

IMPROVING ENROLLMENT IN GROUP THERAPY

Improving Enrollment in Outpatient Group Therapy at a Federally Qualified Health Center:

A Quality Improvement Project

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Abstract

Background: An increase in demand for psychotherapy and a mental health provider shortage have created limited access to psychotherapy services. Group therapy is an evidence-based psychotherapy modality that improves access to psychotherapy but is often underutilized.

Local Problem: An FQHC in Battle Creek, Michigan attempted to initiate a group therapy program to improve access to psychotherapy and provide the benefits of group therapy. The program was unsuccessful due to low enrollment.

Methods: This evidence-based quality improvement project aims to increase enrollment in a group therapy program at an FQHC by structuring the enrollment process using evidence synthesized in a literature review. The enrollment process was implemented using the Plan-Do-Study-Act framework. The outcomes were evaluated based on the referrals received, the number of patients enrolled in group therapy, and patient feedback during the enrollment process.

Interventions: Implementation of a structured enrollment process included written education for referring providers, educational flyers for patients, referral screening, verbal education for patients, and pre-screening/pre-training sessions provided by a therapist.

Results: Enrollment in group therapy increased by 50% and was maintained throughout the sessions, sustaining the program. With the implementation of the interventions, the enrollment rate of patients meeting minimum criteria increased from 8% to about 21%.

Conclusions: A structured group therapy enrollment process that increases appropriate referrals, addresses attitudes towards group therapy, ensures appropriate patient selection, and provides pre-screening/pre-training sessions may improve enrollment in group therapy.

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Improving Enrollment in Outpatient Group Therapy at a Federally Qualified Health Center: A Quality Improvement Project

This project discusses the impact of the mental health provider shortage on psychotherapy services at a local Federally Qualified Health Center (FQHC) and the steps taken to improve access to care through implementation of a group therapy program. Over the last few years, there has been an increasing need for psychotherapy services nationwide compounded with a shortage of mental health resources. The United States Department of Health and Human Services (2023) declared a nationwide mental health crisis. Beginning in 2020, 55% of adults with mental illnesses and 60% of children with depression were not able to receive mental health treatment (Reinert, Fritze, & Nguyen, 2022). According to The Commonwealth Fund, the mental health provider shortage affects 160 million Americans and would require at least 8,000 more mental health providers to meet this demand (Counts, 2023). The lack of treatment due to scarce mental health services increases patients' risks for poor outcomes and mortality (McLaughlin, 2004). During this shortage, disadvantaged and vulnerable populations are disproportionately affected with less access to care (Counts, 2023). This crisis challenges healthcare providers to find efficient solutions and stretch mental health resources to meet the demand and protect those most vulnerable. Group therapy is an evidence-based and effective treatment for mental health conditions that can be utilized to improve access to psychotherapy and stretch mental health resources (Pappas, 2023).

Problem Description

To address issues of lack of access to psychotherapy, an FQHC offered 100 patients with anxiety and/or depression the opportunity to join a six-week long psychoeducation-based therapy group starting in January 2023. Patient selection for group therapy was based solely on existing

referral for individual psychotherapy and a diagnosis of depression and/or anxiety. Enrollment into group therapy was offered over a phone call from the behavioral health referral specialist. The FQHC did not provide education or orientation of the group therapy program to the patients. For the two groups initiated, eight patients (out of the 100 contacted) accepted enrollment, six attended the first session (three patients to each group), and only two attended the second session (one patient to each group). In March of 2023, the group therapy program was suspended due to low enrollment, and the psychotherapy referral list continued to exceed capacity while patients experienced a delay in treatment.

Consistent with national trends, this Federally Qualified Health Center (FQHC) in Southwest Michigan has experienced an overwhelming demand for mental health treatment with a shortage of resources and providers. In the first half of 2023, only 208 of the 1,641 patients referred to behavioral health services at the FQHC were established with psychotherapy. This FQHC maintained a waitlist for psychotherapy with at least 100 referrals at any given time. There was an 8-week waiting period for individual psychotherapy services, which was two weeks (or 33.3%) longer than the national average wait of 6-weeks (Chamlou, 2022).

Research supports weekly appointments, especially when first starting out in therapy, as less frequent appointments are associated with worse outcomes and more chronicity of symptoms (Tiemens, Kloos, Spijker, Ingenhoven, Kampman, & Hendriks, 2019). The caseload at this FQHC made it impossible for therapists to meet patients individually at the recommended weekly interval for sessions. The average caseload for a therapist at this FQHC was approximately 100 patients, much higher than the average case load of 25 to 40 patients (APA, 2022). Due to limited therapist availability from the heavy caseloads, patients were only able to follow-up as frequently as biweekly or even monthly. While the simple solution was to hire more

therapists to meet the demands of the community, it was not possible due to the provider shortage.

Implementing a group therapy program was an evidenced-based solution to meeting the demand while providing patients with high-quality, proven means of mental health treatment. Despite the evidence supporting this program, the initial implementation failed due to organizational, employee, and patient factors. These organizational factors included a lack of program coordination and advertising, as well as a lack of structure in the group enrollment and patient selection process. Employee factors at this organization included a lack of education about group therapy, particularly for the behavioral health referral specialist who plays a key role in connecting patients with group therapy. Lastly, patient factors included a lack of patient knowledge about group therapy and a preference for individual therapy.

Environmental Context

This quality improvement project was implemented at an FQHC in Battle Creek, Michigan. Battle Creek is the 3rd largest city in Michigan by area with a population of 52,123 residents and is the urban center of rural Calhoun County in Southwest Michigan which has a county population of 133,289 residents (United States Census Bureau, 2022). The FQHC was originally established as a women's health clinic in 1986, became a community health center in 1992, and was rebranded in 2015 (Grace Health, 2016). In concordance with the purpose of an FQHC, the organization's mission is "to provide patient-centered healthcare with excellence in quality, service, and access" (Grace Health, 2021). This FQHC has the noble vision to achieve "a community in which all people achieve their full potential for health and well-being across the lifespan," and all staff are "trusted by patients, a valued partner in the community, and creators of positive change" (Grace Health, 2021). The health center serves over 27,000 patients, or about

20% of Calhoun County's total population, including 50% of its Medicaid population and 30% of uninsured residents (Grace Health, 2022; National Health Care for the Homeless Council, 2023).

The FQHC pursues its mission by offering a variety of services to meet the needs of the community including primary care across the lifespan, obstetrics and gynecology care, behavioral health care, physical therapy, optometry, dental services, pharmacy services, and resource connections. The vision of this FQHC aims to: "care for the whole person, see the complexity of each person's life, and believe that addressing a broad range of human needs is the best way to improve a person's health" as well as to "continuously examine the services we provide and what is needed in the community," and, "look for cracks in the health care system, fill those, and move to fill new ones" (Grace Health, 2021). This FQHC is committed to filling gaps in care to better serve the community's needs.

The behavioral health services at this FQHC include psychotherapy, medication management, and collaborative care. Patients are connected to these behavioral health services through referral, either from their primary care provider or self. The organization employs 10 therapists: two licensed psychologists, one licensed professional counselor, one limited licensed professional counselor, two licensed medical social workers, and four limited licensed medical social workers. Psychiatric medication management is provided by primary care providers, a consulting psychiatrist for collaborative care, and a part-time telehealth psychiatrist. Only one other facility, a Community Mental Health Center, provides comprehensive behavioral health services to the underserved population in this area. However, the community's behavioral health needs still surpass the available resources from this FQHC and Community Mental Health

Center. Fortunately, this FQHC is committed to expanding its behavioral health services to meet the demands of the community (see Appendix A).

SWOT Analysis

To evaluate the strengths and weaknesses of this FQHC as an organization and their potential to establish a successful group therapy program, a SWOT Analysis was completed (see Table 1). A SWOT Analysis is an evidence-based strategy for analyzing the strengths, weaknesses, opportunities, and threats inside and outside of an organization that may affect the organization's goals (AHRQ, n.d.). Completing a SWOT Analysis allows project planners to anticipate challenges and develop solutions prior to implementing changes (AHRQ, n.d.). Below is a discussion of the SWOT Analysis completed for this FQHC.

Strengths.

This FQHC had successful experience in developing innovative programs to meet the needs of the community. The employees at this facility were highly skilled and accustomed to adapting workflow to accommodate these types of programs and the immediate needs of patients. This FQHC also pursued grant funding, insurance and federal reimbursement to obtain resources for new programs, and had designated resources reserved for the behavioral health department and its growth.

Weaknesses.

Potential weaknesses at this FQHC included staffing shortages that contribute to time constraints and burn-out that may impede employee buy-in to the group therapy program. A key weakness is that the behavioral health referral specialist had not received formal training or education in behavioral health and could not assess the needs of or provide guidance to referred

patients for treatment resources. Also, many of the behavioral health providers at the FQHC lacked prior experience developing and offering group therapy programs.

Opportunities.

Increased federal funding, based on quality and access to underserved populations, and the availability of grants offered the financial opportunity to implement a group therapy program. The growing demand by the community for psychotherapy services along with increased cultural acceptance for mental health treatment created an atmosphere conducive to the implementation of innovative mental health treatment.

Threats.

Potential threats for this FQHC included competition from the local community mental health center (CMHC); however, the CMHC had partnered with this FQHC to support the expansion of services to meet the overwhelming demand for mental health care. Another threat to this program at this FQHC was the patient's preference for individual psychotherapy, and their choice to decline group therapy and seek services elsewhere or remain on the waitlist. Lastly, there is limited funding for FQHCs due to the lower rate of Medicare/Medicaid reimbursement. Since this is the primary income source for this facility, sustaining new programs can be difficult due to cost.

Available Knowledge

Since the pandemic, there has been a significant increase in demand for mental health services contributing to the lack of access for these services (APA, 2021). This increase in demand has resulted in lengthy waitlists and delays in care (APA, 2021). Not only does delay in treatment for mental illnesses increase risk for co-morbidity, but it also leads to worse outcomes and higher rates of mortality (McLaughlin, 2004). While many mental health providers report

increasing their workload beyond recommended capacity, the demand for mental health care continues to exceed the available resources, and the increased workloads have resulted in burnout among mental health professionals (APA, 2021).

