Addressing the Problem of Appointment Nonadherence With a Plan for a Walk-In Clinic

Patrick Runnels, M.D.

Introduction by the column editors: This column is based on the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. Dr. Runnels asked e-list members of the American Association of Community Psychiatrists for suggestions regarding the establishment of a walk-in program for patients who regularly miss scheduled appointments. Readers are invited to submit suggestions for e-list discussions of management problems to column editors Jules M. Ranz, M.D., at jmr1@columbia.edu, or Susan M. Deakins, M.D., at smd3@columbia.edu.

Patients who do not keep psychiatric appointments—usually referred to as "no-shows"—have been a persistent problem for community mental health centers (CMHCs) since their inception (1,2). The high cost of nonbillable psychiatric time is only one aspect of the problem. Individuals with severe mental illness who do not regularly engage in outpatient psychiatric services are also more likely to utilize high-cost acute care services (3). Given the size of anticipated state budget cuts in the coming years, addressing this problem is one way that the mental health system can lessen the potential consequences of the current fiscal crisis.

Dr. Runnels is affiliated with the Department of Psychiatry, Case Western Reserve University School of Medicine, 10524 Euclid Ave., 13th Floor, W. O. Walker Building, Cleveland, OH 44106 (e-mail: patrick.runnels1@uhhospitals.org). Jules M. Ranz, M.D., and Susan M. Deakins, M.D., are editors of this column.

Research on causes of and solutions to appointment nonadherence in community mental health settings is sparse and not commensurate with the scope of the problem. Furthermore, most studies that address this problem focus on psychotherapy or nonpsychiatric intake appointments. Nonetheless, studies of appointment nonadherence have yielded important data. Studies examining risk factors for intake appointment nonadherence have found some strong predictors, including length of waiting time to the appointment, especially if the wait is greater than two weeks (4), and several social and economic factors, including housing instability, poor employment history, severe symptoms, and a recent history of substance abuse (1,2). Reminder calls before intake appointments appear to increase intake appointment adherence (5,6). No studies were found that focused on other concrete mechanisms to increase appointment adherence.

Problem

Background

The Centers for Families and Children is a CMHC in Cleveland, Ohio. It serves more than 5,000 clients at five sites located throughout greater Cleveland and is one of the largest providers of mental health care in the area. Three of the five sites are located in the city. The largest of the three is the downtown office, which is in a concentrated area of long-term, severe economic depression. The other two sites are located away from the city center in communities where circumstances are significantly less dire. Psychiatric appointment nonadherence at the downtown office is 30%–40%, compared with 20%–30% at the other four offices.

The clinician productivity measure used by the Centers for Families and Children is face-to-face time with patients. In January 2010, productivity rates hovered between 45% and 50%, a rate that was not sustainable on the basis of billing rates for Ohio Medicaid. Minimal differences in productivity were noted among the different types of prescribers: physicians, nurse practitioners, clinical nurse specialists, and physician assistants.

A query about productivity was sent to the e-list of the American Association of Community Psychiatrists (AACP) in May 2011. Association members from CMHCs around the country reported productivity between 60% and 80%, depending on the size of the local pool of psychiatrists and how much time an agency wanted psychiatrists to spend in roles other than direct service provision. Productivity below 50% was broadly deemed unacceptable. These results underscored the need for the Centers for Families and Children to address its problem of appointment nonadherence.

Intervention

The centers had previously tried phone calls, complimentary transportation, and same-day appointments with minimal perceived effect (results were not robustly measured). Administrators were concerned that an increase in the number of appointments scheduled each day would create uneven wait times or shorten the duration of appointments, negatively

affecting client satisfaction and outcomes.

After further discussion, staff members became aware of the significant incongruence between the structure of the service delivery system, which offered scheduled, office-based appointments, and the service use patterns of consumers, who frequently received unscheduled care in emergency departments and inpatient settings. Although walk-in clinics and field-based visits have been part of the psychiatric delivery system for decades, the staff was unaware of any widely implemented service delivery model based on service consumption rather than on symptoms.

AACP e-list dialogue

Staff of the centers decided to ask members of the AACP e-list two additional questions: What experience, if any, have you had with robust, walk-in–based services? Even if you have not had experience, what are your thoughts on the subject?

Responses fell into three groups. The first group echoed the centers' struggles with the problem of appointment nonadherence. As one respondent said, "I vacillate between a dedicated clinic as you describe and having a daily rolling walk-in option where clients are plugged into no-show slots. The dedicated clinic has the potential to result in large amounts of down time, but the continuous option has the potential to really screw up the flow of patients and inconvenience clients who come on time for their appointments."

As medical director at the Centers for Families and Children, I responded, "It's an interesting quandary precisely because of the potential physician down time . . . [but] we have a huge patient population . . . [which is] really bad at keeping appointments, and [this] gums up the schedule. If we could reduce the number of no-shows enough to raise productivity 5%–10% per provider, it might justify the cost."

