Improving Primary Care Engagement of Clients in an Outpatient Behavioral Health Center

Mariel Otter, BSN, RN (Mariel.otter@umaryland.edu)
Katherine Fornili, DNP, MPH, CARN, FIAAN (fornili@umaryland.edu)

Problem

- People with a serious mental illness (SMI) suffer a 10-25 year reduction in life expectancy as compared to the general population.
- Chronic, preventable health conditions are the leading cause of death for this population.
- To improve primary care disparities, the behavioral health outpatient clinic (BHOC) at a small community hospital routinely makes primary care provider appointments and referrals for all clients.
- **No process existed to determine actual engagement/follow-up with primary care resources for referred clients.**
- Procedures for the assessment, treatment planning, referral, and tracking of referred clientele to PCP resources were implemented to overcome barriers to PCP access and improve PC utilization.

Purpose

Short-Term Goals

- 90% of BHOC patients will be assessed for PCP status & access.
- 90% of patients assessed with a need will be provided with a PCP and/or referral appointment.

Mid-term Goals

- 70% of BH clients requiring a primary care (PC) appointment during the primary care needs assessment will be given a documented PC visit appointment.
- Care Coordinators will request and receive PCP records for 80% of BH patients with a PC visit.

Long-Term Goals

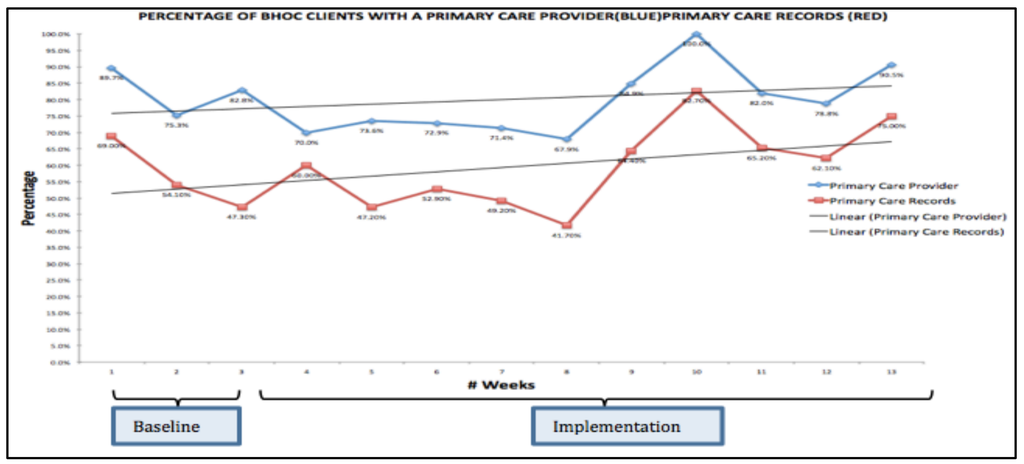
- Improve primary care engagement and access
- Decrease premature mortality rates among the behavioral health population
- Improve health outcomes and chronic disease management
- Improve patient satisfaction with quality of care

Methods

- A primary care needs assessment for BHOC clients was implemented over 13 weeks, following an appraisal of the level & quality of the evidence, using the Seven Steps of Evidence-Based Practice Model (Melnyk & Fineout-Overholt, 2011) and the Mobilize, Assess, Plan, Implement & Track (MAP-IT) Framework.
- Baseline data for primary care provider (PCP) and primary care records (PCR) were collected by daily chart review for scheduled patients (Weeks 1-3).
- During Implementation (Weeks 4-13), the Care Coordinator implemented a primary care utilization tracking protocol for all patients **(n=552),** which included:
  1) Assessing current PCP and need for PCP appointment;
  2) Providing needed PCP appointments;
  3) Tracking PCP appointment attendance; and
  4) Requesting and tracking receipt of PCR.
- During Implementation, the Care Coordinator tracked data at each visit using an Excel spreadsheet (referrals made, appointments kept, dates PCR were requested/received).

Results

- **452 clients (81%)** were **assessed for having a PCP.** Of these, **414 (92%) had a PCP** at time of assessment.
- **339 clients (62%)** were **assessed for needing a PCP appointment.**
  - **Of these, 281 (83%) required no appointment** because of past 30 day appointment with the PCP or not indicated yet per PCR; and
  - **24 (4%) needed an appointment.** Of these, 22 were given an appointment (92%), and PCR were requested for 16 (67%).
- All requested records were received within 24 hours of request (100%)
- Patients with primary care records did not differ between baseline and implementation, X^2 (1, N=977) = 0.3599, p = .5485



Discussion & Limitations

- Many patients were referred to the BHOC by their PCP; the high percentage of BHOC clients with a PCP at baseline (92%) only allowed for minimal improvement during the Implementation period.
- Care Coordinators did not assess each client at each BH visit for PC appointment need until Week 10, after a misunderstanding about the protocol was corrected.
- Prior to Week 10, Care Coordinators only assessed clients with records on file from the past six (6) months.
- Clients typically have monthly BHOC visits; 21% of those who were given PC appointments did not return to BHOC during the Implementation period, and their data could not be tracked.

Conclusions

- The BHOC plans to continue tracking patient needs for a PCP, PC visits, & record requests.
- The Care Coordination staff have expressed interest in more closely targeting this intervention for patients with specific medical diagnoses, especially those prevalent among and relevant to persons with behavioral health needs, such as diabetes, hypertension, and obesity.
- Future quality improvement projects are needed for development of modified procedures for certain sub-groups of patients with medical co-morbidities.

References

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