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Final Scholarly Project: No-Show Rates in Community Mental Health

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In Partial Fulfillment of the Requirements for the Degree

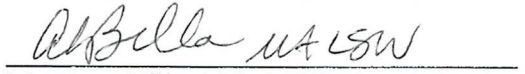
Doctor of Nursing Practice

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No-Show Rates in Community Mental Health

Introduction

A significant concern within the United States of America (U.S.) is the current mental health crisis. The consequence of untreated mental illness is one of the greatest burdens to the U.S. healthcare system and to society. In 2019, spending for mental healthcare reached \$225 billion, accounting for approximately 5.5% of all healthcare spending in the U.S., according to a press release by Open Minds marketing company (2020). Of note, this number reflects spending only for those receiving treatment and does not even account for the expense and consequence of untreated mental illness. Mental illness is among the most common health conditions in the U.S. (The Centers for Disease Control and Prevention, 2021). Shockingly, more than 50% of individuals will be diagnosed with a mental illness at some point in their lifetime (Kessler et al., 2007). One in five Americans will experience a mental illness each year (Center for Behavioral Health Statistics and Quality: Substance Abuse and Mental Health Services Administration, 2016). One in 25 Americans lives with a serious mental illness (SMI), such as schizophrenia, bipolar disorder, or major depression (Center for Behavioral Health Statistics and Quality: Substance Abuse and Mental Health Services Administration, 2016). Furthermore, not only does mental illness affect one psychologically, but mental illness is highly comorbid with chronic physical illness (Carta et al., 2017; Elena Garralda, 2004; Felitti et al., 1998; Lui et al., 2017).

The statistics regarding untreated mental illness are even more sobering. Data reflect that over half of adults with a mental illness do not receive treatment. According to the National Alliance on Mental Illness of California (2020), only 43.3% of U.S. adults with mental illness received treatment in 2018, and that number continues to rise. The percentage of adults with mental illness who report an unmet need for treatment is increasing every year since 2011. Less

than 40% of youth with major depression receive mental health treatment (Mental Health America, Inc, 2022). Unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and poor quality of life are all potential consequences of untreated mental illness (National Alliance on Mental Illness, 2020). The economic cost of untreated mental illness is more than 100 billion dollars each year in the U.S. (National Alliance on Mental Illness, 2022). Untreated mental illness is a significant burden on many including individuals, society, the government, and healthcare organizations as well.

The Significance

With mental illness and suicide rates at an all-time high in the U.S., strategies to reduce missed opportunities in engaging individuals in mental health treatment must be considered. A “no-show” or missed appointment is a lost opportunity that is prevalent in the community mental health arena. No-show rates can decrease revenue in an already struggling entity of the healthcare system. Clinic and provider productivity decrease when scheduled patients do not arrive for their scheduled appointment and the allotted time is not used for the intended purpose. Another, more critical consequence of high no-show rates, however, is that individuals in the community are not receiving much-needed mental health support. When those struggling with mental illness in the community fail to get connected to services, often they are lost to follow-up altogether, suffer clinical decline, use the emergency department inappropriately, and their treatment is interrupted or delayed. No-shows also delay the onset of treatment for other patients who are waiting to be seen. For patients recently discharged from an inpatient unit, initial outpatient non-attendance predicts a higher rehospitalization rate and poorer outcomes (Cullen, 2018). Community mental health clinics experience some of the highest no-show rates, and longer wait times for new evaluations, compared to other subspecialties in healthcare (Mark et

al., 2019). Overall, no-show rates can be as high as 60% in mental health settings (Milicevic et al., 2020). Wait times for provider evaluations for medication management can be on average 6 weeks (Mark et al., 2019). This project aims to understand the factors related to no-shows and interventions that can affect no-show rates in community mental health settings.

The Problem Statement

The existence of unmet need for mental healthcare is well-supported. But how is this finding relevant to the practice of nursing? According to the American Association Code of Ethics for Nurses (2015), the profession of nursing has a duty to “protect human rights, promote health diplomacy, reduce health disparities... and integrate principles of social justice into nursing and health policy” (American Nurses Association, 2015, p. V). The duty of the nursing profession, therefore, is to delve into and tease out any discrepancy that is encountered in the realm of healthcare, for the sake of valuing all individuals who may not have the means for self-advocacy, and where social injustice exists.

Regarding the topic of untreated mental illness in the U.S., one must pose the question, “What are the barriers, and why are people going untreated for mental illness?” The answer to this question is beyond the scope of this project. A cursory glance into the literature, however, cites the following factors: structural barriers (health insurance related), financial barriers, geographical barriers, psychiatric provider shortages, the impact of internal and external stigma, sociocultural barriers (family attitudes and religious beliefs), and racial and ethnic biases (Bertera, 2005; Bishop et al., 2016; Cummings et al., 2017; Marquez & Ramírez García, 2013; Miller et al., 2021; Rowan et al., 2013; Walker et al., 2015). The overarching issue is so overwhelming, and impossible to approach in this paper. However, one small and common aspect of untreated mental illness is appointment non-adherence. Poor adherence to keeping

scheduled appointments is common in mental health settings and is associated with poor care, exacerbation of symptoms, relapse, and hospitalization (Abdoli et al., 2021; Gajwani, 2014).

