Example: Improving Levels of Group Therapy Utilization

Find a process to improve:

Clinic staff and leadership believe that increasing the use of group therapy within their services would lead to substantial benefits for both patients and staff members; however, the clinic has had a very low level of group therapy utilization for the past two years. Past calls to action in starting and maintaining therapy groups have not led to changes in this aspect of the clinic's functioning.

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
- Group Coordinator (if role is present in the clinic)
- Several Clinic providers
- Behavioral Health Technicians
- Front desk staff (booking)

Clarify the current process:

The team looked at potential reasons for low use of group therapy within the clinic. This involved team discussions regarding possible contributing factors.

In addition to these discussions, the team reviewed data from the Clinic Analyzer Tool on the clinic's use of group therapy over the past 2 years. This revealed that only a small percentage of the total appointment volume of the clinic is group therapy.

Uncover the Root Causes/Understand the issue:

The PI team employed several methods to understand the reasons for low use of group therapy. Each method is described below:

- Seeking feedback: Several team members conducted informal discussions with other clinic providers regarding psychotherapy groups, asking about areas such as barriers to starting/ maintaining groups, the referral process for groups, and levels of patient acceptance of group therapy. This was conducted prior to the brainstorming session.
- Brainstorming session: The team white boarded potential factors that could be contributing to the low levels of group therapy usage. They used an affinity diagram to map out potential contributing factors and then grouped them under thematic headings.

After examining information gathered, the team concluded that there were several reasons for the low use of psychotherapy groups within the clinic. Each of these key reasons is listed below:

- (A) There is no standard referral process for the various groups, making it confusing for providers and front office staff to assist in getting patients signed up.

- (B) Many providers believe the groups offered by the clinic are not a good fit for their patients' needs. For example, the clinic offers an eating disorder group that is constantly struggling to find referrals due to the low base rate of eating disorder patients within the clinic.
- (C) Many providers think that starting and running groups is too much work for the RVU "payoff," so they avoid running them. The concerns largely centered on paperwork and scheduling tasks associated with groups.
- (D) Several providers noted that patients do not want to attend group due to negative perceptions of group therapy in general.

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

Increase the amount of group therapy available and the amount of group therapy utilization within the clinic.

Plan the improvement:

Part 1 - Outline of planned improvements

The team decided to address the identified problems using several improvements. Note that each improvement is tied back to one or more of the identified key issues (A-D) thought to be contributing to the problem.

Improvement #1: Implement a streamlined group therapy referral system. This involves classifying groups based on type, with EBP and psychoeducational groups allowing sign-up at the front desk, while interpersonal/process groups still require a discussion with the group's owner. The team utilized the Group Therapy Referral Sheet and SOP to Establish EBP Group Procedures from the Clinic Optimization toolkit. *Addresses issue A.*

Improvement #2: Restructure the clinic's group offerings to better fit the needs of the patient population. The team looked at data from the Clinic Gap Analysis PI project conducted earlier this year to get a sense of what groups are needed. Changes they initiated included:

- Stood up two CBT for depression groups
- Planned to add another Cognitive Processing Therapy group once referrals increase
- Started two psychoeducational groups: 1) stress management, and 2) improving sleep

Addresses issue B.

Improvement #3: Leverage behavioral health technicians to provide clinic and administrative support to the clinic's group therapy program. This will alleviate some of the workload that reportedly makes providers reluctant to maintain these groups. BHTs were asked to assist with:

- Handle booking/scheduling for all groups, including call backs to patients who no-showed for group therapy appointments.
- Attend the group, provide patient tracking/initial note drafting for patients in EBP groups.

- Run (under the supervision of a licensed independent provider) the stress and improving sleep groups.
- Maintain a stock of EBP related materials at the front desk (ABC sheets, group handouts, patient booklets and brochures)

Addresses issue C.

Improvement #4: Create a culture within the clinic where group therapy is an expectation for nearly all patients. This will be accomplished by:

- Leadership support in staff meetings and during treatment team reviews, ensuring that patients are being referred to appropriate groups.
- Modify clinic marketing materials to reflect that group therapy is a primary form of treatment within the clinic. These materials should include information on outcomes whenever possible (e.g., "After 8 weeks of CBT for depression group, the average patient saw a decrease of 48% on their depression scores"). (See Toolkit for sample flyers for EBP groups.)

Addresses issue D.

Part 2-Data collection plan

The team considered several potential measures of performance to determine if the interventions would have the desired impact. They looked at the baseline levels for each measure and planned to re-assess every month for six months.

- % of overall clinic appointments that are group therapy
    - Baseline was 11.2% of total clinic caseload (average amount/month over past 12 months)
- # of group therapy appointments (total kept, including walk-ins)
    - Baseline was 68 appointments per month for the clinic (average amount/month over past 12 months)
- # of patients signed up to groups using the new referral system
    - This was just starting and thus had no baseline date

Do:

The clinic implemented the planned improvements starting in July, with two new depression groups starting right away, and group referrals being logged into a binder at the front desk. Behavioral health technicians began sitting in on existing EBP groups, and also began the two psychoeducational groups. BHTs used forms from the Clinic Optimization toolkit to track attendance and participation for EBP group members, as well as to draft group therapy notes.

After two months, there were enough referrals to start up a second CPT group for PTSD.

Check:

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

- % of overall clinic appointments that are group therapy:
    - At the end of six months, the % of group therapy appointments had increased to 29.4%
- # of group therapy appointments (total kept, including walk-ins):
    - The number of group appointments rose steadily over the six months, finishing at 195 for the month of December.
- # of patients signed up to groups using the new referral system:
    - The number of patients signed up for group also increased steadily during the six months. The clinic needed to start a waiting list for several groups which were already filled so that patients could be added into the next iteration.

Although it was an adjustment for BHTs to be more involved in supporting EBP groups, the majority of techs noted greater job satisfaction, especially regarding running psychoeducational groups. Splitting BHT time between booking appointments and supporting group therapy posed a challenge and needs to be further examined.

Another challenge identified was that the inclusion and exclusion criteria for certain groups was occasionally ignored. This led to some confusion during the first few months of this project.

Act:

The team determined that the interventions were successful in increasing the amount of group therapy used in the clinic.

The clinic noted the challenge of BHTs being split between administrative and clinical duties and submitted a request for another non-BHT medic to support the clinic.

The team recommended that treatment team meetings continue to emphasize the use of group therapy as a modality, and recommended that clinic continue to monitor the referral process to ensure that inclusion and exclusion criteria are followed.