The second group of respondents also echoed the centers' experience but emphasized that the key to success was management of the waiting area. One respondent offered the following guidance: "Be sure to use a lot of groups so as not to waste time and to be as cost-effective as possible. . . . One is a group for walk-in initial evaluations, where a nonpsychiatrist does a one-to-one screen . . . followed by very successful medication groups run by a psychiatrist and a nurse. . . . The nurse takes some patients out of the group for one-on-one reviews . . . [and] the rest of the group continues. . . . The group excludes consumers who are paranoid and narcissistic. Coffee and educational videos are available for those who wait."

Another respondent in this second group described several creative ways of coping in which he had participated in the 1970s and 1980s: "A ticket provided something that most everyone wanted . . . food, coffee, and informal time with groups of other patients, CMHC line staff, psychiatrists and nurses." Another respondent noted, "Often overlooked is the comfort of the waiting area . . . having coffee, comfortable seats and space, forms to fill out, and other engaging activities while waiting for the evaluator encourages patients to stick around. Think of how primary care does it: the patient gets put in a room, screened by the medical assistant, forms are filled out, vitals are taken, and then the clinician breezes in without having to go find the patient in the waiting room."

A third approach to the problem was represented by the response of a single e-list member, who described an experience that was somewhat similar to that of the centers: "I have long believed that on-demand service can play a significant role with our population given that people in general keep doctor appointments only when they have a perceived need. . . . We've recently responded to funding cuts with an expansion of access on a walk-in basis. . . . This walk-in capacity is also becoming the de facto ongoing treatment relationship for individuals who have difficulty keeping appointments."

I asked this respondent, "Do you have a dedicated walk-in clinic, or are you mixing walk-in time with all your prescribing staff?" The respondent replied, "We have a couple of dedicated walk-in sites, but the big shift was our development of walk-in capacity throughout our system—i.e., at adult clinic sites where previously it could take weeks to get an evaluation appointment. . . . Our efforts to be more responsive to primary care [are] a crucial component in our efforts to work toward integrated care with them."

This respondent made several other suggestions on the basis of his experience: "Because of long wait times, client expectations must be managed. When demand exceeds capacity, some less acute clients could be asked to come back the next day. It's challenging to ensure that money isn't being wasted on staffing for hours during which the demand for services turns out to be (unpredictably) low. Staff working conditions are dramatically changed, and a new flexibility is required to which some staff have considerable trouble adapting."

The AACP e-list discussion was notable for its lack of negative responses. In particular, no respondent described negative experiences in implementing such a model, nor did any respondent suggest that trying the model would be a bad idea.

Moving forward

The centers' walk-in clinic project, which is expected to be large, is still in the planning stage. The e-list discussion has helped guide the process in several ways. It has reinforced our initial belief that a departure from a traditional office-based schedule for a subset of clients is worth considering. This conclusion is supported in large part by the near absence of alternatives presented by e-list respondents. Our proposal for the walk-in clinic is similar in nature and in scope to the existing clinic described by the e-list respondent, and the knowledge that such a model exists has helped generate a positive response to our proposal within our agency.

Several areas that need to be considered during the planning phase have been highlighted. Staff members selected for this type of service must have the requisite flexibility and level of comfort needed to work with an unpredictable schedule. Management of the waiting area must also be carefully considered, and the period of time preceding an appointment needs

to be reimagined to create a good patient flow. And stimulating patient flow to avoid excessive physician down time will certainly be an ongoing challenge.

Despite the challenges presented above, the model offers some areas of growth that might meet the needs of the population we serve. A point of commonality between the Centers for Families and Children and the larger Cleveland system is the struggle with long wait times for psychiatric intakes. The walk-in model may allow us to offer next-day intake appointments. Operating under less traditional hours when clients may be more likely to experience acute needs is another consideration. Finally, having a nurse take clients' vital signs and gather data from them might be a first step toward introducing overall health management to a population that sorely needs it.

Communicating and gathering useful information via the AACP e-list have helped staff of the Centers for Families and Children feel more confident about considering a treatment system innovation that will facilitate delivery of needed services to a population poorly served by the existing system. As the project moves forward, staff anticipate using the e-list to report broad results and garner further feedback as they encounter problems or unexpected results.

Acknowledgments and disclosures

The author acknowledges the support of the American Association of Community Psychiatrists for access to its e-list.

The author reports no competing interests.

References

1. Folkins C, Hersch P, Dahlen D: Waiting time and no-show rate in a community mental health center. American Journal of Community Psychology 8:121–123, 1980
2. Zivin K, Pfeiffer PN, McCammon RJ, et al: "No-shows": who fails to follow up with initial behavioral health treatment? American Journal of Managed Care 15:105–112, 2009
3. North CS, Smith EM: A systematic study of mental health services utilization by homeless men and women. Social Psychiatry and Psychiatric Epidemiology 28: 77–83, 1993
4. Gallucci G, Swartz W, Hackerman F: Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. Psychiatric Services 56:344–346, 2005
5. Gariti P, Alterman AI, Holub-Beyer E, et al: Effects of an appointment reminder call on patient show rates. Journal of Substance Abuse Treatment 12:207–212, 1995
6. Greeno CG, Anderson CM, Shear MK, et al: Initial treatment engagement in a rural community mental health center. Psychiatric Services 50:1634–1636, 1999