Outpatient Follow-up in Today's Health Care Environment

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It is the end of another busy afternoon in the emergency department (ED). As you finish up your dispositions, a 35-year-old patient with poorly controlled diabetes and hypertension comes in for a medication refill. Reviewing his medical records, you discover he presents often for medication refills. His demographics sheet is marked as "self-pay."

"Sir, do you have a primary care physician?" you ask.

"No, I don't have any insurance, and they all ask for the payment up front, which I can't afford," he replies.

You have heard this all before. You return to your desk to refill this patient's prescriptions yet again, knowing that he will soon return to the ED when he runs out or, even worse, will present with an exacerbation of his medical conditions because of his inability to obtain medications.

Residency trains physicians to handle all medical emergencies that present to the ED's door, but it does not necessarily train physicians to address the ED's significant social issues. Physicians' best acute clinical care may be undermined by the social factors that affect the way their patients receive follow-up care. The purpose of this article is to discuss the barriers to outpatient care and to identify ways to improve the care for such patients by helping them to navigate the social and systemic barriers they may face.

THE STATE OF ED FOLLOW-UP CARE

Access to care is a pervasive problem in the American health care landscape, and emergency medicine is not immune to the inequality of access. Studies have shown insurance status, sex, and race to be significant predictors of admission to the hospital through the ED, after adjustment for injury and illness severity. For example, in one study, black female and uninsured trauma patients were each 37% less likely to be admitted compared with their white female and insured cohorts, respectively.[1]

Physician and clinical availability has been a limiting factor to access to care as well. The number of physicians providing charity care during the past decade has decreased from 76.3% in 1996 to 1997 to 68.2% in 2004 to 2005. Given the significant increase in the number of uninsured patients (39.6 million in 2000 to 45.5 million in 2004), the net result is that uninsured patients are less likely to have access to a physician outside of the ED.[2] Furthermore, the malpractice liability crisis has made specialists reticent to take calls in the ED for both immediate consultation and outpatient follow-up. This trend among specialists may be because patients from the ED setting have a history of poor reimbursement with high liability, given the lack of no previous physician-patient relationship.

In a landmark 2005 article by Asplin et al,[3] insurance status was found to be an important factor for obtaining timely follow-up in the outpatient setting. In this study, research assistants contacted 499 clinics in 9 US cities. These included safety net clinics cited by site directors where they would send a Medicaid beneficiary or uninsured patient. The authors used 3 diagnoses, pneumonia, asymptomatic hypertension, and possible ectopic pregnancy, as the chief complaints. Callers who stated they had private insurance were 30.2% more likely to receive an appointment than those with Medicaid (64.4% versus 34.2%, respectively) and 39.3% more likely than those stating they were uninsured but were willing to pay $20 and arrange payment of the remainder (64.4% versus 25.1%, respectively). Seventy-two percent of the clinics contacted did not attempt to determine the severity of the callers' medical conditions or the urgency for which they required follow-up. Access to follow-up care for Medicaid patients varied widely from city to city, raising the question of whether varying rates of reimbursement may have led to such discrepancies.[3,4] The findings mirror those of a study conducted 11 years earlier,[4] offering further evidence of the pervasive and consistent problem of providing health care in the ED setting.

In light of this, the barriers to care elucidated in this article must be taken into consideration once the patient leaves the ED. After these barriers have been addressed, a solution must be found using the limited resources available in the ED to maximize the patient's ability to obtain outpatient follow-up.

Table. Factors hindering access to outpatient follow-up.

Presenting Problem	Differential Cause	Intervention
Unable to get outpatient appointment	Uninsured/underinsured	Help with Medicaid application or other applicable insurance plans.
	No primary care physician/specialist available	Call physician/clinic before discharge to obtain appointment.
	No transportation	Provide bus or taxi vouchers and discuss with patient if they have any other means of transport.
	Limited financial means	Help with financial assistance applications.
Unable to understand discharge instructions	History of mental illness or substance abuse	Contact current mental health/substance abuse case manager or establish one if patient does not have one.
	Homelessness	Arrange respite care or an assisted-living facility.
	Does not speak English as primary language	Use translator to ensure discharge instructions are understood clearly.
Does not get prescriptions filled	Does not have insurance or insurance does not cover prescriptions	Enroll patient in insurance plan if applicable, or enroll patient in drug assistance program. Take into consideration cost when prescribing medications.
	Cannot pick up prescriptions	Discuss options such as receiving prescriptions by mail or arranging transportation to pharmacy.

