**Curbside Consultation**

**Taking Care of Disadvantaged Patients**

Commentary by PATRICIA CZAPP, MD, Anne Arundel Medical Center, Annapolis, Maryland

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

This series is coordinated by Caroline Wellbery, MD, Associate Deputy Editor.

A collection of Curbside Consultation published in AFP is available at http://www.aafp.org/afp/curbside.

**Case Scenario**

I find myself feeling frustrated and burnt-out when caring for patients with limited means. I am not adequately prepared to handle their nonmedical needs. For example, I have a 62-year-old patient with hypertension who lives with her relatives near my practice. She recently emigrated from Ghana and speaks very little English. She has no medical insurance. Her family is low income and speaks English fairly well. Her son usually accompanies her to appointments and serves as her translator, which I know is inappropriate.

For the past couple of months, I have attempted to address my patient’s hypertension with escalating dosages of several medications. Despite treatment, her blood pressure is still around 190/110 mm Hg. I suspect that she is not taking her medication properly, although (through her son) she says she is. Because of reassuring basic laboratory test results, I do not suspect a secondary cause of hypertension. Evaluation for uncommon causes of hypertension is beyond what she can afford.

My quality metrics suffer because the preventive measures and chronic disease status markers of my patients such as this one are not good. I am not about to dismiss them from my practice, but what can I do?

**Commentary**

No single person can be responsible for the health of a population. However, there are a number of strategies for taking care of members of disadvantaged populations. These range from targeted compassion and interventions for the individual patient to broad advocacy for disadvantaged groups. Increasingly, as the nation’s health care system prepares for an era of pay-for-outcomes, hospitals and insurance companies are developing resources to address the challenges disadvantaged patients often face, and they are sharing these resources with community physicians. In addition, for perhaps the first time, private and public sector entities are collaborating and coordinating resources to become more effective partners in the care of vulnerable patients. Finally, regarding the constraints that metrics impose, there is discussion at the national level regarding risk-adjusting quality measures to take into account patients’ socioeconomic factors.

Here are some practical interventions that will help this physician at the practice level:

**Provide a patient-centered medical home.** The team-based approach of the patient-centered medical home would reduce this physician’s burden and allow him or her to focus on medical care. Using this approach, the physician could select one or two practice team members to become knowledgeable about community resources for patients’ nonmedical needs of food, clothing, shelter, insurance coverage, and prescription payment assistance. Some insurance companies are starting to pay primary care practices a per-member per-month care coordination fee (on top of traditional payment) to offset the costs of providing and training team members who help patients tap into existing resources in the surrounding medical neighborhood.

**Practice cultural proficiency.** Low-income patients may be labeled noncompliant even when they do not deliberately disregard medical instructions. They may be ashamed to admit that a prescription was too costly to fill, or that they take it every other day to make it last, or that they share it with another family member with the same condition. They may arrive late to an appointment because they have to take three buses to get to their physician’s office. They may not have completed the screening...
test ordered because their employer is unfor-
giving of work absences or they could not
arrange for a reliable person to watch their
children. Practice team members should
maintain a nonjudgmental attitude and care-
fully tease out the “why” of nonadherence.

Screen for socioeconomic challenges. Physi-
cians can assess a patient’s personal
circumstances for any potential barriers to
care. This strategy will help in the selection
of a practical medication regimen. Aware-
ess of the cost of medications is essen-
tial. Unfortunately, there is much volatility
in drug prices. Yesterday’s $4-per-month
generic drug may now cost $8 per pill.
If asked, patients often readily admit that
they cannot afford a medication. Further,
inquiring about housing status will also give
the physician important information about
which medication regimen will work best
for a patient who may not have the means to
safely store a given medication or adhere to
a complicated dosing regimen. In this case,
less expensive medication alternatives and
simplified dosing regimens will increase the
likelihood of adherence.

Set priorities and make a realistic plan
of action. A compassionate approach to the
patient’s circumstances takes into account
limitations and other challenges such as
low income, homelessness, low literacy, and
limited social support. It helps to focus on
one important goal at a time. Family physi-
cians are used to covering multiple, complex
medical problems all at once and issuing
numerous care directives. In the case of the
patient with complex medical and nonmedi-
cal needs, the physician may have to suspend
that skill and focus on what can be accom-
plished with the patient incrementally. Once
the patient has succeeded in completing that
first step (e.g., taking one shot of insulin each
day instead of no insulin), the physician and
patient can celebrate together and move on to
the next goal. Patients do not want to disap-
point their physician or themselves. Making
it easy for patients to succeed will help pre-
vent them from simply giving up.

Help newly insured patients navigate the
health care system. Patients getting insur-
ance for the first time need help. They may
be used to going to the local emergency
department for all of their health needs.
They may not know what a primary care
physician does, or how to make and keep
an appointment or how to get a prescription
refill. Without compassionate direction,
they may revert to a previous set of patterns
that interferes with long-term improvements
in care, such as going to the emergency
department for non-urgent care.

Connect low-income patients and fami-
lies with resources and supportive pro-
grams. Practice staff members have the
following options:
• Access 2-1-1, a community resource that
connects patients with local entities that
provide food, clothing, shelter, utility bill
relief, social services, employment opportu-
nities, and more. This is a free, confidential,
nationwide service that can be accessed 24
hours a day by patients or practice staff. If
a patient has lost insurance coverage and
needs a low-cost alternative for health care,
2-1-1 also lists community clinics and other
resources that are available locally.
• Contact local hospitals to learn about
resources for care coordination of vulnerable
patients, including assistance with applying
for insurance coverage. Hospitals also have
access to services of medical interpreters
and can share that information, or even the
resource itself, with community practices.
• Contact the local health department
or department on aging to learn which
community-based resources are available for
the clinic’s patients, including social services
and transportation.

Address correspondence to afjournal@aafp.org.
Author disclosure: No relevant financial affiliations.

REFERENCES
1. Czapp P, Kovach K; American Academy of Family Physi-
cians. Poverty and health—the family medicine per-
about/policies/all/policy-povertyhealth.html. Accessed
January 10, 2015.
2. National Quality Forum. Risk adjustment for socio-
economic status or other sociodemographic factors.
http://www.qualityforum.org/Publications/2014/08/
Risk_Adjustment_for_Socioeconomic_Status_or_
Other_Sociodemographic_Factors.aspx. Accessed
January 10, 2015.
3. U.S. Department of Health and Human Services,
Office of Minority Health. National standards for
culturally and linguistically appropriate services in
health and health care: a blueprint for advancing
and sustaining CLAS policy and practice. April 2013.
https://www.thinkculturalhealth.hhs.gov/assets/pdfs/
EnhancedCLASStandardsBlueprint.pdf. Accessed Janu-
ary 10, 2015.