A shortage of mental health workers has impacted the issue. While legislators are taking steps to supply education assistance and incentives to increase the behavioral health workforce, it does not help the current situation as it takes a minimum of six years of education and training therapists to become qualified to practice (Lum, 2010; National Conference of State Legislators, 2022). When there is a provider shortage, it disproportionately affects patients, especially those of underserved populations, resulting in many of those patients not getting the care they need (Counts, 2023). Patients with Medicare and Medicaid insurances have increased difficulty in establishing mental health care, as many health care providers do not accept these insurances due to low reimbursement rate (Counts, 2023).

Federally Qualified Health Centers, or FQHCs, are “Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations” (Department of Health and Human Services, n.d.). They provide comprehensive services in addition to primary care, regardless of a patient’s ability to pay for the services (Michigan Primary Care Association, 2023). In addition to medical services, FQHCs provide programs that connect patients with resources to make their healthcare accessible, such as sliding fee programs and medication cost assistance (MPCA, 2023). FQHCs are vital for providing underserved populations access to high-quality healthcare (Lee, Donley, Ciesielski, Freedman, & Cole, 2023). The integrated primary care and behavioral health services provided by FQHCs function as a safety net, capturing patients who otherwise would not be able to afford or access behavioral health

services. FQHCs have been proven to reduce the disparity in access to behavioral health treatment (Newman, Hawrilenko, Jakupcak, Chen, & Fortney, 2022).

Psychotherapy is an essential part of behavioral health treatment and has proven to be an effective treatment for multiple mental illnesses (Wheeler, 2020). Its efficacy and low-risk profile coupled with the increasing demand for mental health treatment have led to the high demand for psychotherapy services. This increased demand combined with the psychotherapy provider shortage has resulted in scarce psychotherapy resources. Psychotherapists have recognized the increase in demand for services, resulting in long waitlists and disparities in care for underserved populations (APA, 2021).

A solution to meet increased demand for psychotherapy is to implement a group therapy program (Medianero, Rivera, & Balva, 2022). Research has shown that group therapy is an effective and efficient way to provide mental health services (Pappas, 2023). Group therapy is psychotherapy delivered by one or more mental health professionals to two or more clients at the same time. Group therapy can use many types of psychotherapeutic modalities, including Cognitive Behavioral Therapy, Psychodynamic Therapy, and Solution-Focused Therapy (Wheeler, 2020). Group therapy is based on Yalom's 11 Therapeutic Factors: The Instillation of Hope, Universality, Imparting Information, Altruism, The Corrective Recapitulation of the Primary Family Group, Development of Socialization Techniques, Imitative Behavior, Interpersonal Learning, Group Cohesiveness, Catharsis, and Existential Factors (Yalom & Leszcz, 2005).

Group therapy is effective for many mental illnesses, including depression, anxiety, and personality disorders, as well as for substance abuse, grief, and support for medical illnesses (Wheeler, 2020). While many formats are utilized for group therapy, the U.S. Centers for

Medicare and Medicaid Services' guidelines require at least one licensed therapist and the involvement of two patients (minimum) to ten patients (maximum) (U.S. Centers for Medicare & Medicaid Services, 2022). Typical group therapy sessions last 45-60 minutes but can vary in duration depending on the group's structure (TheraThink, 2023). Reimbursement is based on the number of clients in attendance and fulfillment of the documentation requirements (U.S. Centers for Medicare & Medicaid Services, 2022). A therapist can only bill for one group session per day (U.S. Centers for Medicare & Medicaid Services, 2022).

Group therapy has many therapeutic and logistical benefits. Group therapy provides patients the opportunity to share their experiences with others who have similar experiences, providing the patients a stronger sense of understanding and relatedness. It also allows participants to gain peer support and work on relational and interpersonal issues in a controlled setting (Wheeler, 2020). Group therapy is as effective as individual therapy in treating mental illnesses (Pappas, 2023). From a logistical perspective, group therapy improves access to psychotherapy and is cost-effective for both the clients and providers (Wheeler, 2020). These benefits make group therapy an effective and efficient treatment option (Pappas, 2023). Despite the evidence supporting group therapy, group therapy only makes up about 5% of mental health treatment services due in part to the challenges of providing group therapy (Pappas, 2023).

Rationale

There are many challenges that affect the provision and utilization of group therapy. These challenges include organizational, employee, and patient factors. Group therapy requires extensive planning prior to implementation to ensure its success (DeAngelis, 2018). The organization's structure and resources affect this planning. It is recommended to have a group program coordinator to organize the logistics of the groups and patient enrollment (DeAngelis,

2018). Planning the group meeting location, date, and time takes careful consideration to prevent barriers to patient attendance (DeAngelis, 2018). An organization must also be able to obtain enough referrals to maintain enrollment for group therapy. A large number of referrals is needed to maintain group size after patients are lost due to eligibility, patient preference, and initial drop-out (Science to Service Task Force, 2007). Additionally, an organization must also have the human resources and time to complete appropriate patient screening and orientation prior to enrollment into group therapy (Substance Abuse and Mental Health Services Administration, 2005). Patient screening and orientation ensures appropriate patient selection, addresses and patient concerns, and potential barriers to the therapeutic process in group therapy (DeAngelis, 2018).

Employee factors that affect the utilization of group therapy include their education, knowledge, experience, and opinions about group therapy. Group therapy education and training prepare therapists for the extensive planning required to develop and conduct a group therapy program (Novotney, 2019). Group therapy can be overwhelming to therapists since they are responsible for patient safety, confidentiality, and facilitating the therapeutic process (Novotney, 2019). Even when a therapist overcomes the challenges of starting and conducting a group, it can be difficult to retain participants for the group's duration (Gulamani, Uliaszek, Chugani, & Rashid, 2020). The extensive work, challenges, and responsibility involved with group therapy can result in therapist opposition towards group therapy (Shay, 2021). Specific education and training in group therapy prepare the group therapist for these responsibilities and can reduce their anxiety and negative opinions about group therapy (Shay, 2021).

Patient factors affecting group therapy utilization relate to patient selection and patient attitudes toward group therapy. One of the most crucial factors in a group's success is selecting

appropriate patients (Novotney, 2019). Selection criteria will vary depending on the purpose of the group, but in general, the goal is to find participants with some shared characteristic, whether that be diagnosis, gender, or past experiences (Science to Service Task Force, 2007). The group therapist must assess patients' personality traits to select patients who will develop cohesion without becoming enmeshed in order to facilitate the therapeutic process (Pappas, 2023; Novotney, 2019; Science to Service Task Force, 2007). It is recommended to screen prospective patients to identify those that meet the criteria and align with the therapeutic goals (Substance Abuse and Mental Health Services Administration, 2005). In addition to the challenge of finding enough appropriate patients for group therapy, many patients have preconceived opinions about group therapy that prevent them from enrolling, such as fears about self-disclosure and confidentiality (DeAngelis, 2018). Past experiences or the potential for judgment and rejection by peers deters many patients from seeking group therapy, contributing to the underutilization of group therapy (Shay, 2021).

To explore solutions to the organizational, employee, and patient factors that impede implementation of group therapy programs, a literature review was conducted. The next section discusses the parameters used for the literature review, the resulting articles, and synthesis of the results.

Literature Review

To investigate interventions to address the organizational, employee, and patient factors impeding the success of group therapy at this FQHC, a literature review was conducted using the following PICOT question to guide the search: In patients seeking psychotherapy at an FQHC, how does structuring the referral and screening process increase the enrollment of patients into a group therapy program? The search was initially conducted using the search parameters

((("group therapy" OR "group psychotherapy") AND ("increas*" OR "improv")) AND ("enrollment" OR "interest")) AND ("FQHC" or "Federally Qualified Health Center") which yielded no results in PubMed or CINAHL. The search was then expanded to include fewer specific criteria, as well as searching Google Scholar, eliciting over 1,200 articles. The abstracts were then narrowed down based on the inclusion criteria of being peer reviewed, based in the United States of America, published in English language, discussion of group psychotherapy implementation, and discussion of barriers to the use of group therapy. Articles were excluded based on discussion of non-psychotherapy support groups and lack of discussion of program planning or feasibility of group therapy. Upon review of the abstracts, 10 articles were found to be most relevant to the search question and were selected for this literature review. The Johns Hopkins Research Evidence Appraisal Tool was used to evaluate the quality of the selected publications (see Table 2). The major limitations to the evidence include date of publication greater than 10 years ago and very few articles meeting criteria for high-level of evidence. While this weakens the evidence used to support the selected interventions, it does validate the necessity of further research and investigation into this topic.

Reviewing the literature revealed common themes behind the success of group therapy. These themes include increasing appropriate referrals, improved program planning, appropriate patient selection, addressing attitudes towards group therapy, and patient preparation for group therapy. After synthesizing the evidence from the literature review (see Table 3), the following conclusions were made:

Theme 1: Increasing Appropriate Referrals.

For group therapy to be successful, an abundance of referrals is needed (Bernard, et. Al., 2008; Piper & Joyce, 1996). A variety of referral sources and advertisement modes should be

used to help generate an adequate number of referrals (Burnett-Zeigler, et. Al., 2023). To ensure that the referrals received are appropriate, clinicians who refer patients should understand the criteria used to select appropriate patients for the group (Bernard, et. al., 2008; Gans & Counselman, 2010).

Theme 2: Improved Program Planning.

When planning a group therapy program, it is important to have an effective program coordinator (Bernard, et. Al., 2008). While offering incentives and follow-up on missed appointments can help with attrition, it is most important to consider logistical barriers to the group during planning, such as location, date and time, and transportation means (Burnett-Zeigler, et. Al., 2023; Gans & Counselman, 2010).

Theme 3: Appropriate Patient Selection.