When appointments for treatment are missed, not only is the individual not receiving care, but the agency, an already struggling entity, is suffering a decrease in much-needed revenue. Clinic productivity, as well as provider productivity, is decreased when scheduled patients do not show and the allotted time goes unutilized. To summarize, the problem is, if the individual does not present for an initial evaluation, then the individual, the community, and the agency are equally at risk.

The setting for this project was a Midwest rural community health clinic experiencing higher than desired no-show rates for the initial diagnostic assessment (DA) appointment.

The PICOT question is: (P) In a rural community mental health clinic, how does (I) using a personal engagement protocol compared with (C) not using a personal communication protocol (O) influence the no-show rate for first-time diagnostic assessment (DA) appointments?

The Evidence

A literature search of the databases Medline, Medline Plus, CINAHL Plus, PsycINFO, and Google Scholar from 2012 to the present was searched using the Boolean operators “no-show, no show, missed appointments, non-attendance” AND “community mental health.” 5,270 publications were populated, and after eliminating duplicates and irrelevant publications, 27 were chosen for closer review. Of the 27 articles, the 12 most relevant were selected for further consideration and use for this project. Inclusion criteria of the literature were: nonattendance, no show, no-show, did not attend (DNA), missed appointment, community mental health, all healthcare settings, and all age groups. Exclusion criteria were: terms such as canceled appointments, premature termination, studies of specific populations that may be too narrow to

generalize to the population for this study (such as eating disorders exclusively, or attitudes in Qatar), studies on environments or systems that may not apply to the population of this project (some universal healthcare processes), and studies on telephone/ text reminders, as that is already in place at the project site and therefore irrelevant. The literature search produced evidence at the following levels: (I) three randomized control trials and two meta-analyses, (II) three systematic reviews, and (III) four quasi-experimental studies.

Very little research on interventions proven to decrease no-show rates in the community mental health setting were noted. After a literature review specifically focused on community mental health no-show rates gleaned few results, the search was broadened to include overall healthcare no-show rates. How knowledge regarding the general medical population translates to the community mental health population is not known. Those living with mental illness may have characteristics unique to them as a population, for example, a potentially greater incidence of overall decreased global functioning compared to the general medical populations.

Due to limited literature pertaining to community mental health no-show rate, the literature search timeframe was broadened to include the last ten years, rather than the standard past five years. A majority of the research found was focused on the determinants of no-shows rather than the study of effective interventions. The research on determinants of no-shows and barriers to attendance were taken into consideration and reviewed, as one could speculate, through knowledge transfer, if the causes of no-shows are understood, then perhaps interventions could be aimed at minimizing such obstacles. In one systematic literature review focused on no-shows across all medical specialties, the most common influencers of missed appointments included a long lead time and prior no-show history. In the same study, patient characteristics more often associated with no-shows included adults of younger age, lower socioeconomic

status, distance to a clinic, and no private insurance (Dantas et al., 2018). Compton et.al (2006). On the other hand, in a study including patients with severe persistent mental illness post-discharge from inpatient mental health units, no-show patterns were more common to those with more severe illness and long wait times before initial appointment. Another meta-analysis, designed specifically to look at community mental health clinics, revealed no-show rates were higher among therapists with less experience, clients with decreased global assessment function scores, personality disorders, or thought disorders (Anestis et al., 2014). In a mixed method systematic review, Sweetman et.al (2021) finds that the primary reasons for missed initial appointments includes: 1) patient misperceptions regarding the seriousness of their problem (for example, patient with severe major depression may feel slightly better by the time of their evaluation and decide that their illness is not that bad), 2) perceived consequences of engaging in treatment (for example, a mother worrying about losing custody of her children because she is diagnosed and receiving treatment for a mental illness), 3) lack of confidence in the provider, 4) failure to provide a prompt appointment, 5) poor patient education regarding types of services, and 6) lack of flexibility around patient's life circumstances. Sweetman et.al (2021) also suggest that evidence-based strategies such as prompt initial evaluation, telephone (text) reminders, patients-centered focused discussions regarding barriers to attendance and how to overcome them, and education regarding types and processes of services may improve attendance.

To summarize the limited evidence in the literature, three overarching barriers to attending appointments were identified. A patient history of no-show was the highest predictor of future no-show behavior. Long wait time for appointments, and poor patient engagement resulting in poor understanding of the plan of care were also common threads woven throughout. Three overarching interventions were identified in the reduction of no-shows: 1) Reminders by

either telephone or text (Moran et al., 2017; Singh et al., 2017); 2) Shorter wait times for evaluations (Cullen, 2018); and 3) Motivating and increasing patient adherence through personal engagement informed by person-centered care (Cullen, 2018; Long, Sakauye, Chisty, & Upton, 2016). Considering the findings, a walk-in clinic may seem to be the answer to some barriers, however, a Canadian quasi-experimental study could not show a cost reduction through a single-session walk-in counseling model, but economic benefits were noted in the way of earlier return to work and decreased use of other healthcare systems (for example, emergency room visits) (Lamsal et al., 2017). Essentially, to date, cost-effective and practical interventions that decrease no-show rates in community mental health clinics are understudied and have not been consistently demonstrated.

