Engagement Clinic: Improving Treatment Compliance for At-Risk Patients

Anne Richardson, MD and Rachel Rebich, LCSW
Behavioral Health Charlotte
Outpatient Medication Services

Introduction

Project Selection
Outpatient Medication Services (OMS) at Behavioral Health Charlotte (BHC) is a fast-paced psychiatric clinic serving a diverse population. OMS provides care to approximately 6,000 patients a year for over 15,600 visits. Nearly 40% of the patients seen in our clinic have Medicaid or no insurance. A challenge for our clinic is meeting the needs of at-risk patients who struggle to be compliant with treatment, including appointment attendance. Many of these patients face significant stressors such as homelessness, substance use, and serious medical conditions, all of which impact their ability to attend appointments and follow treatment recommendations. A large proportion of this group drop out of treatment or are dismissed from the clinic due to numerous missed appointments. These patients are at an increased risk for poor outcomes leading to an emergency room visit or hospitalization due to non-compliance with treatment.

Project Team
Anne Richardson, MD—OMS Assistant Medical Director ● Rachel Rebich, LCSW – Operations Director, Behavioral Health Charlotte Outpatient Clinics ● Dana Martini—Lead Engagement Specialist ● Shannon Fang, RN—OMS Lead Nurse ● Felicia Yarborough—Access/Outreach Specialist ● Lindsay Federmark, LPN—OMS Office Coordinator ● Outpatient Medication Services Nursing Team ● Outpatient Medication Services Access/Outreach Team ● Outpatient Social Work Interns

Engagement Clinic
To address this bio-psycho-social problem involving high-risk patients and appointment nonadherence, our team created an Engagement Clinic (EC) with a goal to meet the needs of this population. We were able to use existing clinic resources with no additional positions or costs added. In January 2017, we created the EC that using a team based approach to engage patients that have missed multiple appointments. The clinical team consists of a psychiatrist, nurse, access/outreach specialist and social work intern. One morning a week, the team meets with each patient individually to determine current clinical needs as well as identity and address barriers to appointment attendance. The team works with the patient to create a plan to improve overall treatment compliance as well as quality of life. When needed, the social work intern and outreach specialist follow up with the patient after the appointment to verify assistance has been achieved. Examples include linking patients with transportation services, therapy services, and housing opportunities. Organizational skills and planning is often reviewed with patients as they are offered free monthly planners to remember upcoming appointments. Free pill boxes are also offered to encourage medication consistency and adherence. The EC directly aligns with Atrium Health’s commitment to improving health outcomes and the patient experience for even the most at-risk populations that need additional support.

Goal
The overall objective for the EC is to partner with patients who frequently miss appointments to improve engagement in care, increase treatment compliance thus improve overall health and well-being.

Engagement Clinic Project Goal:
Re-engage patients who have missed multiple appointments and are at-risk for treatment non-compliance. Target: 50% of patients with multiple missed appointments re-engage in care as evidenced by appointment attendance in the EC.

Results
EC has assisted over 250 at-risk patients with attending appointments leading to improved treatment compliance

67% decrease in the number of at-risk patients who are non-compliant with appointment attendance as a result of the EC care team interventions.

Cumulative data from 1/23/17 through 2/28/18 for the EC demonstrates a 71% show rate in the EC. This number has exceeded our original goal of a 50% show rate.

Outcome Data
Since starting the EC, only 32 established at-risk patients have met criteria for dismissal for treatment non-compliance based on missed appointments. This is a 67% decrease in at-risk patients who are non-compliant with appointment attendance.

Case Report

Additionally, we have gathered data on patient perceptions about their experience in the EC to determine how to best meet patient needs. The data has shown that 87% of the patients seen in the EC report being “highly satisfied” with the care experience. All patients were surveyed and all items as “strongly agree” or “agree” on a five-point scale with a range of “strongly disagree” to “strongly agree”.

Case Report (Ctd)

Dana Martini
Outpatient Social Work Intern

Patient Perceptions of the EC

<table>
<thead>
<tr>
<th>Patient Perception</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>Felt Involved in Process</td>
<td>5.00/5.00</td>
</tr>
<tr>
<td>Felt Concerned about Heart</td>
<td>5.00/5.00</td>
</tr>
<tr>
<td>Helped with Resources to Attend Appointments</td>
<td>4.50/5.00</td>
</tr>
<tr>
<td>Satisfied with EC Services</td>
<td>4.25/5.00</td>
</tr>
</tbody>
</table>

| Percent of Patients Giving “Strongly Agree” Rating | 87%
| Percent of Patients Giving “Agree” Rating | 13%

Engagement Clinic Patient Identification
1. Patient is flagged in scheduling system as having been a no show for two or more appointments in a 12-month period.
2. Patients are contacted after missed appointments. If patient answers, the EC model is explained and the patient is scheduled with an EC appointment. If patient does not respond to that offer, the appointment is transferred to the refill or appointment access/outreach specialist explains EC model to patient and schedules EC appointment.
3. Patient is reminded of appointment starting one week prior to appointment date via text. Patients also receive a reminder phone call from our team the day before the EC appointment.

Engagement Clinic Workflow
1. The patient meets with nurse and psychiatrist to evaluate clinical needs and develop the treatment plan.
2. The clinical team discusses treatment plan and possible barriers to appointment attendance with social work intern and access/outreach specialist.
3. Patient meets with social work intern and access/outreach specialist to discuss barriers to appointment attendance and plan how to address barriers.
4. Patients are provided a pocket calendar to help them track appointments.
5. Patients are provided pill boxes to assist with adherence to medication.
6. Social work intern and/or access/outreach specialist follow up with patient telephonically following appointment to assist with implementing plan to address barriers to appointment attendance.
7. Call back protocol completed with EC patients to provide increased support (in process of being implemented).

Discussion

There were no additional costs in implementing the EC as we re-allocated existing OMS resources to create the EC. However, the increase in treatment compliance has likely led to reduced emergency department visits and hospitalizations resulting in both cost savings and improved patient outcomes. Recently implemented 2018 PDSA efforts will focus on tracking hospital readmissions data for patients and evaluating what we can do to provide additional support to prevent psychiatric readmissions.

The OMS clinic has recently started offering virtual psychiatric medication management visits to patients. We will be evaluating if this could be another option for engaging patients at risk for missed appointments leading to treatment non-compliance. Also being explored is replicating the EC at other outpatient behavioral health clinics due to the success thus far in assisting OMS at-risk patients.

Our Team

Anne Richardson
Medical Director, Behavioral Health Charlotte
Rachel Rebich
Senior Vice President, Behavioral Health Services

Contact Info
Anne.Richardson@atriumhealth.org
Rachel.Rebich@atriumhealth.org

Acknowledgements
Thank you to the following individuals:
Martha Whitecotton, MSN, FACHE – Senior Vice President, Behavioral Health Services ● Wayne Sparks, MD—Senior Medical Director, Behavioral Health Services ● Victor Armstrong, MSW – Vice President, Behavioral Health Charlotte ● James Rachal, MD—Medical Director, Behavioral Health Charlotte ● Eva McNell, MBA—Assistant Vice President of Outpatient Services