DETERMINING THE PATIENT'S BARRIERS TO CARE

In assessing the patient's barriers to care, it may be helpful to delineate between the intrinsic and extrinsic barriers. Intrinsic factors are those barriers that the patient cannot change (race, socioeconomic status, age, history of mental illness, etc). Extrinsic factors are those barriers that may be mutable, including living environment, insurance status, primary care provider status, and ability to access the health care system beyond the ED (Table). A skilled ED social worker or case manager will often focus on the extrinsic factors as a means to help break this recidivist cycle. In the next section, we discuss how these resources can improve care for ED patients.

When evaluating intrinsic factors, consider the age of the patient; research has shown that younger patients are less likely to be compliant with outpatient follow-up.[5] A patient's socioeconomic status will also play a significant role in follow-up because copayments are the standard rather than the exception, even at designated safety-net clinics. Those from a nonwhite background and those with a history of mental illness have traditionally been vulnerable populations whose access to care has been inherently more difficult than that of their respective counterparts.

When evaluating extrinsic barriers to care, take into consideration the patient's social situation. Particularly important factors include homelessness, substance abuse, or a history of untreated psychiatric disease. For patients with a history of mental illness, their chances of follow-up adherence are decreased even further if they are homeless or have a substance abuse problem.[6] If the patient does not live within the immediate community, determine how far away he lives and whether he plans to return to the area. Ask the patient whether he has a feasible means of transportation to the appointment. Also, make a note of his primary language. In today's increasingly diverse population, if patients do not understand their discharge instructions, they are unlikely to follow up appropriately.

Confirm the patient's address and telephone number. The information provided on the patient's demographic sheet may be out of date or incorrect for other reasons. If the patient does not have a primary address or telephone, ask whether he has a family member through which contact can be made.

Insurance status is another extrinsic factor to take into consideration. Often, this information is available on the patient's demographic sheet. Although most emergency providers are familiar with the problems of uninsured patients, underinsured patients (such as those covered by Medicaid) may face similar challenges. In recent years, patients with Medicaid have discovered a dwindling pool of health care providers willing to treat them because of declining reimbursement rates.[7]

Understanding how much a patient has to pay for an office visit and prescriptions can further assist in evaluating the patient's extrinsic barriers to care. Before the Asplin et al[3] study, numerous reports demonstrated that insurance status is a significant factor associated with the likelihood of outpatient follow-up in the pediatric and adult populations.[5,8] If the patient is older and has Medicare, it is appropriate to inquire whether he has secondary insurance that covers additional expenses after the deductible is paid. Those without secondary insurance have been found to have higher rates of complications after discharge from the ED.[9]

Determine whether the patient has a primary care provider and, if so, how often he consults this individual and whether

this is someone with whom he has a good rapport. If the patient states that the ED is the regular health provider, he is likely to be uninsured.[10] Other studies have suggested that having a primary care provider is a stronger predictor of readily available access to care than insurance status.[11] This factor has been validated in psychiatric populations as well.[12]

Ask the patient whether he plans to follow up with someone after leaving the ED. If the patient has reservations, it may help to address social, financial, or emotional limitations that may be behind these reservations.

FINDING A SOLUTION

When it is clear that the patient is uninsured or underinsured or that his social environment will create significant barriers to care, physicians may wish to involve the resources of the ED's care-management team. This team will usually include a social worker or a nurse case manager. The social worker and case manager are likely to have up-to-date information on the status of the ever-changing health care safety net and should be able to match the patient's needs with available resources in the community. If the patient is unable to navigate the complexities of the social system, the team can walk him through the paperwork and necessary calls while addressing additional barriers that may prevent follow-up care. Social workers and nurse case managers may refer patients to substance abuse programs, domestic violence shelters, homeless shelters, or programs for the young and old to establish a social network. The team can contact informal social supports, such as the patient's family and friends, to involve them in the plan for the patient's well-being.

If a care-management team is not readily available, approach the department and hospital administration about the feasibility of starting such a team or providing ready access to this service once the patient leaves the ED. Particularly when dealing with patients who use the ED as a frequent source of care, researchers in one study found that specialized case management decreased the median number of visits, ED costs, and inpatient costs.[13] The study also found that patients had a decreased rate of alcohol use, homelessness, and drug use, and 74% of patients were linked to a primary care provider. From a financial perspective, such case management was cost-effective because the investment in necessary management resources was more than offset by the decreased use of care. These results have been substantiated in a Canadian population as well.[14] Such positive results are not consistent throughout the literature, however, because one study did not find individualized care plans decreased ED utilization by frequent users of the ED.[15]