Scaffolding the Project

Theoretical Framework

The Ottawa Model of Research Use (OMRU) fused with Kristen Swanson's Theory of Caring (TC), are the theoretical frameworks that support this project. The OMRU is a systematic, practical, comprehensive, and interdisciplinary approach that focuses on efficiently guiding research into practice. OMRU comprises 6 key elements: practice environment, potential adopters, evidence-based innovation, transfer strategies, adoption, and outcomes. These elements are used in three stages of application: assess key elements, monitor implementation, and evaluate outcomes. OMRU is a diverse, knowledge translation model that assists in effecting change across multiple settings and organizations, therefore guiding research into practice in diverse settings (Graham & Logan, 2004; Logan & Graham, 2010).

Kristen Swanson's (1993) middle range theory, a theory of caring (TC), focuses on the uniqueness of caring in nursing as described by five overlapping caring processes: maintaining

belief, knowing, being with, doing for, enabling, and client well-being. According to Swanson, “caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility (Swanson, 1991, p. 161).” Swanson’s TC will be interwoven throughout the six-step process of the OMRU model. Staff and providers will be educated on the importance of conveying caring with interpersonal communications. TC will be conveyed in the essence of the project itself, as reaching out personally, showing genuine concern, education on the clinic processes, and escalation to provider intake evaluation are caring interventions. As shown in Appendix A, the author fused the practicality and organization of the OMRU framework with the caring, humanistic, aspect of Swanson’s theory in order to guide the proposed project. The OMRU will guide processes, while Swanson’s theory will be the lens through which all interactions will be filtered.

Project Objectives

A patient-centered, caring, personal engagement intervention was chosen as the innovation for this quality improvement project. The primary aim of this project was to test how a personal engagement intervention, made within two days of referral and weekly thereafter, with newly referred patients, would affect no-show rates for the initial psychiatric DA. A secondary objective was to identify subjects who require escalation of evaluation and treatment.

Methodology

Project Team

The project team consisted of:

A student of the Doctor of Nursing Practice Program, MSN, RN, PMHNP-BC at Otterbein University as Project Coordinator.

The student's advisor, Ph.D., DNP, RN, CNP, PMHNP-BC, ACHPN – Professor & Chair, Department of Nursing, Chief Nurse Administrator, Otterbein University; Principal Investigator and Project Team Leader for this FSP project.

A nursing faculty member, DNP, RN, FNP-BC, NE-C- Associate Professor, Department of Nursing; Otterbein University; Master's to DNP Director; Project Team Member.

The agency Chief of Operations at a Midwest rural community health clinic, MSW, LISW-S, Project Team Member.

The Director of Programming & Clinical Operations at a Midwest rural community health clinic, MA, LSW; Project Team Member.

Setting the Stage

The setting was a Midwest, rural community mental health clinic.

Facilitators identified for this project included the agency CEO and the Director of Clinical Operations. Potential adopters were identified as staff who experience improved patient outcomes and increased patient satisfaction, and community representatives and outreach coordinators who acknowledge increasing services to meet the needs of the community.

Project Design

The innovation implemented based on knowledge transfer of evidence noted in literature was a personal engagement intervention, by telephone contact, made by a specified Community Psychiatric Supportive Treatment (CPST) worker, within 2 business days of referral for services, at which time the client was provided educational information on the intake process, emergency phone numbers, and agency contact information. A personal engagement was made weekly until the patient completed the scheduled DA or missed the appointment, which was the project endpoint for that patient. Those suspected of needing to be escalated for services were to be

referred immediately to a licensed provider for triage. However, this was not required during the study timeframe.

Population and Sample

This project was not an experimental project, but rather a process improvement project. Subjects were selected based on convenience. There were no changes from status quo processes other than a personal engagement made by telephone with patients while waiting on their scheduled DA appointment.

Inclusion criteria:

1. Any legally competent person over the age of 18, that was seeking mental health services from the agency whether a self-referral or referral from a patient representative (primary care provider, for example).

Exclusion criteria:

1. Patients discharged from an inpatient hospitalization were already seen and evaluated within 2 business days of discharge, according to agency policy.
2. Patients who declined to participate.
3. Patients under 18 years of age.
4. Patients who did not have the legal competency to make their own decisions.

Human Subject Protection

Considering that human subjects were involved in this project, Institutional Review Board (IRB) approval was obtained from Otterbein University. Otterbein IRB approval was granted, Protocol HS # 22/23-14, as noted in Appendix E.

The community mental health agency had no IRB policy in place. There was a policy in place for research and process improvement for the agency, as seen in Appendix F. The decision-

makers responsible for approving this QI project are the CEO and Director of Clinical Operations.

Informed consent, as seen in Appendix G, was obtained, by the intake coordinator and verified by the CPST worker, from clients participating in the project.

Private health information of participants was protected by assigning a random numeric identifier to each participant. Patient names and personal information was kept locked in the CPST worker office drawer, also behind a locked door.

Instruments and Tools

The instruments and tools utilized in this study are attached in the appendices.

