


# The Empty Chair Appointment

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## Abstract

The objective was to test an intervention to reduce failed rates for psychiatric appointments. We collected data for this study of the characteristics of patients who missed appointments from March 2011 through September 2012. A phone triage assessment intervention was implemented to address chronic first-time failed attendance appointments ( $N = 78$ ). The main reason for failed appointments was transportation difficulties. The first-time appointment show rate increased after implementing an assessment intervention. Phone assessment intervention was practical and may improve nonattendance for psychiatric appointments. The discussion reflects speculations about causes and possible measures to make services more accessible.

## Keywords

psychiatry, behavioral sciences, social work, social sciences, environmental management, social issues in management, management, sociology of mental health, sociology of health and illness, sociology, business communication, organizational communication, human communication, communication studies, communication

## Introduction

A perennial problem at university psychiatry clinics has been high failure-to-show patients, often without notification. As far back as 1963, a study at University of California, Los Angeles found a 66% failed appointment rate at university outpatient psychiatry clinics (Adler, Goin, & Yamamoto, 1963). Nonattendance rates vary but are reported between 12% and 60% in outpatient psychiatric clinics, and the rate of failures to show for initial appointment in psychiatric clinics is twice that of most other specialties (Mitchell & Selmes, 2007a).

Sparr, Moffitt, and Ward (1993) found that one puzzling factor was that 79% of the patients still suffered from the presenting complaint after their no-show appointment. In addition, patients who failed to keep first-time psychiatric appointments suffered consequences such as more frequent hospital emergency room visits and hospitalizations (Cheng, Huang, Tsang, & Lin, 2014). Missed patient appointments at university psychiatry clinics have been a major source of financial concern given the wasted time of faculty and resources (Peters & Bayer, 1999). There has been a plethora of recent studies that recommend ways to increase appointment attendance (Basem & Alapont, 1993; Cruz et al., 2013; Killaspy, Banerjee, King, & Lloyd, 2000; Lister & Scott, 1988; McNeil, Gormley, & Binder, 2013; Mitchell & Selmes, 2007a, 2007b; Murphy, Mansell, & Craven, 2014; Paige & Mansell, 2013; Paolilio & Moore, 1984; Peters & Bayer, 1999; Shoffner, Staudt, Marcus, & Kapp, 2007; Sims, Sanghara, Hayes, Wandiembe, & Finch, 2012; Sparr et al.,

1993; Stein et al., 2014). We hypothesized that a better scheduling alliance would be associated with higher treatment adherence for first-time patient appointments.

## Background

Missed first-appointment factors include male sex, younger age, low socioeconomic status (SES), comorbid substance abuse disorders, poor family support, poor adherence to psychotropic drugs, lack of or limited health care insurance, poor social functioning, unemployment, longer periods from contact to appointment, higher numbers of previous hospital admissions, and shorter hospital stays (Cheng et al., 2014; Stein et al., 2014). Additional administrative barriers known to affect failed appointment rates included distance traveled to the clinic, hours offered for the appointment, transportation difficulties, cost, appropriateness of service (e.g., matched for the acuity or chronicity of the patient), language or cultural barriers, and biases held by patients (Basem & Alapont, 1993; Cheng et al., 2014; Cruz et al., 2013; Sims et al., 2012; Stein et al., 2014).

Paige and Mansell (2013) suggested that patient perceptions, attitudes, beliefs, and internal and external locus of control toward mental health are all obstacles that can hinder

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How can we help and what type of help are you seeking?  
 How long have you struggled with this problem?  
 What are your symptoms? Are they overwhelming?  
 Do you have major health problems? Are they managed successfully?  
 Have you ever had problems with alcohol or drugs? Are you attending a support group?  
 Are you having problems of self-harm? If so, how are you coping with this?  
 Have you seen another clinic or doctor regarding this problem? Was this successful?  
 What medications are you prescribed? Are these medications helpful?  
 Have you ever been hospitalized? What was the nature of the hospitalization?  
 What was your diagnosis? Has this been an ongoing battle?  
 What type of support (family, friends, and neighbors) do you have?  
 Do you have reliable transportation?  
 What was the original incident leading to your seeking help?  
 Was this call for an appointment your choice or suggested by others?