The success of the group is dependent on selecting appropriate patients for the group (Gans & Counselman, 2010). Pre-screening of the referred patients should be completed to assess their appropriateness. Patient characteristics associated with higher likelihood of success and attrition in groups include some level of interpersonal skills, psychological mindedness, issues in interpersonal relationships, motivation for and commitment to the group and to making personal changes to improve their symptoms, a positive attitude towards group, and a willingness to help others (Bernard, et. Al., 2008; Gans & Counselman, 2010; Jensen, Mortensen, & Lotz, 2014; Piper, 2008; Strauss, Spangenberg, Brähler, & Bormann, 2015). Patient characteristics associated with a lower likelihood of success and attrition in groups include having limited psychological mindedness, lack of any social skills, poor motivation to improve symptoms, a tendency to overpower or consistently disrespect others, and severe symptoms or acute suicidal crisis (Bernard, et. Al., 2008; Gans & Counselman, 2010; Jensen, Mortensen, & Lotz, 2014).

Theme 4: Addressing Attitudes towards Group Therapy.

Patients most often prefer individual therapy due to the inherent anxiety they have when it comes to group therapy (Bowden, 2002; Hahn, 2009; Strauss, Spangenberg, Brähler, & Bormann, 2015; Shechtman & Kiezel, 2016). Patients worry about confidentiality, judgement, safety, and potential adverse effects from the group (Bowden, 2002; Piper, 2008; Piper & Joyce, 1996; Shechtman & Kiezel, 2016; Strauss, Spangenberg, Brähler, & Bormann, 2015). Even therapists can have concerns when it comes to groups, but proper training can help eliminate those concerns (Piper, 2008; Piper & Joyce, 1996).

Theme 5: Patient Preparation (Pre-group screening and training).

Completing a pre-group preparation, training, or meeting is vital to group success. It creates the opportunity to establish and improve therapeutic relationships, alleviate and address anxieties about the group, clarify expectations, and address potential problems to improve attrition and patient success (Bernard, et. Al., 2008; Hahn, 2009; Jensen, Mortensen, & Lotz, 2014; Piper, 2008; Piper & Joyce, 1996; Gans & Counselman, 2010). During pre-group preparation, providing written materials is an effective way to relay and reinforce the structure of the group (Bernard, et. Al., 2008).

Specific Aims

This quality improvement project's aim was to increase enrollment in group therapy at an FQHC by addressing organizational, patient, and employee factors that negatively impacted patient access to therapy. The project objectives are detailed in Table 4. The primary project objective was to have 12 appropriate patients enrolled in group therapy by 02/02/2024 (project objective nine, see Table 4). Interventions to achieve this objective were adapted from the best available evidence to target organizational, employee, and patient factors and were applied

within the unique organizational context. The internal and external review of the current process suggested a need for improvement in the patient referral and selection process. Project interventions for process improvement were aimed at: 1) increasing appropriate referrals to group therapy, 2) facilitating appropriate patient selection, and 3) preparing patients for group therapy (Bernard, et. Al., 2008; Burnett-Zeigler, et. al., 2023; Hahn, 2009; Jensen, Mortensen, & Lotz, 2014; Leszcz, & Kobos, 2008; Piper, 2008; Piper & Joyce, 1996; Gans & Counselman, 2010; Shechtman & Kiezel, 2016; Strauss, Spangenberg, Brähler, & Bormann, 2015). Interventions to improve patient and provider awareness of the FQHC's group therapy program and increase understanding of the benefits of group therapy were also implemented.

The first two objectives targeted the initial referral process to increase the number of appropriate referrals and increase patient and provider knowledge of the group therapy program. Project objective one was to send an email to referring providers about the group therapy program and enrollment process to increase awareness of the program and clarify the steps to refer patients to group therapy (see Table 4) (Bernard, et al., 2008; Burnett-Zeigler, et al., 2023; Piper & Joyce, 1996). Project objective two was to distribute 250 informational flyers about the group therapy program to patients in patient waiting areas to increase patient awareness about group therapy and its benefits (see Table 4) (Burnett-Zeigler, et al., 2023). To ensure an adequate number of referrals were available prior to patient selection, project objective three was to obtain 100 psychotherapy referrals during the group enrollment period between 01/01/2024 and 01/31/2024 (see Table 4) (Bernard, et. Al., 2008; Piper & Joyce, 1996).

The next project objectives focused on appropriate patient selection, increasing patient understanding of group therapy, and preparing patients for group therapy. Project objective four was to aid in appropriate patient selection by having the behavioral health referral specialist

screen the psychotherapy referrals for those meeting the minimum criteria for the group therapy program (see Table 4) (Bernard, et. Al., 2008; Gans & Counselman, 2010; Jensen, Mortensen, & Lotz, 2014). Project objective five aimed to improve patient knowledge of group therapy by having the behavioral health referral specialist inform referred patients (that meet the minimum criteria) about the group therapy program (Bowden, 2002; Piper, 2008; Piper & Joyce, 1996; Shechtman & Kiezel, 2016; Strauss, Spangenberg, Brähler, & Bormann, 2015). Then, patients that agreed to meet with the group psychologist were forwarded to the group psychologist; those that declined were assessed for their reason why (project objective six, see Table 4).

Project objectives seven and eight focused on patient preparation and selection for group therapy. The group psychologist was to meet with patients forwarded by the behavioral health referral specialist, for pre-screening, pre-training, and to address patient concerns about group therapy (project objective seven, see Table 4) (Bernard, et. Al., 2008; Hahn, 2009; Jensen, Mortensen, & Lotz, 2014; Piper, 2008; Piper & Joyce, 1996; Gans & Counselman, 2010). Patients that declined enrollment in group therapy were to be assessed for their reason for declining; gathered information was intended to advise future implementations (project objective eight, see Table 4).

Project objectives one through eight were used to guide the implementation of this project and meet the primary objective. The main objective of this project, objective nine, was to enroll 12 appropriate patients in the group therapy program by 02/02/2024 (see Table 4). The next section of this paper will further specify how these objectives were accomplished.

Methods

This quality improvement project was implemented at an FQHC in Battle Creek, Michigan that offers integrated primary care and behavioral health services. The project was

coordinated by a Doctor of Nursing Practice student. Key players for this project included the referring providers, the behavioral health referral specialist, the psychologist conducting the group therapy sessions, and the patients seeking psychotherapy services. Implementation of this quality improvement project was structured using the Plan-Do-Study-Act framework discussed next.

Implementation Framework

The Plan-Do-Study-Act (PDSA) is an evidence-based implementation framework for quality improvement projects. PDSA is a preferred framework because it breaks the implementation process into manageable steps and allows the investigator to provide careful consideration to each step of the process (AHRQ, 2015). The first step, Plan, is intended to guide the planning process of the intervention and keep the goal of the intervention in focus. The second step, Do, has the investigator reflect on observations of the intervention's implementation. The third step, Study, is where the investigator analyzes the outcome of the intervention, whether the goal was met, and what was learned through the implementation process. The fourth step, Act, is for the investigator to draw conclusions from the process and consider changes for improvement when continuing or re-implementing the intervention (AHRQ, 2015). The PDSA process is beneficial in that it is built to be a cycle of continuous evaluation, so that current processes can be improved, and new interventions can be tried and adjusted to meet the environment's needs (AHRQ, 2015). Figure 1 shows how the PDSA framework was used to plan the implementation of the project's interventions. The specific interventions designed to meet the project's objectives are detailed in the following section.

Intervention Implementation and Study

To address all parts of the enrollment process, the project's interventions were divided into three phases. The first phase (Phase A), Improving Program Planning and Increasing Referrals, focused on increasing the number of appropriate referrals and advertising group therapy by disseminating information about the group therapy program to referring providers and patients (project objectives one through three, see Table 4). The second phase (Phase B), Screening Referrals, focused on appropriate patient selection and further addressing patient attitudes through referral review and patient outreach by the behavioral health referral specialist (project objectives four through six, see Table 4). The third phase (Phase C), Patient Preparation, involved the pre-screening and pre-training of patients by the group psychologist prior to enrollment into the group therapy program (project objectives seven through nine, see Table 4). For an overview of the project's methods, refer to Figure 2.

Phase A: Improving Program Planning and Increasing Referrals

Using the “All Staff” email group through the organization’s email network, an email was to be sent out on 12/18/2024, about one week before the enrollment period for the group therapy program, to referring providers (primary care providers and therapists) informing them about the program. This email was to include information about the group therapy program's logistics, the benefits of group therapy, and how to refer patients to it. This objective’s evaluation was based on whether the email was sent to the referring providers.

To increase awareness in patients (potential enrollees) about the group therapy program, a flyer highlighting the program and its benefits was to be distributed to patient waiting areas by 12/18/2024, with a goal of 250 flyers distributed (see Figure 3). The flyer was also to be posted on the organization’s social media pages and sent to patient email addresses enrolled in the organization’s elective email notification system.

Phase A was to continue for one month from 01/01/2024 to 01/31/2024, tracking the number of referrals received by the behavioral health referral specialist, with the goal to receive 100 psychotherapy referrals by the end of the open enrollment period (project objective three, see Table 4). The behavioral health referral specialist was to record the number of incoming referrals during the one-month open enrollment period for the group therapy program on a daily tracking log (see Table 5). The project coordinator was then to collect this information from the referral specialist weekly during the open enrollment period.

In preparation for Phases B and C, the project coordinator would meet with the behavioral health referral specialist and the group psychologist on 12/29/2023 to review the following: education about the group therapy program and script for the behavioral health specialist when contacting referred patients, project implementation methods for both the referral specialist and group psychologist, data recording instructions, as well as answer any questions prior to the start of the open enrollment period.