Appendix B reflects the CPST script utilized to guide the CPST worker in a standard procedure of communication with the client. Appendix C reflects a standardized decision tree utilized to support CPST in the case that the client expresses safety concerns. Appendix D is the CPST spreadsheet utilized to collect data.

Implementation Plan

The project intake process/ enrollment in the study is described below and can be seen in Appendix C:

1. Patient/ agent thereof contacts the agency for mental health services, per usual.
2. Intake specialist completes intake information, per usual.
3. An appointment for a DA with a social worker is made by the intake specialist, per usual.
4. The intake specialist will ask for consent for participation in the study during the intake process and keep a list of referrals that meet the study criteria. The list of individuals consenting

to participate in the study will be shared with the CPST worker. The project sample will be a convenience sample.

5. CPST worker will attempt to make telephone contact with the new patient within 2 business days. During the contact with the new patient, the CPST worker will explain the intervention and verify consent to make weekly contact by telephone, educate the patient on the services that are available, give emergency and agency contact information, and answer any questions. The patient will be assigned a random numeric identifier for the data collection form, and the CPST worker will keep contact information secured, locked in a desk drawer, behind a locked office door.

a. If a patient is indicated that they intended to harm themselves, or expressed feeling unsafe, the CPST worker was to notify a designated licensed provider, and the provider would contact the client and decide the correct action to be taken.

b. If a patient indicated that they could not wait to be seen by a provider, the CPST worker again was instructed to notify a licensed provider, who will coordinate an escalation of services.

6. The CPST worker attempted weekly telephone contact with the patient.

7. Once the DA was completed or the appointment was missed, the subject had completed the study, and the CPST worker terminated weekly calls for that subject.

Timeline and Budget

A timeline and budget, as shown below, were established, and presented to key players during the planning stage of the project.

The original timeline had a start date of October 01, 2023, for enrollment to begin, but due to delays in the IRB process, the actual start date was October 25, 2023. Another factor that

delayed the data analysis and completion of the project was delays in obtaining the final data collection from the CPST worker at the end of the project. The CPST worker expressed some challenges in performing the usual duties of the position and the additional duties of the project within the allotted three hours dedicated to the project.

Table 1

FSP Timeline

Date	Action
09/01/2022-10/01/2022	Engage key players. Plan collaborative planning meetings. Educate and discuss protocols and tools. Address barriers. Utilize facilitators. Provide encouragement and motivation. IRB application.
10/01/2022-	Begin enrollment process. Troubleshoot and address barriers ongoing. Support intake specialist and CPST daily. Troubleshoot issues ongoing
03/01/2023	End enrollment on 01/01/2023. Continue to collect data until last patient enrolled has completed the DA process.
03/01/2023	Begin to analyze and interpret data.
04/01/2023-04/24/2023	Final scholarly report drafted. Create poster. Disseminate findings. Share with key players in agency and community. Present to Otterbein colleagues.

Budget

The total expense of this project was projected at \$3240.00 with the value of the licensed provider included. However, the licensed provider will be donating the time, therefore, the total expense will be less than \$1000 and will be absorbed by the agency. There were no budgetary obstacles encountered.

Table 2*Projected Budget*

Item	Expense
CPST hours devoted to follow-up phone calls	3 hours per week- 3 x \$20/hr = \$60/ week x 12 weeks = \$720.00, paid by the agency.
PMHNP as a support person to CPST worker and data collection.	3 hours per week- 3 x \$70/hr= \$210/ week x 12 weeks = \$2520
Educational materials would be provided regardless. Total project expense	\$00 / \$3240.00

Data Collection

The CPST worker managed the data collection worksheet, as seen in Appendix D. The document was shared between the intake specialist, CPST worker, the clinical director, and the author. Client names were protected and replaced with a random numeric identifier. The information recorded on the spreadsheet included weekly date of engagement, unable to contact, or voicemail left; escalation of services (yes/no); and notes regarding indicating a need.

Outcomes and Evaluation**Data Analysis**

Statistical analysis assisted the team to determine whether the results showed a difference in no-show rates prior to and post-intervention. Because this was a process improvement project, sample size and differences were considered, but did not serve as a primary determinant of success. The success of the intervention was based on a decrease in the no-show rate post-intervention.

The data from the CPST spreadsheet was reviewed, calculated, and reported using descriptive statistics. The pre-intervention no-show rate was obtained from the agency's

electronic medical record software and was measured against the post-intervention data utilizing the same guidelines. Appointments rescheduled by clients were excluded in the no-show rates. Appointments canceled but not rescheduled were included as a no-show in both pre-and post-study groups.

Results

The project sample group was a convenience sample and 224 patients voluntarily enrolled as participants in the quality improvement project. Four subjects were excluded from the study due to rescheduling outside of the project endpoint, resulting in 220 patients' data being calculated in the outcomes.

The agency no-show rate prior to the intervention implementation for a 90-day period, extracted from the agency database, measured from September 1, 2022, to November 30, 2022, was 31.3%, based on 291 total intakes, of which, 91 were reported as no-shows for the initial DA.

