*Example Process Improvement Projects*

# Decreasing Wait Times for Follow-Up Appointments

## Find a process to improve:

A clinic notices that they have had progressively longer wait times for follow-up appointments in their schedules, which is generating patient complaints. This situation is also a source of low morale within the clinic as providers want to be able to see patients within a reasonable timeframe for follow-up.

## Organize a Team that knows the process:

The following clinic personnel were recruited to serve on this Process Improvement (PI) project team:

- Clinic manager
- Departmental PI coordinator
- Several clinic providers
- Front desk staff (booking)

## Clarify the current process:

The team examined potential reasons for longer wait times for follow-up appointments using guidance on how to create clinic level reports in excel based on data from the EMR, as well as discussions with clinic providers and appointment booking staff. This revealed that:

- New intakes have been fairly steady with a slight trend up over the past several months. However, this slight uptick in intakes was not deemed to be a key cause of the increased wait times.
- EBPs for key conditions such as PTSD and depression are not often used and there are no EBP groups being offered. This was thought to lead to a larger overall number of sessions being needed to treat these common conditions.
- The clinic has a very high number of patients who have been in therapy for more than 20 sessions.
    - The diagnoses in this high utilizer group varied; however, the majority had either PTSD, depression, or some vague diagnosis (other unspecified conditions). A small percentage of these cases had some type of severe or persistent condition such as bipolar disorder.
    - While all providers have at least a few such cases, most of these cases are concentrated within a fairly small number of clinic providers. Discussion with the appointment booking staff revealed that a good portion of the clinic's providers were closed to new intakes due to having full patient caseloads.

## Uncover the root causes/Understand the issue:

The PI team employed several methods to understand the reason for long between-session wait times. Each method is described below:

- Discussions with providers, especially those who carry large numbers of long-term therapy cases: This was done in an informal manner with team members approaching providers to ask about caseloads, barriers to termination with patients, etc.
- Brainstorming session: The team white boarded potential contributing factors to the low use of EBPs and large numbers of long-term therapy cases. The team used the Fishbone Diagram form. This allowed the team to group the various factors from the brainstorming session into a cause-and-effect sequence.

After examining information from these tools, the team concluded that there were several key reasons to explain why so many patients were being seen in therapy for long periods of time. Each of these key reasons is listed below:

(A) Low visibility on symptom levels to anyone but the primary provider.

(B) Providers not terminating therapy past the point where individual therapy is therapeutically necessary. This was due to having vague treatment goals or failure to end care even after initial goals were met.

(C) Providers avoiding termination with sub-clinical cases in order to minimize openings in their panels.

(D) A lack of EBP groups for PTSD or depression.

## Select the improvement (establish the goal you want to accomplish):

Reduce the wait times for follow-up FTR appointments within the clinic.

## PLAN the improvement:

**Part 1 - Outline of planned improvements**

The team decided to address the identified problem using several improvements. Note that each improvement is tied back to one or more of the key issues identified as contributing to the problem.

Improvement #1: Started team-based treatment planning meetings for patients with more than 20 sessions with the goal of aligning level of care to level of patient need. These meetings happened once a month. The team used the 20/20 Treatment Team Review form from the Clinic Optimization Toolkit and patients were able to provide feedback by completing the Patient Input into Treatment Team Review form. *Addresses issues A, B, & C.*

Improvement #2: Started several new groups within the clinic, which included:

- CPT for PTSD to address unmet need for EBPs with this population. *Addresses issue D.*
- Shifted existing Depression group to be more CBT focused. *Addresses issue D.*
- Began two new process groups, giving providers a place to refer sub-clinical patients. *Addresses issues A, B, & C.*

**Part 2 - Data collection plan:**

The team looked at several measures of performance to determine if the interventions were being carried out and whether they had the desired impact. They looked at the baseline levels for each measure, and planned to re-assess every month for six months.

- Average wait time for an FTR appointment (in days)
  - Baseline was 22.6 days
- % of overall clinic caseload that have been seen for >20 appointments
  - Baseline was 21% of total clinic caseload
- # of providers with >10 long-term therapy cases
  - Baseline was 12 providers
- # of patients reviewed in the monthly treatment team meeting
  - This was just starting, and thus had no baseline date
- # of group therapy appointments
  - Baseline was 55 appointments per month for the clinic

## Do:

The clinic began carrying out monthly treatment team meetings focusing on those patients who had already reached more than 20 sessions. This was done following the 20/20 review model with the clinic manager and two or more providers meeting with the provider for each of the identified high utilizer cases.

Several new groups were started including CPT for PTSD and two process groups. The clinic provider who ran an interpersonal process group for depression did not want to change the focus of the group, so another provider was tapped to start a separate CBT for depression group.

## Check:

Six months after starting the planned interventions, the clinic reassessed progress on the measures, with the following results.

- Average wait time for an FTR appointment (in days)
    - Declined to 10.2 days
- % of overall clinic caseload that have been seen for >20 appointments
    - Declined to 12%
- # of providers with >10 long-term therapy cases
    - Declined to 4 providers
- # of patients reviewed in the monthly treatment team meeting
    - Clinic averaged 7.5 cases per meeting for a total of 45 cases reviewed
- # of group therapy appointments
    - Increased to 134 appointments per month for the clinic, with most gains coming from the new groups

## Act:

The project team concluded that the interventions were indeed effective in helping meet the clinics goal, as the wait times for FTR appointments decreased by half.

The treatment team meetings led to many sub-clinical patients being transferred to a more appropriate level of care. This process also led to an increased awareness of the need for time limited therapy models being the norm for the entire clinic.

Anecdotally, providers reported using more EBP therapies in individual treatment, which also likely contributed to faster recovery rates.

The team recommended that the treatment team process be continued, and that the clinic also continue the new groups that were started as part of this project.