

The Challenge of Ambulatory Follow-up Care

by Ann Curtin Ward, MD

This article was written and submitted by Dr. Ann Ward, a practicing psychiatrist in New York who has participated with ValueOptions for 12 years. She is also a member of the ValueOptions Practitioner Advisory Committee. We asked Dr. Ward to share her approach to ambulatory follow-up care during the critical post discharge time period. Each clinician or practice may vary somewhat but please use this as an opportunity to revisit and evaluate your practice protocol. ValueOptions is looking to increase the number of patients seen within 7 days of discharge from acute inpatient care to improve patient outcomes. Each case is considered for authorization based on the member's benefit plan, eligibility and medical necessity.

Treating patients discharged from an inpatient stay is challenging, especially patients new to your practice. It is important that care be continued on an outpatient basis to prevent readmission and increase the potential for a successful long-term outcome.

Oftentimes your involvement begins with a call from the social worker at a hospital requesting your availability for follow-up treatment for a patient being discharged from acute inpatient care. I recommend you begin by reviewing the case with the social worker to assess risks, and if there is a need for a day program with individual therapy. If this is unavailable, then you are the sole resource for the patient. The following steps will provide the patient with a standard of care that is comprehensive and responsible. All professional contacts must be documented in the record of the patient, signed, and dated.

1. Request an immediate fax of admission assessment and discharge summary with prescriptions for medications documented. Usually the patient is provided with one week's supply of medications.
2. Make two appointments for the patient initially. One for the day of discharge, and one for two days later.
3. Interview the patient comprehensively, reassessing the diagnosis that was determined in the hospital. All differentials must be considered: Bipolar, Major Depressive Disorder, Borderline Personality, and Substance Abuse. Take a careful suicide assessment at each interview for at least the first two weeks to insure patient safety. Adolescents are especially vulnerable at this time, and may make a second attempt at suicide. Explore the anger, disappointment, and sadness that are the residue of an incomplete suicide attempt. Occasionally, there is a sense of gratitude at surviving this episode.
4. Convey a sense of availability by providing reliable methods of contact (I give access to all telephone numbers including home number to the patient). Be sure to have on file a phone number for a relative, friend, or alternate phone number in case of a missed appointment. Always track down the patient after missed appointments. Once the patient is stabilized, appointments can be spaced appropriately.

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5. Conduct therapy that is intense, interpretive, and accurate in assessing the dynamics of risks.
6. Review your treatment plan and submit an Outpatient Treatment Report if required to be sure you have enough authorized sessions during this period of adjustment for the patient.

After completion of the first two weeks of treatment, the patient usually will have improved, stabilized, and be ready to go back to work, school, or a home routine. Prepare the patient for this very carefully, as there will predictably be negative and positive attitudes from co-workers, friends or family. Reduce the frequency of visits, and educate the family, spouse, and patient on the necessity of taking medications and keeping follow-up appointments.