The no-show rate for the project sample group, utilizing the personal engagement intervention, measured from October 25, 2022, to January 25, 2023, was 33.2%, based on 220 intakes in the project group, of which, 73 were reported as no-shows for their initial DA. A comparison of the pre- and post-intervention data is shown in Appendix H.

The wait time from the intake process to the DA appointment ranged from 9 days to 78 days, with the average wait time from intake to the DA appointment being 46 days.

Zero clients required escalation of services. One patient in the project sample required an emergency well-check visit by the police due to impulsively ending the DA process and running

from the building. The patient was found to be safe and no further action was warranted. The patient did go on to complete the DA process and access services.

The CPST worker made 1,474 phone calls. A voicemail message was left in 18.5% of the phone calls, resulting in no personal engagement. Contact was unable to be made in 4% of attempts, due to either a nonworking number, no answer, and no option to leave a voicemail.

It was noted, as shown in Appendix I, that longer wait times for appointments did increase no-show behavior for the initial DA, with the highest rate of no-shows, 39%, noted when the wait time was 43-59 day wait category.

Evaluation

Limitations of this quality improvement project include small sample size and no accounting for confounding factors, such as demographics (rural setting), payor, sex, age, diagnoses, comorbidities, or socioeconomic status. Other possible limitations include factors difficult to measure, such as the attitudes and commitment of the staff initiating patient engagements. Also, the patients' perceptions of the personal engagement intervention was not measured in this study.

Conclusions and Recommendations

Conclusions

In conclusion, the project outcomes support that a personal engagement intervention for patients waiting to access mental health services may not reduce no-show rates for initial DA appointments in rural community mental health clinics.

Based on the results of this QI project, money, and effort may be better spent on reducing the time to treatment. The challenge remains, however, in finding cost-effective and operationally effective ways to meet this challenge.

Recommendations

Considering the outcomes of this quality improvement project, further study is needed in identifying ways to reduce the no-show rate in community mental health clinics. Literature suggests that the most effective way to reduce no-show rates in community mental health is to provide services within 2 business days of referral. Most community mental health clinics are unable to meet this demand if practicing in their current model, as appointments are booked far in advance and the wait times for the DA are several weeks, followed then by a wait time for medication management of several more weeks. It may take a patient several months before seeing a provider for medication management.

This project suggests that decreasing wait time for initial appointment to under 42 days may make a significant impact on no-show rates, and less than 25 days, even a greater impact on no-show rates in the community mental health setting.

Summary

In summary, a mental health crisis does exist in the U.S. Untreated mental illness is a tremendous strain on individuals and communities alike (Center for Behavioral Health Statistics and Quality: Substance Abuse and Mental Health Services Administration [SAMHSA], 2016; Elena Garralda, 2004; Felitti et al., 1998; Isvoranu et al., 2021; National Alliance on Mental Illness, 2020; Open Minds, 2020). The problem is that even when mental healthcare is accessible, many individuals with mental illness still do not access care (The Centers for Disease Control and Prevention [CDC], 2021; Anestis et al., 2014; Babbar et al., 2018; Compton et al., 2006; Cullen, 2018; Milicevic et al., 2020). No-show rates in community health clinics are much higher than in other healthcare entities (Lefforge, Donohue, & Strada, 2007; Parikh et al., 2010). When patients do not access care, often they risk re-hospitalization, inappropriate use of the

emergency department, or decompensation in the community. The question is, how can we affect no-show rates in a community health setting? Furthermore, how do we advocate for those who are mentally ill and are unable to follow through with scheduled appointments and access treatment? According to the Code of Ethics for Nursing, the profession of nursing has a duty to advocate for the underserved and also for society as a whole (American Nurses Association, 2015). Therefore, it is the responsibility of the psychiatric nurse practitioner to implement and evaluate strategies that will affect no-show rates in the community mental health care setting.

Based on the findings of this quality improvement project, the implementation of a person-centered engagement intervention may not reduce no-show rates in community mental health clinics.

