Taking Care of Disadvantaged Patients

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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.

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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.[1] 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.[2]

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.[3] 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 unforgiving 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 carefully tease out the "why" of nonadherence.

Screen for socioeconomic challenges. Physicians 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. Awareness of the cost of medications is essential. 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 physicians 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 nonmedical needs, the physician may have to suspend that skill and focus on what can be accomplished 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 disappoint their physician or themselves. Making it easy for patients to succeed will help prevent them from simply giving up.

Help newly insured patients navigate the health care system. Patients getting insurance 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 families with resources and supportive programs. 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 opportunities, 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.

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