See article by Smith et al

A Simple Suggestion: Make Follow-Up Appointments for All Patients After Discharge, Especially Those With Co-Occurring Addictions

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The remarkable article by Smith and colleagues[1] asks a seemingly banal question: does scheduling an appointment for outpatient treatment for a patient prior to discharge from an inpatient psychiatric hospitalization increase the probability that they will actually have that appointment? Using administrative databases in New York State for a Medicaid population, the authors built a propensity score adjustment to account for clinical and demographic differences between those scheduled and those not scheduled to have outpatient treatment after discharge and examined, after adjusting for those scores (by quintile), whether scheduling an appointment increases the likelihood that the patient will attend an outpatient mental health visit within 7 and 30 days after discharge. Simple enough: it does. These results, however unsurprising, are nonetheless disturbing and suggest that stigma against people with addictions and racism against Black communities may lead to lower levels of follow-up and thus inadequate care for people with mental illness.

One might not think it even a question that patients admitted to the hospital should have outpatient appointments made for them. Of course they should. The authors list an array of national organizations that believe such an appointment is the standard of care (the Veterans Health Administration, for example, includes appointments made within 7 days of discharge in its performance measures, though it is an integrated system of care), but the results of this study give pause. They suggest—and this should be obvious to everyone already—that giving a patient an appointment is a predictor of whether the patient actually goes on to complete one, even if they have significant characteristics (including homelessness and having a substance use disorder) that might predict not completing one. We need to view these results with a specific mind toward understanding how stigma toward patients with substance use disorders (which screams from the data) reduces their quality of care and how racism may compound the problem.

When does our response to results turn from medical in our understanding of them to political? Smith and colleagues do a lovely job of answering this question. They reasonably suggest that it would be "neither feasible nor appropriate to attempt a randomized clinical trial to estimate the impact of routine discharge planning practice such as scheduling follow-up appointments"[1(p8)]—the act of participating in such a trial as a hospital might itself change behavior so much as to make randomization irrelevant—so they adjust using propensity scores for the kind of covariates that one expects might bias the outcome: homelessness, substance use disorders, and not being engaged in care prior to admission. Even with these adjustments, those having as co-occurring substance use disorder were still more likely to attend an outpatient appointment, with an even higher adjusted odds ratio, more than double at 7 days and nearly so at 30 days. Patients with substance use disorder benefit just as much as, or more than, those without them from having outpatient follow-up appointments arranged for them in terms of assuring their attendance at those appointment, but are significantly less likely to have one made in the first place.

Why might patients with co-occurring addictions be treated differently? The authors suggest several reasons, including that patients might be prematurely discharged after experiencing withdrawal symptoms or severe cravings or do not have appointments made due to refusal to accept substance use aftercare recommendations. Although these are hypotheses on the part of the authors (and not found themselves in the data), they do belie a kind of stigma that may not be uncommon in mental health and other medical providers; that is, that patients with addictions are there by their own fault and that if they only followed recommendations of health care providers they would be better off. Unfortunately, precisely these kinds of attitudes may instead lead patients to disengage even though substance use disorders can be effectively treated and withdrawal and cravings recognized and addressed while premature and unnecessary discharges are avoided.[2,3] Training for interviewing patients with addictions using evidence-based motivational enhancement may effective, even in complex populations, but not necessarily well taught or implemented.[4] That even patients with co-occurring addictions have improved follow-up rates if appointments are made should underscore that, whatever biases or preconceived notions treaters have about their patients,

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no patients should be discharged without a follow-up appointment in place.

While the differentially worse treatment of people with addictions seems clear from the analyses, less obvious from these data (but perhaps more important) may be how race results in poorer delivery of care. The rate of outpatient appointments prior to discharge differs across New York State, with New York City and the adjacent Hudson River Region having the lowest rates. One cannot help but wonder the extent to which race plays a role in this difference. The region (by far) with the largest number of patients is New York City. While race and ethnicity did not predict differences overall, more than a third of all patients in the analyses are Black. It stands to reason that the quality of care is structurally lower in New York City. The factors associated with structural racism and implicit bias in health care delivery are many, but the failure to ensure adequate follow-up, for whatever reason—the population studied in this analysis, on Medicaid, is by definition low income—cannot stand, especially if that reason is stigma and racism.[5,6]

The study report does not have data on whether attending an outpatient appointment actually has an impact on outcomes (such as rehospitalization or death, for example), but the absence of those data do not permit us to ignore the results of this study. We must still implement the necessary change that would address this problem: every patient discharged from an inpatient mental health hospitalization must have follow-up care arranged for them. Every patient. There ought not be excuses as to why that cannot be. The seriously ill populations whose care is paid for by Medicaid need more attention to the details that might improve their treatment than more resourced and less marginalized populations, and one important target needs to be improvement in continuity of care.

I would not have thought that a study asking such a straightforward and perhaps self-evident question about whether follow-up appointments made during inpatient stays improve continuity of care would raise such important issues about how differently we treat people. There may be solutions, but they will involve an upending of our current way of doing things. Implicit bias that affects decision-making and structural racism that prevents people from getting care need to be systematically reversed. Stigma toward patients with addiction—including blaming them for their problems and failing to provide them with standard-of-care treatment—needs to end. Better integration of and broad training in techniques effective in treating addictions, such as motivational interviewing, should be standard, but better training in addiction across mental health care is essential. And simple measures, like making sure that all patients who are psychiatrically hospitalized—with no excuses for why not—receive a follow-up appointment for outpatient care, should be followed without exception.

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