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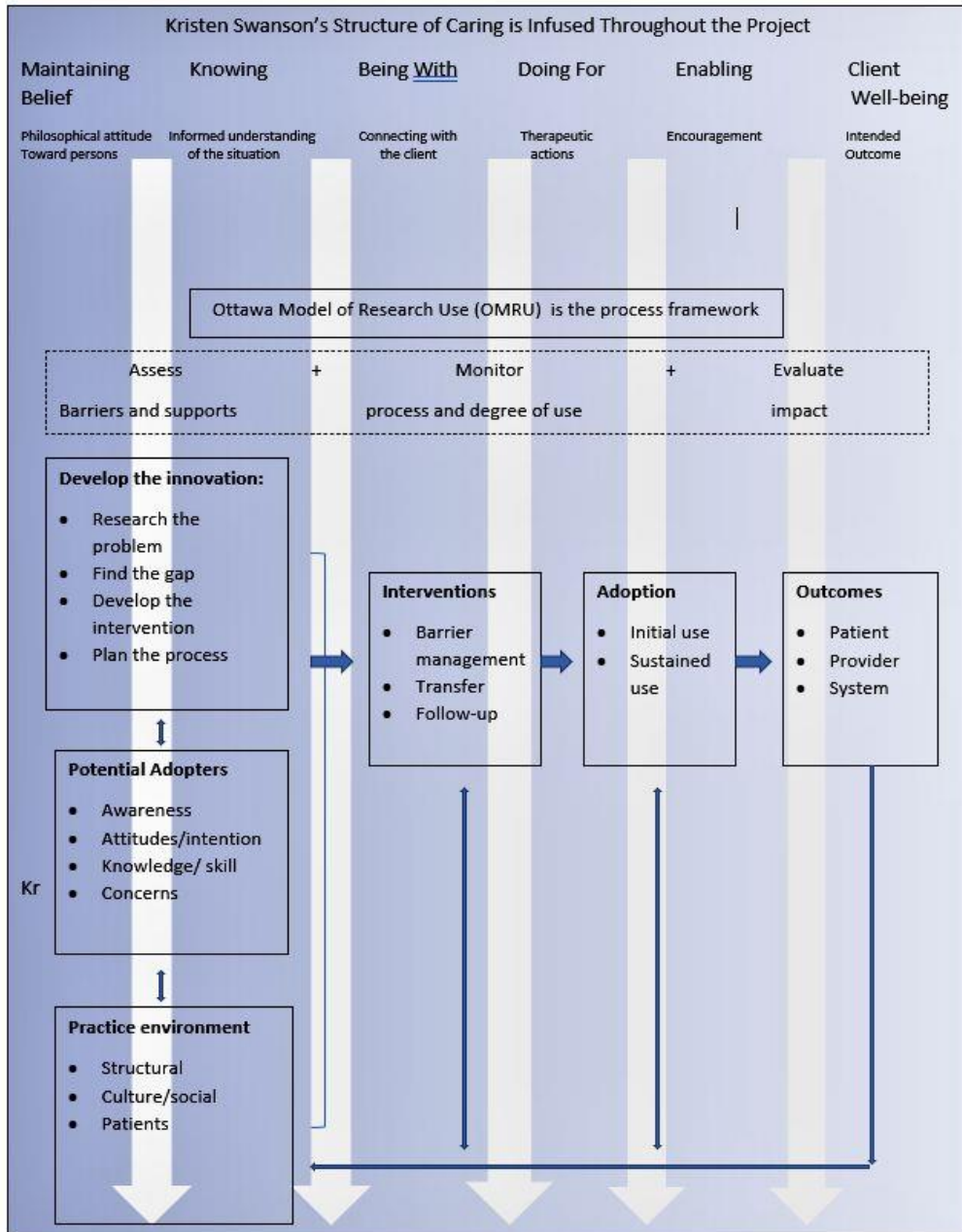
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Appendix A

Fusion of OMRU and Kristen Swanson’s Theory of Caring

Figure 1



(Logan & Graham, 2010; Swanson, 1991)

Appendix B**CPST Script****Figure 2**

Hello _____ (pt name) _____

My name is _____ from (Midwest rural community health clinic).

I wanted to touch base with you and give you some information about what to expect at your upcoming intake appointment.

So we have you scheduled for an intake appointment on _____.

At that appointment, you will meet with a counselor who will get to know you and determine how we can

assist you. This appointment will take about 45 minutes to an hour.

During your treatment, we may also refer you to a medical provider, who can help you with medication therapy.

The whole process can take a few weeks. We know that it can feel like a long time, so we just want to stay in touch

with you during the process. I will call you about once a week and stay connected until you get through the process.

I would also like to give you some phone numbers and information on resources available to you while you wait.

Do you have a pen to write a couple of numbers down?

Our number here is XXX-XXX-XXXX.

If you have a crisis, you can call XXX-XXX-XXXX or (crisis intervention org) at XXX-XXX-XXXX.

If you have an emergency, you can call 911.

If you feel like you might harm yourself or someone else, please call 911.

Do you have any questions about what we've gone over?