Phase B: Appropriate Patient Selection and Addressing Attitudes Towards Group Therapy

Phase B of this project was focused on patient selection in addition to informing patients about the structure, logistics, and benefits of this FQHC's group therapy program. Upon starting the open enrollment period on 01/01/2024, all incoming psychotherapy referrals would be screened by the behavioral health referral specialist for those meeting the minimum criteria of the group therapy program: current diagnosis of anxiety or depression, age 18 years or older, and not in acute crisis. Those meeting the minimum criteria were to be recorded on the tracking log and contacted by the behavioral health referral specialist. During this contact with the referral specialist, each patient would be informed of the group therapy program and the benefits of group therapy from a script of recommended dialogue provided to the referral specialist by the

project coordinator. The referral specialist would then offer a meeting with the group's lead psychologist. Those agreeing to meet with the psychologist were to have their contact information forwarded to the lead psychologist. Those who declined to meet with the lead psychologist would be asked for the reason they declined and then remain on the waitlist for individual psychotherapy services. The data for phase B was recorded on a tracking log by the behavioral health referral specialist (see Table 6) and then collected weekly and analyzed by the project coordinator at the end of the open referral period on 01/31/2024.

Phase C: Patient Preparation for Group Therapy (Pre-screening and Pre-training)

Phase C of this project's implementation focused on patient preparation and further informing patients about group therapy. Starting 01/01/2024, the psychologist leading the group therapy program was to contact each of the referrals forwarded to him for group therapy within three days of contact from the referral specialist. The psychologist would then meet with the patients either via telephone or in-person to provide preparation for group therapy, including pre-screening and pre-training. The pre-screening would include further evaluation of each referred patient to assess for characteristics indicating inclusion or exclusion from the group. This preparation time would also be used as pre-training to set expectations for the group and address potential issues or patient concerns.

The patients receiving approval from the psychologist would be offered enrollment into the group; those who accepted enrollment would be enrolled into the group therapy program. Those who declined were to be further assessed for the reason they declined. Those not offered enrollment would be directed to other behavioral health services. To evaluate the effectiveness of this intervention, information was to be collected on the number of referrals for group therapy the psychologist received, whether the patient was contacted within 3 days, the number of

patients he completed pre-screening/pre-training with, the number of patients offered a spot in group therapy, the number enrolled into the group therapy program, and the reasons why any patients declined enrollment. This data would be recorded by the lead psychologist on a tracking log (see Table 7), then collected weekly and analyzed by the project coordinator at the end of the open referral period on 01/31/2024.

The project lead was to meet with the referral specialist and psychologist weekly to monitor the tracking logs as well as address any data collection concerns. Once the data was collected and analyzed, the process would be adjusted based on observations and conclusions from the first round of implementation to improve the process for the next open referral period. Consistent with the PDSA model, the process would be re-evaluated after each round of implementation to continuously improve and simplify the process for sustainability. The second implementation cycle was to begin the open enrollment period on 03/01/2024 running until 03/31/2024 for the next group therapy session to start on 04/04/2024. For an overview of the project's timeline, see Table 8.

Measures and Analysis

To quantitatively track improvement in access and utilization of therapy through implementation of the group therapy program, the number of referred patients was counted during each phase. In Phase A, the first measure collected was the number of referrals received by the behavioral health referral specialist during the enrollment period for the group therapy program. This measure was compared to the 100 referrals used in the initial implementation of the group therapy program, with the goal to obtain at least 100 referrals during the open enrollment period. This measure was used to evaluate the quantity of incoming referrals to ensure the remaining measures were not affected by a significant increase or decrease in the

number of incoming referrals. The next measure was the number of referrals meeting the minimum criteria for the group therapy program and was to be used to calculate the proportion of patients moving through the next phases. In Phase B, the number of patients agreeing to meet with the lead psychologist was counted to determine the effectiveness of the communication intervention completed by the behavioral health referral specialist. In Phase C, the number of patients that complete the preparation meeting with the psychologist was measured to track loss of patients from initial contact to follow-up. The last measure collected was the number of patients enrolled in the group therapy program and was used to calculate the proportion of referred patients meeting minimum criteria that were enrolled in group therapy, with the goal to exceed the enrollment rate of the first group therapy program of 8%. Qualitative data of patient responses to why they declined the meeting with the psychologist or why they declined enrollment into group therapy was collected to assess other factors that may be affecting access and utilization of group therapy.

Ethical Considerations and Risk Analysis

To maintain patient confidentiality, all data collected was limited to quantitative measures or qualitative patient responses, excluding protected health information and patient identifiers. There was ethical concern surrounding the inherent necessity to exclude some patients from the group therapy program based on the criteria mentioned above; however, these exclusion criteria were supported by evidence as a protective measure to prevent enrolling patients in group therapy where they could experience adverse effects or inflict harm to themselves or others (Bernard, et. al., 2008; Gans & Counselman, 2010; Jensen, Mortensen, & Lotz, 2014). Additionally, prior to the implementation of the interventions, this project was reviewed by Michigan State University's Internal Review Board to verify that as a quality improvement

initiative it was not research and did not require federal regulations for human participant protection (see Appendix B).

Concerns for feasibility included the time commitment required of the behavioral health referral specialist and psychologist leading the group therapy program. Fortunately, the psychologist's motivation and administration's support to implement this program made successful implementation of these interventions possible. Reimbursement potential for group therapy at an FQHC by Medicare and Medicaid insurances made this project financially possible (see Appendix C). Another feasibility concern was buy-in from referring providers and patients, which was prophylactically being targeted through informative interventions to increase awareness.

To mitigate risks associated with this project, internal and external factors that could complicate this intervention were assessed. Internal factors at this FQHC included time constraints of the psychologist, patient education responsibilities delegated to the referral specialist, and lack of experience developing and offering group therapy programs within the FQHC. Time was a limiting factor for this intervention as the main aspects of the interventions were time consuming and there were limited personnel resources to share the commitment. Few of the behavioral health staff had experience developing and conducting a group therapy program, so most of this responsibility fell on the psychologist that is developing the group therapy program and providing the pre-screening and pre-training to patients. While this psychologist had previous group therapy experience and was highly motivated to implement the pre-screening/pre-training to help ensure the success of the group, the time used for the pre-group planning would take away from time providing individual psychotherapy to his already full case load. The administration is supportive of this project and allowed the psychologist time

in his schedule for the interventions, but this did take away from billable time. The goal was to mitigate financial risk through successful implementation and reimbursement of the group therapy program. Another limiting factor was the delegation of screening the referrals and educating patients to the behavioral health referral specialist. These responsibilities were not only time-consuming, but the referral specialist also lacked background in patient education and behavioral health. To mitigate this risk, education was provided to the referral specialist about group therapy along with a sample dialogue of how to explain group therapy to the patients.

External factors that could have limited the success of this project included lack of funding for FQHCs, patients' preference for individual therapy, and competition from other facilities that provide mental health services. While group therapy was a reimbursable service by Medicare and Medicaid, only the sessions were reimbursable, not the time and resources used to develop and plan the group therapy program. To ensure that the group therapy program was sustainable long-term, the effectiveness of the implemented processes was evaluated to simplify the referral and planning process and eliminate ineffective interventions in future implementations. This group therapy program could have faced competition, since there were other facilities in the area that offer mental health services; however, only one other facility offered group therapy and the other mental health facilities were sending overflow to this FQHC due to demand for services exceeding their capacity. Lastly, while patient preference for individual therapy remained an external factor, it was mitigated through patient education and pre-training to address patient concerns, along with the opportunity for patients to avoid wait lists and receive prompt treatment through group therapy.

Changes to Implementation Plan

After receiving approval from Michigan State University's Internal Review Board on 12/11/2023, the project's implementation was delayed and altered due to organizational circumstances. The therapist originally intended to lead the group therapy program no longer had interest or availability and was replaced by another therapist in the organization. The new lead therapist selected a different topic for the program due to his preference and expertise. The group therapy program topic changed from "Coping Skills for Anxiety" to "Coping Skills for Chronic Illnesses. From 12/11/2023 to 1/22/2024, the new lead therapist and the student project coordinator developed the group therapy program material, including group therapy agenda, patient criteria for enrollment, group format, session schedule, and location. Because the quality improvement project focus is enrollment in group therapy and not the thematic content of group therapy, the QI project's objectives did not change and re-submission to IRB was not necessary.

Final approval from the FQHC for the changes to the group therapy program was received on 01/22/2024. Project implementation began on 01/29/2024 with education of the referral specialists by the student project coordinator. On 01/31/2024, open enrollment began, and the email informing staff of the group therapy program was sent. The advertisement flyers were approved by the lead therapist on 01/31/2024 and sent for printing. The printed flyers were received back and distributed to patient waiting areas on 02/05/2024. Due to the time constraints of the lead therapist, the student project coordinator completed the pre-screening/pre-training sessions with the referred patients. The pre-screening/pre-training was completed over the telephone due to the project coordinator's limited on-site availability. The open enrollment period concluded on 02/23/2024. The group therapy program began its sessions on 02/28/2024 with enough enrollees to continue the group therapy program (see Figure 4).

Results

At the beginning of the open enrollment period on 01/31/2024, there were 55 outstanding psychotherapy referrals. Throughout the open enrollment period, 59 new psychotherapy referrals were received, totaling 114 psychotherapy referrals that were reviewed for the group therapy program (see Table 9). Of the 114 psychotherapy referrals, 28 met the minimum criteria for the group therapy program.

Of those 28 referrals meeting criteria, 24 were contacted regarding the group therapy program. The four referrals that were not contacted were due to: one patient having a legal guardian, thus not being appropriate for group therapy; one patient needing a psychiatric evaluation to confirm their diagnosis; and two patients specifically mentioning only wanting individual therapy in the referral. Of the 24 referrals contacted, 19 were provided with group therapy education by the referral specialist. The remaining 5 referrals did not answer or return the calls from the referral specialists. Of the 19 referred patients that were provided education about group therapy by the referral specialist, 11 agreed to be contacted by the student project coordinator. The eight patients that declined contact from the student project coordinator provided the following reasons: still only wanting individual therapy (7 patients), being unavailable during group sessions dates/times (2 patients), and too far of drive to location (1 patient) (see Table 10).

