No-show rates in community mental health clinics

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ABSTRACT

EFFECTS OF NO-SHOW RATES IN COMMUNITY MENTAL HEALTH CLINICS:

- FAILURE TO RECEIVE SERVICES- clinical decline
- FISCAL RESPONSIBILITY –suffers
- PRODUCTIVITY - longer wait times
- PATIENT SATISFACTION - unmet patient needs
- PROVIDER SATISFACTION - productivity demands by employers increase stress
- COMMUNITY BURDEN - inappropriate use of emergency departments, crime, homelessness
- HIGHER RE-ADMISSION RATES (Abdoli et al., 2021; Gajwani, 2014; Lamsal et al., 2017; NAMI, 2020).

INTRODUCTION

National Mental Health Crisis

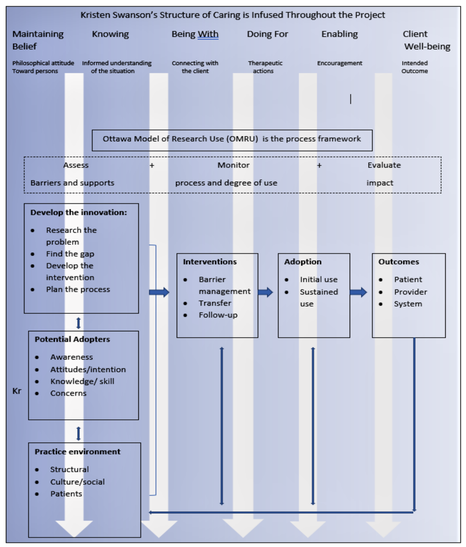
- 1 in 5 Americans experience mental illness at some point in their life (SAMHSA: CBHSQ, 2016).
- 1 in 25 Americans live with SMI (serious mental illness): schizophrenia, bipolar disorder, or MDD (SAMHSA: CBHSQ, 2016).
- Mental illness is highly comorbid with chronic physical illness as well (Carta et al., 2017; Felitti et al., 1998; Elena Garralda, 2004).
- Over half of adults with mental illness do not get treatment (NAMI of Ca., 2020).

PROBLEM STATEMENT AND SIGNIFICANCE

No-show for mental health appointments results in:

- Patient does not receive care, risking comorbid complications and decompensation
- Agency and provider productivity is decreased .
- Community resources are inappropriately utilized.
- Patient, community, and agency are all equally at risk. (Abdoli et al., 2021; Gajwani, 2014).

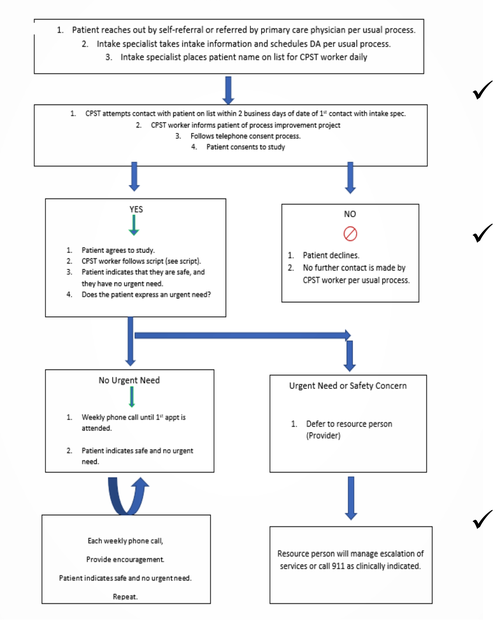
PROJECT DESCRIPTION AND DESIGN



- Ottawa Model of Research Use (operational construct) (Graham & Logan, 2004; Logan & Graham, 2010).

fused with

- Kristen Swanson's Theory of Caring (theoretical framework unique to nursing) (Swanson, 1991; Swanson 1993)

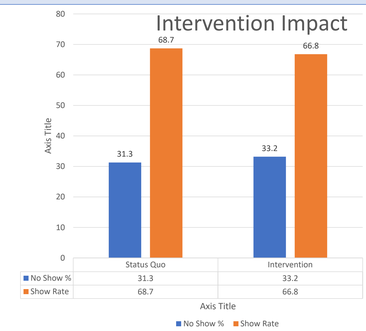


- ✓ Intake specialist completes informed consent and enrolls pt.
- ✓ CPST makes weekly call, utilizing a person-centered, caritive approach until diagnostic evaluation (DA) is either attended or a "no-show."
- ✓ Evaluate impact

Compare pre and post intervention data over 90 days…

REFERENCES

OUTCOMES AND EVALUATIONS



- Pre-intervention no-show rate was 31.3%
- Post-intervention no-show rate was 33.2%
- 224 patients enrolled in the intervention group
- 4 patients were disqualified due to rescheduling outside the study endpoint.
- 73 patients (33.2%) did not show for their DA
- 1,474 phone calls were made.
- 18.5% of the calls went to voicemail and no personal conversation occurred.
- 4 % of calls resulted in inability to contact patient or leave voicemail.
- Average wait time for DA was approx. 46 days; and to see provider can be another 1-2 months from DA.
- Patient may wait several months before seeing a provider when medical management is needed.

CONCLUSIONS

1. A personal engagement intervention ***did not*** impact no-show rates over a 90-day trial.
2. No-show rate increased with increased wait time:
   - 9 -25 days – 23% no-show rate
   - 26-42 days – 28 % no-show rate
   - 43-59 days – 39% no-show rate
   - 60-78 days – 35% no-show rate

RECOMMENDATIONS

1. Resources may best be utilized in decreasing wait time for appointments, or meeting patients where they are.
2. No-show behavior is a multifactorial and common issue among community mental health clinics.
3. Further investigation is needed in order to identify effective strategies so that patients in the community are accessing mental health care.