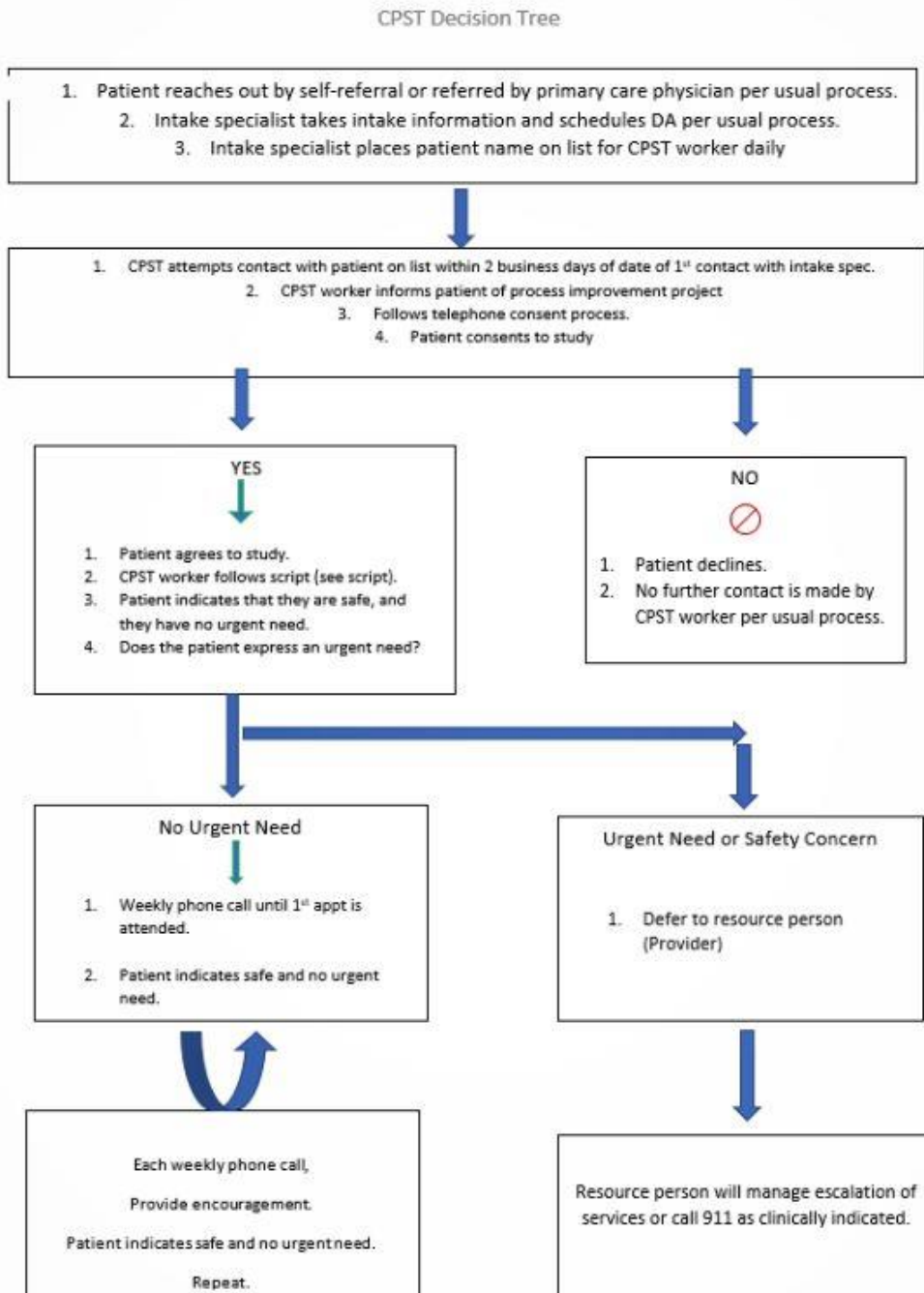
Do you foresee any issues with keeping your appointment?

Ok, we really do look forward to getting to know you and helping you to feel better.

Appendix C

CPST Decision Tree

Figure 3



Appendix E

Institutional Review Board Approval

Figure 5



INSTITUTIONAL REVIEW BOARD

- Original Review
 Continuing Review
 Amendment

Dear Dr. Chovan,

With regard to the employment of human subjects in the proposed research:

HS # 22/23-14**Chovan & Jordan: No-Show Rates in Community Mental Health**

THE INSTITUTIONAL REVIEW BOARD HAS TAKEN THE FOLLOWING ACTION:

- Approved
 Approved with Stipulations*
 Limited/Exempt/Expedited Review
- Disapproved
 Waiver of Written Consent Granted
 Deferred

*Once stipulations stated by the IRB have been met by the investigator, then the protocol is APPROVED.

1. As Principal Investigator, you are responsible for ensuring all individuals assisting in the conduct of the study are informed of their obligations for following the IRB-approved protocol.
2. It is the responsibility of the Principal Investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the Principal Investigator leave the university, signed consent forms are to be transferred to the IRB for the required retention period.
3. If this was a limited, exempt, or expedited review, there is no need for continuing review unless the investigator makes changes to the proposed research.
4. If this application was approved via full IRB committee review, the approval period is one (1) year, after which time continuing review will be required.
5. You are reminded you must promptly report any problems to the IRB and no procedural changes may be made without prior review and approval. You are also reminded the identity of the research participants must be kept confidential.

Signed: Noam Shpancer
 IRB Chairperson

Date: 10-19-2022

Appendix F

Agency Policy

Figure 6

SUBJECT: Research Involving Consumers

DIRECTIVE: To define the agency's policies regarding research involving consumers.

POLICIES:

●●● shall not conduct, permit, or participate in, research of an experimental nature involving consumers.

●●● management may collect, study, and report information obtained from consumers

for the purpose of program evaluation, to provide evidence of contractual compliance,

and for performance improvement purposes. Such activities shall be strictly limited to:

the collection and study of existing data that is publicly available, or is routinely

collected by the agency in the course of providing services;

information collected without direct or indirect consumer identifiers; and,

paper and pencil questionnaires involving the solicitation of non-threatening

information. (In this situation, return of the questionnaire implies voluntary consent.)

RESPONSIBILITIES: ●●● management staff shall ensure that the collection and study

of any consumer information is in accordance with the above stated policies.

Non-supervisory staff shall not collect/study consumer data without prior approval of the

Executive Director or Director of Programming & Clinical Operations.

