HEALTH POLICY/ORIGINAL RESEARCH

Insurance Status and Access to Urgent Primary Care Follow-up After an Emergency Department Visit in 2016

Shih-Chuan Chou, MD, MPH*; Yanhong Deng, MPH; Jerry Smart, CHW; Vivek Parwani, MD, MHA; Steven L. Bernstein, MD; Arjun K. Venkatesh, MD, MBA

*Corresponding Author. E-mail: shih-chuan.chou@yale.edu or achou01@gmail.com.

Study objective: We examine the availability of follow-up appointments for emergency department (ED) patients without established primary care by insurance and clinical condition.

Methods: We used "secret shopper" methodology, employing 2 black men to telephone all 53 primary care practices in greater New Haven, posing as new patients discharged from the ED and requesting follow-up appointments. Each practice received 6 scripted calls from each caller during an 8-month period, reflecting all possible scenarios based on 3 insurance types (Medicaid, state exchange, and commercial) and 2 conditions (hypertension and back pain). Primary outcome was the proportion of calls that obtained an appointment in 7 calendar days (7-day appointment rate). Secondary outcomes included overall appointment rate and appointment wait time.

Results: Among the total of 604 calls completed, the 7-day appointment rate was 30.7% (95% confidence interval [CI] 22.6% to 38.8%). Compared with commercial insurance, Medicaid calls had lower 7-day rate (25.5% versus 35.7%; difference 10.2%; 95% CI 2.2% to 18.1%) and overall appointment rate (53.5% versus 77.8%; difference 24.4%; 95% CI 13.4% to 35.4%). There was no significant difference between state exchange and commercial insurance calls in 7-day rate (30.9% versus 35.7%; difference 4.8%; 95% CI –3.1% to 12.6%) or overall appointment rate (73.4% versus 77.8%; difference 4.4%; 95% CI –2.7% to 11.6%). Back pain, compared with hypertension, had lower 7-day appointment rate (27.6% versus 33.7%; difference 6.1%; 95% CI 1.0% to 11.2%), but no significant difference in overall appointment rates (67.0% versus 69.4%; difference 2.4%; 95% CI –2.7% to 7.5%).

Conclusion: For patients without established primary care, obtaining timely follow-up after acute care in the ED is difficult, particularly for Medicaid beneficiaries. [Ann Emerg Med. 2017;■:1-10.]

Please see page XX for the Editor's Capsule Summary of this article.

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INTRODUCTION

Background and Importance

Follow-up is an essential component of the outpatient care provided by emergency departments (EDs). In 2013, EDs across the United States received more than 130 million visits, of which more than two thirds resulted in patient discharge with instructions for close outpatient follow-up.[1] Timely access to follow-up appointments provides further diagnosis and treatment of acute and chronic conditions that were addressed during ED visits. Numerous clinical guidelines, including hypertension, pneumonia, and pregnancy, support this practice.[2-6] However, many ED patients, particularly the newly insured, report difficulty accessing timely appointments.[7,8] In fact, 1 in 7 ED patients reported no usual source of care besides the ED.[9] Securing timely follow-up appointments therefore can be challenging.

During the past 2 decades, "secret shopper"—or simulated patient—methodology has been adopted to objectively measure access to timely appointments for unscheduled illnesses because provider or patient surveys are prone to selection, recall, and nonresponse bias.[10] In 1994, prompted by increasing nonurgent ED visits by Medicaid beneficiaries, the Medicaid Access Study Group conducted a secret shopper study, which found that Medicaid patients had significantly poorer access to timely appointments than the privately insured.[11] In 2002, Asplin et al[12] used secret shopper methodology to further examine access to follow-up appointments after ED visits for potentially life-threatening conditions, which

Editor's Capsule Summary

What is already known on this topic

Access to prompt primary care after an emergency department (ED) visit can be challenging for patients in certain regions.

What question this study addressed

Does appointment availability differ by insurance type (private, state exchange, or Medicaid) after ED discharge in Connecticut?

What this study adds to our knowledge

In a secret shopper study, 31% of 604 attempts to arrange prompt ED follow-up for back pain or high blood pressure resulted in an appointment within 7 days. Medicaid patients were less likely than those with private insurance or state exchange coverage to obtain a prompt appointment.

revealed persistent disparity in appointment availability for Medicaid patients. However, health care delivery and financing have changed significantly since then, highlighted by the passage of the Patient Protection and Affordable Care Act (ACA), through which an estimated 20 million people obtained new health insurance coverage.[13] A contemporary evaluation of the disparity in health care access for discharged ED patients is therefore warranted.

Because the ACA sought to improve health insurance coverage and primary care access, the current state of access to timely primary care follow-up for discharged ED patients is unclear. Connecticut was among the first states to implement the ACA, in 2013, highlighted by the expansion of Medicaid eligibility, the creation of a nationally recognized state health insurance exchange, AccessHealth CT, and extension of increased primary care Medicaid reimbursement rates when federal support ended in 2015. This has allowed an additional 130,000 Connecticut residents to gain coverage through Medicaid and another 111,000 through the state exchange,[14,15] decreasing the uninsured rate from 9.4% to 6.0% from 2013 to 2015.[16] Policymakers and providers have feared that coverage expansion would further strain an overburdened primary care infrastructure and worsen primary care access, similar to the experience after health insurance reform in Massachusetts.[17,18] However, empiric investigations have yet to be conducted in Connecticut. Although recent secret shopper evaluation after ACA implementation provided early evidence of improved appointment availability for Medicaid recipients nationally and those insured by the state exchange in California, these studies have focused on new routine primary care appointments.[19-22] The current state of access to timely primary care follow-up after ED discharge for acute, unscheduled illness remains unclear, particularly given the unique clinical and social vulnerability of ED patients.

Beyond insurance status, follow-up visits after ED discharges differ from new primary care appointments because they are focused on the diagnosis of the preceding ED visit. Previous work examining access to primary care follow-up after ED discharge used clinical conditions with a similar degree of urgency for follow-ups, such as hypertension and pneumonia, and, unsurprisingly, found no difference between scenarios.[11,12] However, it is possible that acute illnesses with lower severity or notable stigma, such as low back pain in patients who may be perceived as malingering for secondary gain, lead to additional access barriers.[23,24]

Goals of This Investigation

We used a secret shopper methodology to directly examine patients' experience with seeking timely primary care follow-up appointments after ED discharge in a state with full implementation of the ACA. Our primary objective was to examine differences in follow-up appointment availability and wait time by insurance status. As a secondary objective, we also examined differences in availability of follow-up appointments by clinical condition. The primary outcome was the proportion of calls that obtained an appointment within 7 calendar days. Secondary outcomes include the overall appointment rate and appointment wait time.

MATERIALS AND METHODS

Study Design

We performed a secret shopper study, also known as audit or simulated patient survey, modeled after studies by Asplin et al[12] and Medicaid Access Study Group.[11] Studies examining health care access often rely on physician or patient surveys; the accuracy of the reported information may often be limiting. Physician surveys also frequently have low response rates and tend to overestimate practices' ability to accept new patients.[10,25] Secret shopper studies circumvent these biases by using trained callers to pose as patients seeking appointments and report their direct observations of a system under normal operation. This study was deemed exempt by the institutional review board.

Setting

We included all active primary care practices in New Haven and its inner-ring suburbs, including the cities of

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