**Figure 1.** Phone assessment questions.

seeking services. As appointments draw near, individuals weigh possible benefits against negative concerns becoming fearful of sharing their difficulties (Murphy et al., 2014). Several authors have cited certain clinic attributes such as reminder phone calls and reminder texts that play a part in improving attendance rates of psychiatric clinics (Paige & Mansell, 2013; Shoffner et al., 2007).

In response to an alarming 60% failed appointment rate (no-shows or late cancellations) at a university psychiatric clinic in the Midsouth, a patient-centered scheduling intervention was undertaken to reduce the higher than expected failed appointment rate. This study reports the results of the intervention.

## Method

### Information Collected

The university psychiatry department clinics schedule 10,045 outpatient visits (both initial and returning appointments) per year, with an average of 250 monthly inquiries for service. Six faculty and 11 residents were assigned to see patients in this setting. Clinics were organized into resident clinics (underinsured) and faculty clinics (full pay), a structure that had the effect of segregating patients by ability to pay and limited access of poorly insured patients to specialties in the clinics. The project was divided into two phases. Phase 1 analyzed existing data on patient registration, visit information, demographics, and physician assignments that were available in the General Electric IDX software used by the department. Data from November 2010 through November 2011 were obtained.

### Institutional Review Board Approval

Institutional review board approval was granted to review patient charts. Available information included wait time for an appointment, latency from initial contact until the first visit, age, gender, marital status, and insurance type (which was used as a proxy for SES). Race was not available in the registration information.

For 3 months during 2012, a second phase included contact by the receptionist of any patient who missed a first-time appointment to identify the reason(s) for the missed appointment. After the initial institutional review board approval in March 2010, a second approval was gained to contact patients regarding reasons for their failed initial appointments during 3 months in 2012 and to collect pre- and post-intervention data for 2012 and 2013. No identifying patient information was documented.

### Intervention

The patient-centered scheduling intervention protocols consisted of the following: a shortened period between the inquiry and the first visit, having a licensed clinical social worker conduct a phone assessment, and seeing all potential resident clinic patients within 1 week of an inquiry. If patients were assessed suitable for an outpatient university clinic but an appointment was not available within 1 week, they were placed on a waiting list and called 2 weeks before an available appointment time to see if they were still interested. The social worker assessed suitability and motivation for psychotherapy and ability to keep appointments (e.g., reliable transportation, short distance from the clinic). Callers who were deemed too acute for outpatient treatment were referred to a more appropriate treatment venue by the social worker. A clinic failed appointment policy was discussed at the first session for all patients accepted for treatment that designated the consequences of missing an appointment.

The clinic social worker triaged phone calls and scheduled a psychosocial assessment first before a potential psychiatric assessment. The goals of the phone assessment were to (a) allow potential patients to assert their ability to engage in the scheduling process (internal locus of control) by giving them a voice in treatment options, (b) focus on positive communication and encourage inquirers to disclose their concerns, thereby conveying a sense of partnership with treatment decision making, (c) assess motivation and treatment needs, and (d) highlight the benefits of services offered and address fears and concerns about treatment. The telephone assessment content (Figure 1) focused on approach-avoidance factors, locus of control dynamics (e.g., "I am calling for an appointment" vs. "my spouse wanted me to call"), psychological motivation, accessible and reliable transportation, and desire and willingness for services. The patient-scheduling telephone assessment took 20 to 30 min. Of the initial telephone inquiries, 68% were contacted for a telephone assessment.

**Table 1.** Percentage of Reasons for Initial Failed Appointments for 3 Months, 2012.

Reason	<i>n</i>	%
Patient recording error (wrong date or time, wrong location)	29	37
Transportation failure	24	30
Patient forgetting	22	28
Decreased desirability	3	4
Hospitalized for medical reasons	1	1
Total	79	100

### Statistical Analysis

Statistical analysis was conducted using SPSS 7.0 Mann-Whitney tests to investigate the differences between first-appointment attendees and non-attenders. The *p* value for statistical significance was set at .05.