Reviewed/Revised: 11/13/07, 12/29/08, 01/08/10, 12/27/10, 01/06/12, 03/14/13, 03/11/15, 06/01/17, 11/3/21

Appendix G

Client Consent Form

Figure 7

QI Project Informed Consent:

(Midwest rural community mental health clinic) is conducting a process improvement exercise.

We want to improve our outreach and connectivity by increasing contact and relationships with our patients.

It is important for you to know that none of your personal information will be disclosed in any way at any time, unless as mandated by law (911 in the case of an emergency).

The time commitment required of you will be 5-10 minutes per week, or less, by phone.

There will be no change in the process of referral other than contact with a CPST worker.

The CPST worker will reach out to you initially and give some information and education on our agency policies, processes, and phone numbers that you can keep in case of emergencies.

After this initial contact, the CPST worker will make weekly contact.

Do you have any questions?

Do you agree to participate in this process improvement trial?

If at any time, you wish to withdraw from this project, please tell the CPST worker the next time they call.

Telephone consent given:

Yes (patient name / signature of staff if telephone consent Date/ Time _____

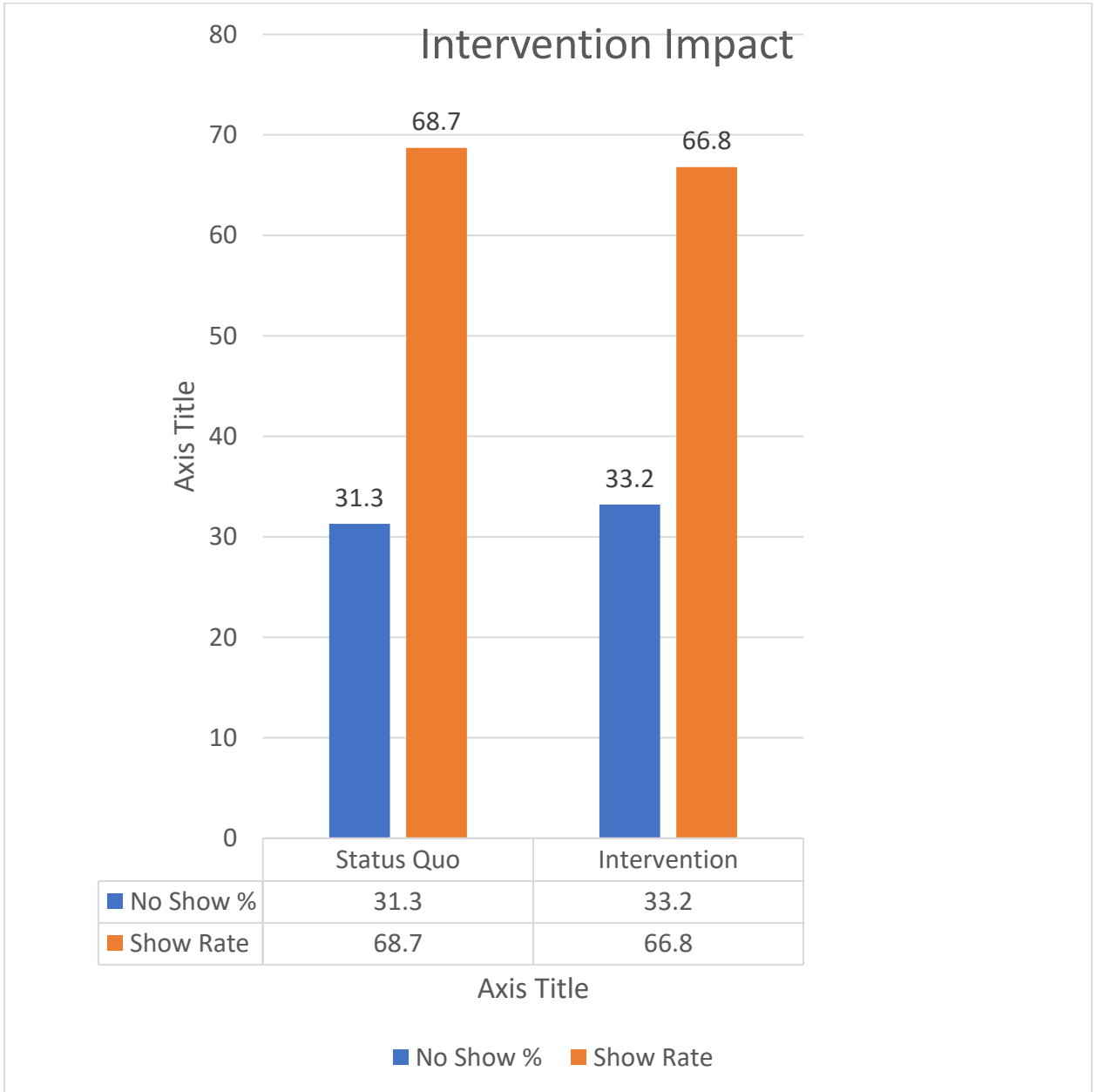
Signature of client _____ date _____

(The client will sign the consent form when they sign all other consent forms at their first visit.)

Appendix H

Outcomes Pre- and Post- Intervention

Figure 8



Appendix I

Outcomes According to Wait Time

Figure 9