The student project coordinator could not reach three of the 11 patients over the phone, and therefore could not complete the pre-screening/pre-training with them. Of the eight patients that completed the pre-screening/pre-training, six were approved and enrolled into the group therapy program. Of the two patients that were not enrolled, one patient originally enrolled and later called back to cancel without reason, and the other patient expressed not having enough time for group therapy due to having multiple upcoming medical appointments. At the end of the

enrollment period, six patients were enrolled in group therapy (see Table 11). Of those six patients, five attended the first session of the group therapy program and then continued to attend the remaining sessions.

Outcomes of Project Objectives

Objective one, to send an email informing referring providers about the group therapy program, was completed on 01/31/2024. Objective two was completed on 02/05/2024 with the distribution of 250 flyers. Objectives one and two were delayed from the original schedule due to the change in lead therapist and need to wait for approval. The adaptability of the implementation plan allowed for continuation of the interventions despite these delays.

Objective three, to have 100 referrals sent to the behavioral health referral specialist during the open enrollment period, was met and exceeded: 114 referrals were obtained during the open enrollment period. Objective four, screening incoming referrals for the minimum criteria for the group therapy program, was successfully completed by the behavioral health referral specialists. During the open enrollment period, 28 of the 114 referrals met the minimum criteria. Objective five, contacting the patients who met criteria to provide education about group therapy, was also completed by the behavioral health referral specialists. Eleven of 28 patients agreed to speak with the lead therapist. Those patients who declined were asked for a reason; patient responses were collected to meet objective 6.

The lead therapist was able to complete pre-screening/pre-training with eight patients for objective 7. The lead therapist collected responses from patients that declined group therapy for objective eight. Objective nine, to enroll 12 patients in the group therapy program, was partially met as six patients enrolled. While only 50% of the intended goal, it met the threshold to proceed with the group therapy program. The enrollment rate of patients meeting minimum criteria

increased from 8% in the site's first attempt to start a group therapy program, to 21% with the implementation of the project's interventions.

Elements that Impacted Implementation

As with any quality improvement project, organizational changes occurred which impacted implementation. The first organizational change was the switch of the lead therapist. Change in this clinician also led to a new program topic, "Coping Skills for Chronic Illnesses", that then impacted the selection of patients enrolled in the group therapy program. This new topic needed patients to have a chronic illness in addition to depression and/or anxiety, which was more exclusive than the original criteria. Additionally, the day and time of the group therapy program changed to work with the lead therapist's schedule. Planned therapy sessions moved from Friday morning to Wednesday afternoon, presenting scheduling conflicts for some patients.

Another change in context was the hiring of a second behavioral health referral specialist. Having two referral specialists provided greater human resources to make calls for the group therapy program. However, there is more variation to the education provided to patients during these phone calls when having two referral specialists make the calls.

As previously mentioned, the lead therapist was unable to perform the pre-screening/pre-training intervention due to lack of availability, so the student project coordinator performed this intervention. The student's limited schedule only allowed for this intervention to be conducted over the telephone on Wednesday and Friday afternoons, reducing the ability to reach all patients interested in group therapy. Additionally, the student has limited experience with group therapy, impacting the effectiveness of the pre-screening/pre-training intervention.

Due to loss of support from the project site, only one round of the PDSA cycle was completed. To prevent wasting the resources required for the group therapy program, the site was

unwilling to plan for a second cycle of group therapy before ensuring the first cycle was successful. It was also uncertain if all the human resources needed for the second round of implementation would be available after the first round. While a therapist and the student project coordinator volunteered to co-lead the first group, they did not have the long-term availability to lead additional cycles. Thus, another new lead therapist was needed before future cycles could be started.

Additionally, a few months prior to the implementation of the group therapy program, the site shortened individual therapy sessions (from 1-hour sessions down to 45-minute sessions), allowing therapists to see more patients daily. This served to decrease the number of outstanding referrals and thus lessened the necessity of starting a group therapy program for improved access to psychotherapy services.

Even after the first cycle was successful, the site was still unsure how they wanted to continue the group therapy program. While the patients enrolled in the group therapy program requested to extend the sessions at the end of six-weeks, the long-term feasibility was still questionable. The co-lead therapists agreed to alternate leading weekly sessions so they could continue to provide group therapy for these patients a few weeks longer, but this was only a short-term solution until a new therapist was found to lead the program long-term.

With more patients interested in joining the group therapy program, the site was also deciding how to enroll them. To optimize the lead therapist's time, it had been discussed to enroll more patients into the current group so that one large group therapy session could be held weekly instead of multiple smaller groups. However, the site had yet to determine how they planned to continue the enrollment process without a therapist to replace the student project coordinator for

the pre-screening/pre-training sessions. Additionally, there were concerns about how the addition of new patients in an established group would affect the group dynamic.

Associations between Outcomes, Interventions, and Environment

When evaluating the associations between the environment, interventions, and outcomes, it is important to recognize the difference between implied effect and causality. While the nature of this study cannot establish causality, each intervention was carefully planned using best-evidence from literature to produce the desired outcome. Thus, the following inferences were made.

The majority of the patients enrolled in the group therapy program were referred by their individual therapist or medical provider, emphasizing the importance of addressing provider attitudes towards group therapy and ensuring they are informed about group therapy programs being offered. The education provided by the referral specialists was well received and resulted in more patients having an interest in group therapy, even if they ultimately did not enroll; this highlights the importance of addressing patients' attitudes towards group therapy. The pre-screening/pre-training sessions provided an opportunity to further address patient attitudes about group therapy, and effectively swayed some patients that were unsure about joining group therapy. These sessions also prepared patients for the expectations of the group therapy program, improving attendance to group, and initiated therapeutic rapport prior to the first group session.

Unintended Consequences

During implementation, some unexpected issues and benefits developed. Since the student completed the pre-training/pre-screening intervention, it eliminated the cost associated with therapist's wage to complete these sessions. Also, providing the pre-screening/pre-training intervention over the phone made it easier for the patients to complete this intervention at their

convenience and eliminated the barrier of transportation to another appointment. A minor issue developed when the behavioral health referral specialists were screening incoming referrals requiring clarification from the student project coordinator; this clarification was to specify which diagnoses qualified as meeting the criteria for “depression”, such as Major Depressive Disorder, Bipolar Disorder, and Adjustment Disorder, and which diagnoses did not qualify as a chronic illness, such as a mental health or substance use disorder alone.

Missing Data

It was originally intended to have the open enrollment period last for four full business weeks; however, due to the start date being delayed until 01/31/2024, the open enrollment period was shortened by two days, therefore lacking referral data from 01/29/2024 and 01/30/2024.

Discussion

After the quality improvement interventions, enrollment in group therapy increased by 50% and the enrollment rate of patients meeting the minimum criteria increased to 21%. It is inferred that the attitudes of providers towards group therapy were influenced by the email intervention as there was an increase in referrals, some specifically for group therapy. Patient attitudes towards group therapy seemed to be influenced by the education provided by the referral specialist, since 11 of 19 patients agreed to meet with the student project coordinator, as well as during the pre-screening/pre-training sessions, where six of eight patients agreed to enroll in group therapy. The pre-screening/pre-training sessions aided in appropriate patient selection and preparing patients for group therapy, as five of the six patients who enrolled in the group therapy program attended group sessions consistently.

A strength of this project was the ability to adapt the QI interventions to the evolving nature of a busy FQHC. The structured process developed for enrollment can be utilized in other

group therapy programs regardless of the topic. The interventions of this project posed negligible risk and burden to the patients with the potential for substantial benefits.

Interpretation

The implementation of quality improvement interventions correlated with an increase in enrollment in group therapy. While there is a lack of subsequent trials demonstrating reproducibility and efficacy of these interventions, the outcomes of this QI project support the work of Bernard, et. al., 2008; Burnett-Zeigler, et. al., 2023; Hahn, 2009; Jensen, Mortensen, & Lotz, 2014; Leszcz, & Kobos, 2008; Piper, 2008; Piper & Joyce, 1996; Gans & Counselman, 2010; Shechtman & Kiezel, 2016; Strauss, Spangenberg, Brähler, & Bormann, 2015; and emphasize the importance of increasing appropriate referrals, addressing attitudes towards group therapy, appropriate patient selection, and pre-screening/pre-training sessions when developing a group therapy program.

The project resulted in some patients receiving access to group therapy. This project also increased provider engagement and interest in group therapy; referring providers asked many questions about the group therapy program and expressed excitement about being able to offer their patients this opportunity. Providers at the FQHC expressed interest in future group therapy programs and topics. This project positively affected the patients that enrolled in group therapy; they gave positive feedback to the lead therapist about the usefulness of the group therapy program. The lead therapist also received feedback from one patient's individual therapist about improvement in mood and affect to the extent the patient required less frequent sessions for individual therapy.

Unfortunately, the final enrollment number of six patients was less than the project goal of 12. This may be partially explained by a decrease in the number of patients meeting minimum

criteria for the group due to a change in inclusion criteria. Only 28 patients out of the 114 referrals obtained had both a chronic illness and a diagnosis of depression and/or anxiety. To improve future enrollment, it may be beneficial to first review outstanding referrals to determine the group therapy topic most needed. This could optimize the number of patients that meet the minimum requirements for the group therapy program. It would be anticipated that educating and completing pre-screening/pre-training on a larger number of patients would result in more patients enrolled in the group therapy program. This project also hoped to gather more specific information as to why patients declined group therapy. To get more specific answers, it would be beneficial to have a more detailed survey completed by patients who declined group therapy to investigate why they preferred individual therapy.

The overall cost of the group therapy program was reduced significantly with the utilization of the student project coordinator for the pre-screening/pre-training sessions. This saved the FQHC the anticipated wage of the therapist plus lost earnings from therapist's time away from patients. With these cost savings, this program was profitable despite not reaching maximum enrollment. While the group therapy program did not eliminate the need for individual therapy, it did help reduce the frequency of individual therapy for at least one patient. This shows the potential to ease the pressure of heavy caseloads and a long waitlist for therapy, and would be an outcome of interest for future quality improvement efforts.