## Results

### Initial Phase: Chart Analysis

Initially, we found that Medicare geriatric patients kept their returning scheduled appointments during the chart review for 2011 and 2012 (*n* = 2,411, 92.2%) at a higher rate than did younger, disabled Medicare and Medicaid patients (*n* = 5,980, 79.2%). Failed returning appointments due to bumps (clinician-cancelled appointments) were more than twice as likely to occur with residents and interns than with faculty. Elderly patients over the age of 65 had half the failed appointment rate of any other patient group. No-shows were relatively rare in all groups but were still higher in the low-SES population covered by Medicaid. There was no difference in no-show rates of males and females.

### Reasons for Failed Initial Appointments

The initial data analysis prompted assessing reasons for failed first-time appointments for the psychiatric residents who saw the majority of younger, disabled Medicare patients. This initial finding matched other studies citing lower SES as a factor with missed psychiatry appointments (Cheng et al., 2014; Mitchell & Selmes, 2007a; Paige & Mansell, 2013; Stein et al., 2014). For 3 months during 2012, patients were contacted to ask their reasons for missing initial appointments. The reasons were precoded into five categories (Table 1): patient recording error, transportation failure, patient forgetting, decreased desirability, and hospitalization.

### Intervention Results

As a result of the failed appointment data, we implemented a patient-centered scheduling intervention to assess patients who were more willing to keep their scheduled appointments.

**Table 2.** 2012-2013 First-Time Post Intervention Kept Appointments by Insurance Type Versus 2011 Versus 2012 Pre-Intervention Data.

Insurance type	Appointment record	Appointment record	Total
	Kept %	Failed %	<i>n</i>
Medicare disabled < 65	69	31	61
Medicaid	66	34	114
Medicare > 65	77	24	31
Private insurance	68	33	22
2012-2013 totals post intervention	69	31	228
2011-2012 totals pre-intervention	40	60	119

Pre-intervention data based on the previous scheduling protocol were collected for 10 months in 2011-2012, and post-intervention data based on patient-centered scheduling were collected for the same period in 2012-2013 to assess first-time failed versus first-time kept appointments. The kept-appointment rate prior to our intervention was 40% (48 of 119). The post-intervention period kept-appointment rate was 69% (158 of 228). As we hypothesized, patient attendance was significantly higher post intervention (*p* < .05). The failed appointment intervention showed promising results with the show rate for first-time appointments improving from 40% to 69%. The post-intervention data for first-time appointments included elderly Medicare patients who kept their appointments at a higher rate than younger patients (Table 2). Females (70%) had only a slightly higher rate for kept appointments than did males (67%).

## Discussion

### Reasons for Nonattendance

Prior to the study's intervention, the department handled initial appointments by scheduling every call regardless of reasons for seeking services, the degree of chronicity of symptoms described, and the length of time before the appointment (some appointments were scheduled months after the call date). No mention about the importance of keeping the appointment was made, and no policy was in place to address the numerous no-shows.

Patient-centered scheduling addressed the quality of a working alliance between the clinic scheduler and the person seeking services. This process included forming a consistent relationship and shared responsibility with potential patient populations and increasing the treatment goal of first-time appointment attendance (McNeil et al., 2013). Specific changes included providing a shortened waiting time from contact to first appointment, making a phone assessment, scheduling patients discharged from the hospital for an

outpatient appointment within 5 days, training the scheduler to be respectful and responsive to individual preferences, assessing by phone the needs and values of potential patients, making phone reminders within 48 hr of the appointment time, returning inquiry phone calls within 24 hr, mailing appointment cards, offering flexible appointment hours with clinic information and map directions, and requiring referrals originate from a physician.

Patient recording error (37%) and patient forgetting (20%) highlight the importance of reminder interventions. Reminder phone calls, mailed appointment cards and directions, scheduling within a shorter time frame, and understanding the obstacles patients face are critical and are consistent with previous findings (Cruz et al., 2013; Shoffner et al., 2007; Stein et al., 2014). Surprisingly, 32% of the no-shows could not be reached by phone. Addressing registration contact information, primary phone numbers, and secondary phone numbers should ensure viable phone contacts when needed.