If a patient has a tenuous social situation, the care-management team may also determine whether the patient is eligible for an assisted-living facility, which provides a stable living environment and improves health care access for patients with long-term living conditions. In a pediatric population, one study found that improving a patient's continuity of care decreased ED utilization.[16] In an elderly population, such a living environment decreased the number of nursing home admissions, although it did not alter the rate of ED use.[17] In those with a history of alcohol abuse, such a program decreased ED usage, inpatient admissions, and EMS use.[18]

CLOSING THE LOOP

Once the barriers to care have been addressed and the patient is at the end of his visit to the ED, a disposition must be made. If at all possible, physicians should secure a specific follow-up appointment for the patient because this has been found to improve rates of follow-up.[5,19] If this is not feasible, make an attempt to call his primary care provider, if he has one, or the on-call specialist if he will require follow-up with a specialist on an outpatient basis. Research has shown that success with follow-up increases from 59% to 79% when emergency physicians contact the on-call specialist to discuss the case,[20] whereas no ED consultation has been found to be a cause for the failure of outpatient follow-up.[5]

If the patient requires medications at discharge, take into consideration the cost of the medications and the patient's ability to pay for these. Discuss the medication costs with the patient and try to determine the optimal medications for the patient when considering his financial constraints. Determine whether and to what extent the patient's insurance plan covers prescriptions. Try to prescribe an acceptable medication that is covered by the insurance plan. Medications on prescription plan formularies may be found in programs such as Epocrates (San Mateo, CA) or by visiting the prescription plan's Web site. Many hospitals also offer discount prescription programs for patients with limited financial means. The hospital's outpatient pharmacy should be able to provide the names of the medications included in this formulary.

When physicians are not familiar with medication costs, they may consider calling a local or hospital pharmacy. Most pharmacists will readily provide this information. Online resources may provide data on prices, but most patients do not use online services to fill their prescriptions, especially for short-term prescriptions, so these prices may not reflect the amount patients may have to pay. Consider creating a list of the costs of common prescriptions prescribed in the ED, and post the list in the department so that colleagues have ready access to this information.

If the patient is uninsured, briefly ask the patient what he has done to obtain insurance. Many patients have plans available through their employers but opt not to enroll because of financial or personal reasons. Certain states offer programs to help employees subsidize their insurance premiums when the employer offers coverage but the employee does not think he can afford it. The care-management team will be aware of these programs and can screen the patient for basic program eligibility. For patients who may qualify for Medicaid, have the care-management team talk with them about filling out an application or create a system in which application packets can be provided. Many EDs already have a program in place to

screen patients for program eligibility. A study completed in a pediatric ED found that providing packets to patients during their stay in the ED was an effective way to enroll patients in the Medicaid program.[21] Given the potential for increased revenue for the hospital, it is an appealing project to which hospital administrators may be willing to devote resources.

Finally, determine how soon the patient needs to be treated. Do not fill that last open appointment later in the week if the patient can still be followed up appropriately within the next 2 weeks. Urgent follow-up appointments should be reserved for urgent medical conditions that require close monitoring. Also take into consideration that some disease processes require time to declare themselves, and a period between the ED visit and outpatient follow-up might be in the best interest of the patient and the outpatient provider.

Although relying on the care management team is important, emergency physicians should also attempt to learn about the resources available in their community and become involved in the development of these resources. Contact information for such resources should be kept up to date and readily available to clinicians either through a Web-based interface or through other easily accessible venues in the ED.

CONCLUSION

ED patients face numerous barriers to care, both intrinsic and extrinsic. Emergency physicians should be aware of these barriers, as well as of the resources available to address these to ensure appropriate follow-up for patients under their care.

The patient presented at the beginning of this article is typical of a patient whose care requires attention beyond the basic clinical diagnosis and treatment. He is uninsured and does not have a primary care provider, and his history of repeated visits to the ED is probably related to a lack of regular outpatient access to care. Given the fact he is unable to afford the payment for clinic visits, it is likely that he has limited financial means to pay for his medications. As the emergency physician attempts to address these factors, a call to the ED's care-management team may improve the possibility of the patient's breaking the cycle of repeated ED visits and help the patient find continuity of care in a primary care setting. By involving the care-management team and attempting to establish a specific plan for outpatient follow-up for the patient, the emergency physician improves the odds that this patient will have better continuity of care and better health outcomes.

With some additional effort, emergency physicians may make great strides toward increasing the chances that patients receive appropriate follow-up and avoid repeated unnecessary ED visits. Although such effort may require even more time in the already busy ED, the potential for decreased return ED visits and better overall patient health makes this a valuable investment of physician and hospital resources.

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