Limitations

Limitations to this project's generalizability include the specificity of the interventions that were adapted to the site based on available resources. It is important to note that there was limited data from the organization's prior attempts to initiate a group therapy program and this weakens the validity of the conclusions drawn from comparisons the QI project data. Qualitative

data collected during this project was minimally structured, leaving room for interpretation errors. Additionally, there was no randomization in the project design which creates a risk for bias. The inability to repeat the interventions for another PDSA cycle also limits the reliability of the data.

Conclusion

The results of this evidence-based quality improvement project suggest an enrollment process that increases appropriate referrals, addresses attitudes towards group therapy, ensures appropriate patient selection, and provides pre-screening/pre-training sessions may increase enrollment in group therapy. The results of this project could be useful for mental health providers and facilities looking to develop or improve a group therapy program. However, for the results to become reliable and generalizable, more research and quality improvement projects investigating the development of group therapy programs are needed.

This organization would benefit from a second PDSA cycle to assess the reliability of the interventions. Before developing the topic of the next group therapy program, it would be beneficial to review outstanding referrals and diagnoses to identify the most salient topic based on need. It is also recommended to develop a more structured qualitative survey to investigate the reasons a patient declines group therapy. This would unveil additional factors that influence patients' attitudes towards group therapy. The sustainability of these interventions at the project site requires increasing the number of therapists or reserving time in a therapist's schedule to lead the group therapy program. Additionally, enrollment would need to further increase to cover the cost of the therapist's time, which could be facilitated by having less restrictive enrollment criteria. Overall, this QI project demonstrated how structuring the enrollment process can

improve enrollment in group therapy at an FQHC, and the feasibility of group therapy to improve access to evidence-based mental health treatment.

References

- Agency for Healthcare Research and Quality. (2015). Plan-Do-Study-Act (PDSA) directions and examples. *Health Literacy Universal Precautions Toolkit* (2nd ed.).
<https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html>
- Agency for Healthcare Research and Quality. (n.d.). Strength, weakness, opportunities, and threats analysis. *Digital Healthcare Research*. <https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/swot-analysis>
- American Psychological Association. (2022). Health service psychologists across work settings [Interactive Data Tool]. *Data tool: Work settings*.
<https://www.apa.org/workforce/publications/health-service-psychologists-survey/work-settings>
- American Psychological Association. (2021, October 19). *Demand for mental health treatment continues to increase, say psychologists* [Press release].
<https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand>
- Bernard, H., Burlingame, G., Flores, P., Greene, L., Joyce, A., Kobos, J. C., Leszcz, M., MacNair-Semands, R. R., Piper, W. E., Slocum McEneaney, A. M., & Feirman, D. (2008). Clinical practice guidelines for group psychotherapy. *International Journal of Group Psychotherapy*, 58(4), 455-542. <https://doi.org/10.1521/ijgp.2008.58.4.455>
- Bowden, M. (2002). Anti-Group Attitudes at Assessment for Psychotherapy. *Psychoanalytic Psychotherapy*, 16(3), 246-258. <https://doi.org/10.1080/14749730210163453>
- Burnett-Zeigler, I., Zhou, E., Martinez, J. H., Zumpf, K., Lartey, L., Moskowitz, J. T., Wisner, K. L., McDade, T., Brown, C. H., Gollan, J., Ciolino, J. D., Schauer, J. M., & Petito, L.

- C. (2023). Comparative effectiveness of a mindfulness-based intervention (M-Body) on depressive symptoms: study protocol of a randomized controlled trial in a Federally Qualified Health Center (FQHC). *Trials*, 24(1), 115. <https://doi.org/10.1186/s13063-022-07012-2>
- Chamlou, M. (2022, August 8). What to do on a therapy waitlist. *Psychology.org*.
<https://www.psychology.org/what-to-do-on-a-therapy-waitlist/#:~:text=The%20National%20Council%20of%20Mental,services%20is%20about%20six%20weeks.>
- Counts, N. (2023, May 18). Understanding the U.S. behavioral health workforce shortage. *Commonwealth Fund*. <https://doi.org/10.26099/5km6-8193>
- DeAngelis, T. (2018). Making group therapy a winning part of your practice. *APA Practice Organization*. <https://www.apaservices.org/practice/good-practice/group-therapy.pdf>
- Department of Health and Human Services. (n.d.). Federally Qualified Health Center (FQHC). *U.S. Centers for Medicare & Medicaid Services*.
<https://www.healthcare.gov/glossary/federally-qualified-health-center-fqhc/>
- Gans, J. S. & Counselman, E. F. (2010). Patient selection for psychodynamic group psychotherapy: Practical and dynamic considerations. *International Journal of Group Psychotherapy*, 60(2), 197-220. <https://doi.org/10.1521/ijgp.2010.60.2.197>
- Grace Health. (2016, July 21). Grace health celebrates 30th anniversary. *Grace Health*.
<https://www.gracehealthmi.org/grace-health-celebrates-30th-anniversary/>
- Grace Health. (2021). Mission, vision & values. *Grace Health*.
<https://www.gracehealthmi.org/health-care-mission-vision-values/>
- Grace Health. (2022). Our impact in 2022. *Grace Health*. <https://www.gracehealthmi.org/>

- Gulamani, T., Uliaszek, A. A., Chugani, C. D., & Rashid, T. (2020). Attrition and attendance in group therapy for university students: An examination of predictors across time. *Journal of clinical psychology, 76*(12), 2155–2169. <https://doi.org/10.1002/jclp.23042>
- Hahn, W. K. (2009) Ingenuity and uneasiness about group psychotherapy in university counseling centers. *International Journal of Group Psychotherapy, 59*(4), 543-552. <https://doi.org/10.1521/ijgp.2009.59.4.543>
- Jensen, H. H., Mortensen, E. L., & Lotz, M. (2014). Drop-out from a psychodynamic group psychotherapy outpatient unit. *Nordic Journal of Psychiatry, 68*(8), 594-604. <https://doi.org/10.3109/08039488.2014.902499>
- Lee, E. K., Donley, G., Ciesielski, T. H., Freedman, D. A., & Cole, M. B. (2023). Spatial availability of federally qualified health centers and disparities in health services utilization in medically underserved areas. *Social science & medicine (1982), 328*, Article e116009. <https://doi.org/10.1016/j.socscimed.2023.116009>
- Leszcz, M. & Kobos, J.C. (2008). Evidence-based group psychotherapy: using AGPA's practice guidelines to enhance clinical effectiveness. *J. Clin. Psychol., 64*, 1238-1260. <https://doi.org/10.1002/jclp.20531>
- Lum, C. (2010). Licensure requirements for professional counselors–2010. *American Counseling Association*. https://www.counseling.org/docs/licensure/72903_excerpt_for_web.pdf
- McLaughlin C. G. (2004). Delays in treatment for mental disorders and health insurance coverage. *Health services research, 39*(2), 221–224. <https://doi.org/10.1111/j.1475-6773.2004.00224.x>

Medianero, G., Rivera, R. M., & Balva, D. (2022, March 1). Group therapy in a COVID-19 era.

Society of Group Psychology and Group Psychotherapy.

<https://www.apadivisions.org/division-49/news-events/psychology-student-training>

Michigan Primary Care Association. (2023). What are health centers? *MPCA*.

<https://www.mPCA.net/about/michigan-health-centers/>

National Conference of State Legislators. (2022). State strategies to recruit and retain the behavioral health workforce. *NCSL*. <https://www.ncsl.org/health/state-strategies-to-recruit-and-retain-the-behavioral-health-workforce>

National Health Care for the Homeless Council. (2023). Grace Health. *National Health Care for the Homeless Council: HCH Grantee Directory*. <https://nhchc.org/grace-health/>

Newman, M. W., Hawrilenko, M., Jakupcak, M., Chen, S., & Fortney, J. C. (2022). Access and attitudinal barriers to engagement in integrated primary care mental health treatment for rural populations. *J Rural Health*, 38, 721–727. <https://doi.org/10.1111/jrh.12616>

Novotney, A. (2019, April 1). Keys to great group therapy. *Monitor on Psychology*, 50(4). <https://www.apa.org/monitor/2019/04/group-therapy>

Pappas, S. (2023, March 1). Group therapy is as effective as individual therapy, and more efficient. Here's how to do it successfully. *Monitor on Psychology*, 54(2).

<https://www.apa.org/monitor/2023/03/continuing-education-group-therapy>

Piper, W. E. (2008). Underutilization of short-term group therapy: Enigmatic or understandable? *Psychotherapy Research*, 18(2), 127-138. <https://doi.org/10.1080/10503300701867512>

Piper, W. E. & Joyce, A. S. (1996). A Consideration of factors influencing the utilization of time-limited, short-term group therapy. *International Journal of Group Psychotherapy*, 46(3), 311-328. <https://doi.org/10.1080/00207284.1996.11490783>

- Reinert, M., Fritze, D., & Nguyen, T. (2022, October). *The state of mental health in America 2023*. Mental Health America. <https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf>
- Science to Service Task Force. (2007). *Practice guidelines for group psychotherapy*. The American Group Psychotherapy Association.
<https://www.agpa.org/home/practice-resources/practice-guidelines-for-group-psychotherapy>
- Shay, J. J. (2021, February 2). Terrified of group therapy: Investigating obstacles to entering or leading groups. *The American Journal of Psychotherapy*, 74(2), 71-75.
<https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20200033>
- Shechtman, Z. & Kiezel, A. (2016). Why do people prefer individual therapy over group therapy? *International Journal of Group Psychotherapy*, 66(4), 571-591.
<https://doi.org/10.1080/00207284.2016.1180042>
- Strauss, B., Spangenberg, L., Brähler, E., & Bormann, B. (2015). Attitudes towards (psychotherapy) groups: Results of a survey in a representative sample. *International Journal of Group Psychotherapy*, 65(3), 410-430.
https://doi.org/10.1521/ijgp_2014_64_001
- Substance Abuse and Mental Health Services Administration. (2005). 3 Criteria for the placement of clients in groups. *Treatment Improvement Protocol (TIP) Series* (No. 41). [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK64215/>
- TheraThink. (2023). CPT code 90853: Group therapy billing & coding guide [2023].
TheraThink. <https://therathink.com/cpt-code-90853/#description>
- Tiemens, B., Kloos, M., Spijker, J., Ingenhoven, T., Kampman, M., & Hendriks, G. J. (2019). Lower versus higher frequency of sessions in starting outpatient mental health care and

the risk of a chronic course; a naturalistic cohort study. *BMC Psychiatry*, 19(228).