Another frequent reason for no-shows was a lack of motivation for treatment. The two common lack of motivation factors were experiencing poor service at clinics in the past or having another person besides the patient schedule the appointment when it was not wanted. The intervention highlighted the need for individualized interventions. Administrative barriers such as poor clinic procedures, unhelpful staff, and long intervals before being given an appointment should be a focus of attention, because a possible source of failed appointments reflects a lack of patient-centered scheduling protocols (Cruz et al., 2013; McNeil et al., 2013; Mitchell & Selmes, 2007b; Paige & Mansell, 2013).

### Provider Bias

The relatively high rate of bumps (provider cancellations) was a unique and unexpected finding. It accounted for 5% to 10% of failed appointments. No provider is free of personal illness or emergencies that may necessitate canceling appointments, but these reasons are usually minimal. It is important to look for a widespread problem that may represent reverse bias against the poor, a problem in professionalism of residents and interns, or an individual outlier who skews the group totals. The number of frequent bumped appointments led to patient frustration with the system and created the need for the resident providers to learn the importance of scheduling and to develop reliable schedules, significant factors, and the bases for initiating patient-centered scheduling (Cruz et al., 2013; McNeil et al., 2013).

### Appointment Barriers

When dealing with high-acuity populations (sudden onset of psychiatric symptoms) with limited resources, high cancellation rates may be expected for reasons ranging from child care and work conflicts for younger patients to hospitalization

or medical illness for the elderly, as well as other barriers to care such as not having transportation. SES remains a significant impediment to traditional care. Stein et al. (2014) highlighted the need to assess all factors including lower SES as a barrier to treatment. High acuity combined with psychological difficulties and limited resources can create a daily barrier, which manifests itself in different ways for these potential patients (McNeil et al., 2013). Our patient-centered scheduling intervention demonstrated results that other authors reported: If clients have scheduling obstacles but are motivated, they are still able to keep their scheduled appointments (Paige & Mansell, 2013).

Lack of culturally competent care must also be considered as a cause for failed appointments. Cultural issues exist for all groups. Cultural subgroups include gender, social class, sexual orientation, and age (generational differences) and are not restricted to simply racial or ethnic groups. An evolving definition of cultural competence captured in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) emphasizes the patient's definition of the problem, perceptions of cause, context and support, factors that affect self-coping, past and current help seeking, and treatment preferences (Sakauye, 2012). We found that patients often may not comply with treatment because they do not agree with the formulation or plan of care. Sensitivity to this aspect of care by the resident provider may also help improve failed appointment rates.

### Conclusion

Initial improvements were promising, but further changes may include more intensive interventions to provide even better outcomes. The high rates of failed appointments, especially in lower socioeconomic groups, have been an unsolved problem for decades (Adler et al., 1963; Shoffner et al., 2007; Sims et al., 2012; Stein et al., 2014). To improve compliance, administrative procedures must be reviewed to remove barriers to access and to ensure that appropriate professionalism is displayed by all staff. As in other studies, our initial findings reflected a system's problem and not a lack of interest by the patient that accounted for low attendance (Cruz et al., 2013; McNeil et al., 2013; Paige & Mansell, 2013).

Prior to our intervention, scheduling occurred as a convenience to the practitioners rather than to potential patients. Implications of the study included the following factors. Culturally competent care must be provided, as defined by not undervaluing situational explanations for observed behaviors and by trying to find solutions for them, as well as understanding the patients' causal beliefs and treatment preferences. Paige and Mansell (2013) reported the importance of addressing the approach-avoidance dynamic. Dissatisfaction with treatment and feeling mistreated may reflect not understanding patients' expectations and needs from their perspective and are indirectly manifested in failed appointments. Recommendations include programs regularly monitoring



and trying to analyze unique causes for high-failed appointment rates with the collaboration efforts across medical specialties and disciplines.

This study had a few limitations including that the study was based in one university clinic and included a limited number of psychiatry residents and faculty members. The location and sample size limit the generalizability of the findings. Nonetheless, the study's results demonstrate significant findings. Future research might explore missed mental health appointments across professions, rural areas versus urban settings, differences with patient diagnosis, and rewards for keeping first-time appointments.

### Declaration of Conflicting Interests

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