BACKGROUND
Tulane University School of Medicine operates Student Run Free Clinics (SRFCs) serving underserved populations throughout greater New Orleans:
- Weekly at 2 men’s emergency homeless shelters
- Opportunity to provide a variety of interventions:
  - Point of care health screening (BP, DM, TB, HIV, HCV)
  - Counseling
  - OTs/Cs
  - Prescriptions
- Referrals to more sustainable complete, care such as Health Care for the Homeless (HCH)
  - A potential medical home for homeless patients

STUDY AIM
This study aims to characterize Tulane SRFCs’ potential role in linking New Orleans’ underserved patients to HCH. Specifically, analysis was organized by the following questions:
A. Who are our patients?
   Are our anecdotal experiences an accurate representation of our patient population and the problems they face?
B. Do patients follow up at HCH when we refer them?
   Are they being seen once or establishing long-term care?
C. What predicts a patient’s referral and a successful follow up appointment?
   Can we harness that information to improve how we connect our patients with care?

STUDY DESIGN
- TuPACT: Tulane Patient Assessment & Care Tracking database started 10/2016 to serve as a flexible architecture to continuously learn about clinics. Tulane IRB approved.
  - Survey via REDCap: secure, HIPPA compatible web app
  - Tracked patients for HCH follow up within 90 days of clinic visit
  - 1 full year data (10/2016-10/2017)
- Analyzed predictive factors of referral & successful follow up
  - Logistic regression model; backwards elimination
  - Significance threshold p<0.05
- Variables included: race, insurance, chief complaint, number of complaints, PMHx and other risk factors

RESULTS: A. Who are our patients?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Odds Ratio Estimate (95% CI)</th>
<th>p</th>
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<tbody>
<tr>
<td>Mental health related chief complaint</td>
<td>4.50 (1.0 – 19.6)</td>
<td>0.0446</td>
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Figure 1. Patient self identification of race (absolute patient number indicated)

Figure 2. Patient insurance status (absolute patient number indicated)

Figure 3. Patient past medical history (absolute patient number indicated)

Figure 4. (left to right) Percent of all patients referred to HCH, Percent of patients referred to HCH with history of prior appointment and Percent of patients who followed up at HCH with in 90 days of referral categories by history of prior appointment.

27% of all patients were referred
21% of referred patients had been to HCH before
30% of ALL referred patients followed up

RESULTS: B. Do patients follow up at HCH?

57% of patient with no prior HCH appointment attended more than 1 appointment with in 90 days

RESULTS: C. What predicts follow up?

STUDY CONCLUSION
- While the proportion could be greatly improved
  - Homeless patients DO follow up with primary care
  - Homeless patients DO establish longitudinal care at primary care provider
- Medicaid patients were less likely to follow up with HCH
- Better tailor referrals given insurance status
- Mental health predicted both referral and follow up to HCH
- Are we missing mental health complaints in other patients?
- Supports increased mental health screening and advocacy