<https://doi.org/10.1186/s12888-019-2214-4>

United States Census Bureau. (2022). Calhoun county, Michigan; Battle Creek city, Michigan.

Quick Facts.

<https://www.census.gov/quickfacts/fact/table/calhouncountymichigan,battlecreekcitymichigan/PST045222>

U.S. Centers for Medicare & Medicaid Services. (2022). Local coverage determination (LCD):

Psychiatry and psychology services. *CMS*. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34616>

U.S Department of Health and Human Services. (2023, May 3). Fact sheet: Celebrating mental

health awareness month 2023. *U.S. DHHS*.

<https://www.hhs.gov/about/news/2023/05/03/fact-sheet-celebrating-mental-health-awareness-month-2023.html>

U.S. Department of Labor. (2022). Occupational employment and wage statistics. *U.S. Bureau of*

Labor Statistics. <https://www.bls.gov/oes/data.htm>

Wheeler, K. (2020). *Psychotherapy for the advanced practice psychiatric nurse: A how-to guide for evidence-based practice* (3rd ed.). St. Louis: Mosby

Yalom, I. D., & Leszcz, M. (Collaborator). (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books/Hachette Book Group.

Zhu, J. M., Renfro, S., Watson, K., Deshmukh, A., & McConnell, K. J. (2023). Medicaid reimbursement for psychiatric services: Comparisons across states and with Medicare.

Health affairs (Project Hope), 42(4), 556–565.

<https://doi.org/10.1377/hlthaff.2022.00805>

Table 1: *SWOT Analysis of Project Site*

Strengths • Prior experience developing and implementing new services to meet the community's healthcare needs. • Highly skilled and adaptable work force accustomed to frequent changes in workflow to better serve patients. • Designated resources reserved for the behavioral health department and its growth.	Opportunities • Increased federal funding based on quality and access to underserved populations and the availability of grants. • Growing demand by the community for the services provided. • Increased cultural acceptance for mental health treatment.
Weaknesses • Staffing shortages lead to time constraints and burn-out. • The behavioral health referral specialist has not received formal training or education in behavioral health. • Many behavioral health providers lack previous experience developing and offering group therapy programs.	Threats • Not the primary mental health provider in the community. • Patient preference for individual psychotherapy and availability of individual psychotherapy at other healthcare organizations. • Lack of funding in general for FQHCs via Medicare/Medicaid reimbursement.

Table 2: *Literature Review Evidence Table*

Citation	Study description/aim	Method	Data source	Sample	Measurement	Outcomes	Strength/ Weakness
(Bernard, et. Al., 2008)	To support and guide practitioners in their practice of group therapy.	Literature review and synthesis by experts in behavioral health and group therapy.	N/A	N/A	N/A	The American Group Psychotherapy Association recommends evidence-based guidelines to improve the success of group therapy. These include advisements on group planning, patient selection, and pre-training.	Level IV, Low Quality S: Professionally sponsored, expert reviewed, and extensive literature review. W: Literature review methods not defined and greater than five years old.
(Bowden, 2002)	To describe patients' attitudes towards group therapy	Quasi-Experiment Survey of referred patients	Survey responses	Convenience sample of 150 patients, of which 69 responded.	The proportion of respondents who selected each answer choice.	Patients have certain fears and beliefs about group therapy that lead them to prefer individual therapy.	Level III, Good Quality S: Sufficient sample size and recommendations supported by data. W: Non-randomized sample and lack of control for compounding variables.
Burnett-Zeigler, et. Al., 2023)	To evaluate the effectiveness of a mindfulness group	Randomized controlled trial with control group comparing	Clinical Interviews, Surveys, and	274 participants selected using defined criteria	IDS-C scale and MINI scale improvements.	Multiple modes of recruitment resulted in sufficient	Level I, Good Quality

	intervention on treating depression in Black women at an FQHC. To assess the attitudes towards and the feasibility of the intervention.	a mindfulness group intervention to enhanced usual care.	Biometric Measurements.	and eligibility requirements.	Biometric measurement collection stopped due to COVID-19 precautions.	referrals. Participation incentives were provided to encourage patient involvement and follow-up on missed appointments was utilized to maintain patient involvement.	S: Study design and application to FQHC setting. W: Study incomplete due to COVID restrictions.
(Gans & Counselman, 2010)	To provide guidance on the patient-selection process for group therapy to improve enrollment.	Literature Review.	Screening interviews.	Not defined.	Not defined.	Selecting appropriate patients for a group is vital to the group's success. Appropriate patients can be selected and prepared for a group by pre-screening them for certain characteristics and logistical barriers.	Level 5, Good Quality S: Expertise of authors is evident, and conclusions are logical. W: Data supporting the conclusions was not provided.
(Hahn, 2009)	To share solutions to common problems associated with providing group therapy at a university	Expert opinion on review of practices at the university counseling center.	Literature review, collaboration with other clinicians, and program outcomes.	A single university counseling program.	Expert Opinion.	Pre-training reduces participant anxiety and helps establish structure to the group to facilitate	Level 5, Good Quality S: Expert appears credible and provides logical arguments for opinions.

	counseling center.					therapeutic environment.	W: Lack of data supporting rationale.
(Jensen, Mortensen, & Lotz, 2014)	To investigate predictors of drop-out for group psychotherapy.	Comparing demographic, clinical, self-reported symptoms, and personality variables to drop-out in a group therapy program.	Demographic and clinical information and psychiatric assessment tools.	329 patients referred to a group therapy program.	Demographic and clinical information, SCL-90-R, MCMI-II, and correlation with drop-out.	Selecting appropriate patients and providing pre-training to patients prior to beginning group reduces dropout rates.	Level III, High Quality S: Large sample size, generalizable results, and consistent recommendations. W: Potential for multiple confounding variables.
(Leszcz, & Kobos, 2008)	To demonstrate application of AGPA practice guidelines.	Clinician experiences applying the guidelines in practice.	Clinical Experience	N/A	Outcomes of the applied guidelines.	The recommendations of the AGPA guidelines are applicable to various clinical settings and can solve common problems associated with group therapy.	Level V, Good Quality S: Expertise appears credible and draws definitive conclusions. W: Lack of data supporting scientific rationale.
(Piper, 2008)	To investigate the reasons for and potential solutions for underutilization of group therap.	Expert opinion of available literature.	Published Literature.	N/A	N/A	Patients and therapists can be resistant to group therapy for many reasons, but there are strategies to	Level V, High Quality S: Evident author expertise and scientific rationale clearly reported.

						address these reasons to improve group therapy utilization.	W: Age of evidence.
(Piper & Joyce, 1996)	To explore patient and therapist factors that limit the use of short-term group therapy.	Literature Review	Published Literature.	N/A	Data supporting efficiency of TSGT and factors affecting its use.	Therapists may oppose group therapy for many reasons. Patients can experience adverse effects from group therapy, but proper selection and preparation can reduce the likelihood of adverse effects. Adequate referrals are required to obtain enough appropriate patients for group therapy.	Level V, Good Quality S: Literature review clearly defined, data relevant to topic, and recommendations provided. W: Completed greater than 5 years ago and sources used were more than 5 years old.
(Shechtman & Kiezel, 2016)	To identify patients' beliefs and attitudes about group therapy.	Compare questionnaire responses regarding opinions about group therapy.	Demographics and Questionnaire Surveys	224 students from two different colleges volunteered to participate.	Arguments supporting and opposing individual and group therapy.	Patients have intrinsic knowledge of the benefits of group therapy and fears. The fears of group therapy drive patients away from choosing group therapy.	Level III, Good Quality S: Relevant design and moderately relevant integration of data. W: Potential for bias in sample and interpretation of results.

(Strauss, Spangenberg, Brähler, & Bormann, 2015)	To investigate attitudes towards and experiences of group therapy in the general population.	Study assistant administered survey of a randomized sample.	Survey responses and demographic information.	2512 participants meeting geographic and selection criteria agreed to participate in the study.	The proportion of participants that selected each option regarding their experiences and attitudes relating to group therapy.	Respondents inherently view group therapy as an anxiety provoking experience, but those with greater adaptability, less psychological symptoms, or prior group experience are more likely to have a positive attitude about group therapy. Still, most respondents would recommend individual therapy.	Level III, Good Quality S: Sufficient sample size and reasonable attempt at randomization. W: Lack of recommendations from results.
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Table 3: *Literature Synthesis Table: Target Aims of Interventions to Increase Enrollment in Group Therapy*

Source	Increasing Appropriate Referrals	Improved Program Planning	Appropriate Patient Selection	Patient Preparation (Pre-group screening and training)	Addressing Attitudes towards Group Therapy	Other
(Bernard, et. Al., 2008)	X	X	X	X		
(Bowden, 2002)					X	
(Burnett-Zeigler, et. Al., 2023)	X					X
(Gans & Counselman, 2010)	X	X	X	X		
(Hahn, 2009)				X	X	
(Jensen, Mortensen, & Lotz, 2014)	X		X			
(Leszcz, & Kobos, 2008)	X	X	X	X	X	
(Piper, 2008)			X	X	X	
(Piper & Joyce, 1996)	X			X	X	X
(Shechtman & Kiezel, 2016)					X	
(Strauss, Spangenberg, Brähler, & Bormann, 2015)					X	

Table 4: *Project objectives*

Phase	Obj. #	Objective Type (Process or Outcome)	Target Aim(s)	Objective	Date(s)	Measure(s)
1	1	Process	Increasing Appropriate Referrals Addressing Attitudes Towards Group Therapy	An email will be sent out informing the referring providers about the group therapy program and enrollment process.	By 12/18/2023	Email sent
	2	Process	Increasing Appropriate Referrals Addressing Attitudes Towards Group Therapy	Informational flyers about the group therapy program will be distributed to patients via paper copy in patient waiting areas.	By 12/18/2023	250 paper flyers distributed.
	3	Outcome	Increasing Appropriate Referrals	100 referrals will be sent to the behavioral health referral specialist.	01/01/2024 to 01/31/2024	Number of Referrals
2	4	Process	Appropriate Patient Selection	The behavioral health referral specialist will screen all incoming referrals for the minimum criteria for the group therapy program.	01/01/2024 to 01/31/2024	Number of Referrals Meeting Minimum Criteria
	5	Process	Addressing Attitudes Towards Group Therapy	The behavioral health referral specialist will contact referred patients meeting the minimum criteria for group therapy to	01/01/2024 to 01/31/2024	Number of referred patients agreeing to meet with the lead psychologist.

