

Discussion

This pilot study found that a two-visit limit at ECHO did not increase the number of diabetic patients linked to long-term primary care at IFH. Older patients in both groups had higher linkage rates, possibly due to more complex healthcare needs and diabetes-related complications. The visit limit may have been associated with fewer total clinic visits and decreased continuity. Limited follow-up at IFH sites may be related to concerns over immigration status exposure, preference for ECHO's Saturday hours, or true or perceived costs of sliding-scale fee visits. Further systems changes may be necessary for effective transfer after two visits. Patients in both groups were referred to an IFH site and given visit reminders, but no additional transition processes were implemented. The visit limit may have decreased the time to build rapport between patients and providers, limiting effective communication about the importance of transfer. Based on these considerations, limiting ECHO visits may have caused patients to seek care elsewhere or not at all.

A larger sample size will help to clarify the visit limit's impact on patient access to long-term preventive medical care and may allow for comparison of quality of care and health outcomes. Analysis of patients with chronic diseases other than diabetes will enhance generalizability. These results may be pertinent to other SRCs operating with a visit limit and may spur similar programmatic evaluations. Further innovation is needed to enable access to high quality care while preventing as many patients as possible from falling through the cracks.

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