nia (CAP)[2,3] but also they can be useful for the differential diagnosis of chest pain and dyspnea in the emergency department.[4,5] We agree that point-of-care ultrasound (POCUS) should be explored in future studies on clinical decision rules for CAP, in addition to other point-of-care (POC) tests such as c-reactive protein.

However, POCUS is not yet ubiquitous nor has it replaced CXR as the current reference standard for diagnosing CAP. We express caution about the broad use of POCUS, as it suffers from subjective interpretation where interrater reliability varies[6] and should be limited to clinicians with sufficient training and adequate patient volume.[7] Most previous studies have been done in the emergency department or inpatient settings where there is a higher volume; whether primary care clinicians can duplicate that accuracy with lower volume requires further study. In addition, because pneumonia is relatively rare in primary care patients (about 3% to 4% of patients with lower respiratory tract symptoms), even a fairly accurate test can have a poor positive predictive value, leading to antibiotic overuse. We, therefore, advocate that future studies focus on the integration of simple heuristics, the overall clinical impression,[8] validated clinical decision rules, and validated POC tests (eg, c-reactive protein)[9] to identify patients at very low risk of CAP in the outpatient setting, as well as those who may benefit for further diagnostic testing, whether it be CXR or POCUS.

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## Re: Timely Outpatient Follow-Up Is Associated with Fewer Hospital Readmissions Among Patients with Behavioral Health Conditions

*To the Editor:* I commend Dr Nadareh Pourat and colleagues[1] for their important work on timely outpatient follow-up and hospital readmissions among patients with behavioral health conditions. I do, however, have a few concerns.

First, the concept of trust in the doctor-patient relationship is an essential one that affects clinical outcomes,[2] while distrust has been associated with treatment discordance.[3] Thus, patients that were dissatisfied with the inpatient care during the index admission may not be predisposed to attend follow-up or comply with treatment. It would have been informative if their regression models accounted for patient's trust in their health care providers and how it may affect compliance with follow-up, especially in this patient population.

Second, although the authors admirably adjusted for many confounders in their regression models, I wonder if Pourat and colleagues[1] considered controlling for anxiety or homelessness/unstable housing, both of which are drivers of hospitalization and readmissions.[4,5] It may be interesting and revealing to assess compliance with follow-ups in homeless individuals with behavioral health conditions, such as anxiety disorders, and how both factors might affect timely follow-up outpatient visits.

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The above letter was referred to the author of the article in question, who declined to respond.