3				provide them with information about group therapy and offer a meeting with the lead psychologist.		
	6	Process	Addressing Attitudes Towards Group Therapy	The behavioral health referral specialist will assess for reasons the referred patients declined the meeting with the lead psychologist.	01/01/2024 to 01/31/2024	Patient responses for why they declined the meeting.
	7	Process	Pre-group Screening/ Training Appropriate Patient Selection Addressing Attitudes Towards Group Therapy	The psychologist leading the group therapy program will meet with referred patients agreeing to the meeting to complete pre-screening, pre-training, and address any patient concerns about group therapy.	01/01/2024 to 01/31/2024	Number of referred patients that completed the pre-screening/ pre-training with the psychologist.
	8	Process	Addressing Attitudes Towards Group Therapy	The lead psychologist will assess for reasons the referred patients that completed the pre-screening pre-training declined enrollment in group therapy.	01/01/2024 to 01/31/2024	Patient responses for why they declined enrollment in group therapy.
	9	Outcome	All	12 patients will enroll in the group therapy program.	By 02/02/2024	Number of patients enrolled in the group therapy program.

Table 5: *Sample of Incoming Referrals Tracking Log for Referral Specialist*

Existing Psychotherapy Referrals						
Number of Incomplete/Outstanding Psychotherapy Referrals at the Beginning of Open Enrollment for Group Therapy (as of 01/29/2024)						
Number of New Psychotherapy Referrals						
Week/Date (MM/DD-MM/DD)	Monday	Tuesday	Wednesday	Thursday	Friday	Weekly Total
Week 1 (01/29-02/02)						
Week 2 (02/05-02/09)						
Week 3 (02/12-02/16)						
Week 4 (02/19-02/23)						

Table 6: *Sample of Group Therapy Referral Tracking Log for the Referral Specialist*

[illegible]

Table 7: *Sample of Group Therapy Referral Tracking Log for the Lead Group Psychologist*

[illegible]

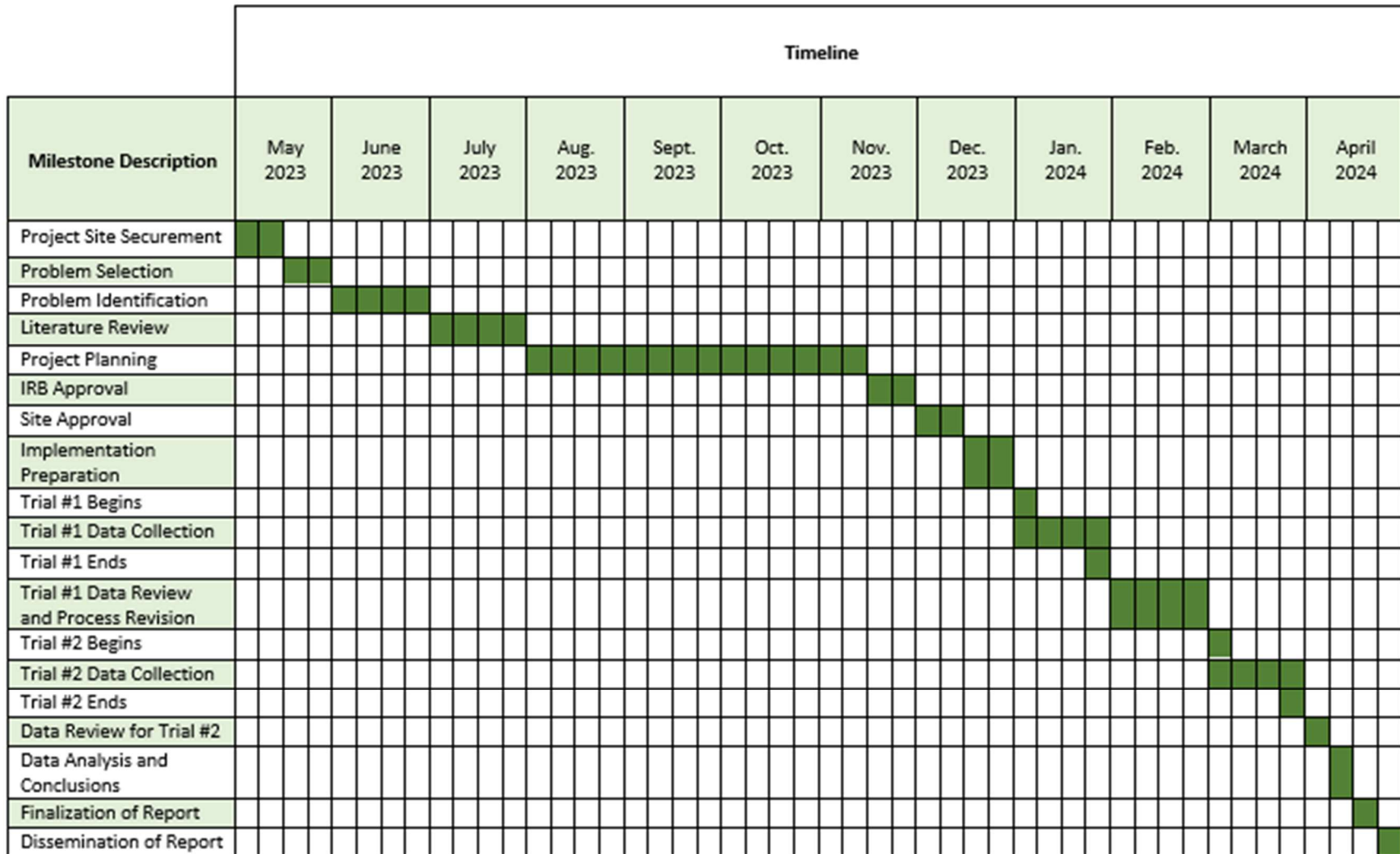
Table 8: *Project timeline, Gantt chart*

Table 9: *Incoming Referrals Tracking Log for Referral Specialist*

Existing Psychotherapy Referrals						
Number of Incomplete/Outstanding Psychotherapy Referrals at the Beginning of Open Enrollment for Group Therapy (as of 01/29/2024)					55	
Number of New Psychotherapy Referrals						
Week/Date (MM/DD-MM/DD)	Monday	Tuesday	Wednesday	Thursday	Friday	Weekly Total
Week 1 (01/29-02/02)	N/A	N/A	0	0	5	5
Week 2 (02/05-02/09)	0	0	0	12	1	13
Week 3 (02/12-02/16)	9	0	8	3	0	20
Week 4 (02/19-02/23)	7	0	3	8	3	21
					Monthly Total	59

Table 10: *Therapy Referral Tracking Log for the Referral Specialist*

Patient MRN	Contacted About Group Therapy? Y or N	Group Therapy Information Provided? Y or N	Accepted Meeting with Therapist (If yes, forward referral to Therapist. If no, assess reason for declining)	Reason for Declining
67624	Y	Y	N	Lives too far from group therapy location
64327	Y	Y	N	Unavailable during group therapy times
30402	Y	N	N/A	Did not return call
23370	Y	Y	N	Only wants individual therapy
42082	Y	Y	N	Unavailable during group therapy times
84074	Y	Y	Y	
71773	Y	Y	Y	
80070	Y	N	N/A	Did not return call
47907	Y	N	N/A	Did not return call
53616	N	N/A	N/A	Not appropriate for group therapy (lacks legal competency)
35282	Y	Y	N	Only wants individual therapy
102925	Y	Y	N	Only wants individual therapy
109884	Y	N	N/A	Did not return call
55562	Y	N	N/A	Did not return call
53828	Y	Y	N	Only wants individual therapy
13604	N	N/A	N/A	Needing psychiatric evaluation/diagnosis
54192	Y	Y	N	Only wants individual therapy
72794	Y	Y	Y	
54563	Y	Y	Y	
87520	Y	Y	Y	
28719	N	N/A	N/A	Only wants individual therapy
27278	N	N/A	N/A	Only wants individual therapy
96086	Y	Y	Y	
22028	Y	Y	Y	
86441	Y	Y	Y	
81781	Y	Y	Y	

15358	Y	Y	Y	
105120	Y	Y	Y	

Table 11: *Therapy Referral Tracking Log for the Lead Group Psychologist*

Patient MRN	Meeting for Pre-screening/ Pre-training Completed?	Appropriate for Group Therapy? (If no, send referral back referral specialist with note "Not eligible for group therapy").	Accepted Enrollment into Group Therapy? (If yes, add patient to new group therapy roster. If no, please assess reason for declining)	Reason for Declining
84074	Y	Y	N	Originally agreed and then cancelled; no reason given
71773	Y	Y	Y	
87520	Y	Y	Y	
72794	Y	Y	Y	
54563	Y	Y	Y	
96086	Y	Y	Y	
22028	N	N/A	N/A	Did not return call
81781	Y	Y	Y	
86441	N	N/A	N/A	Did not return call
15358	Y	Y	N	"Too many appointments"; does not have time for group therapy
105120	N	N/A	N/A	Did not return call

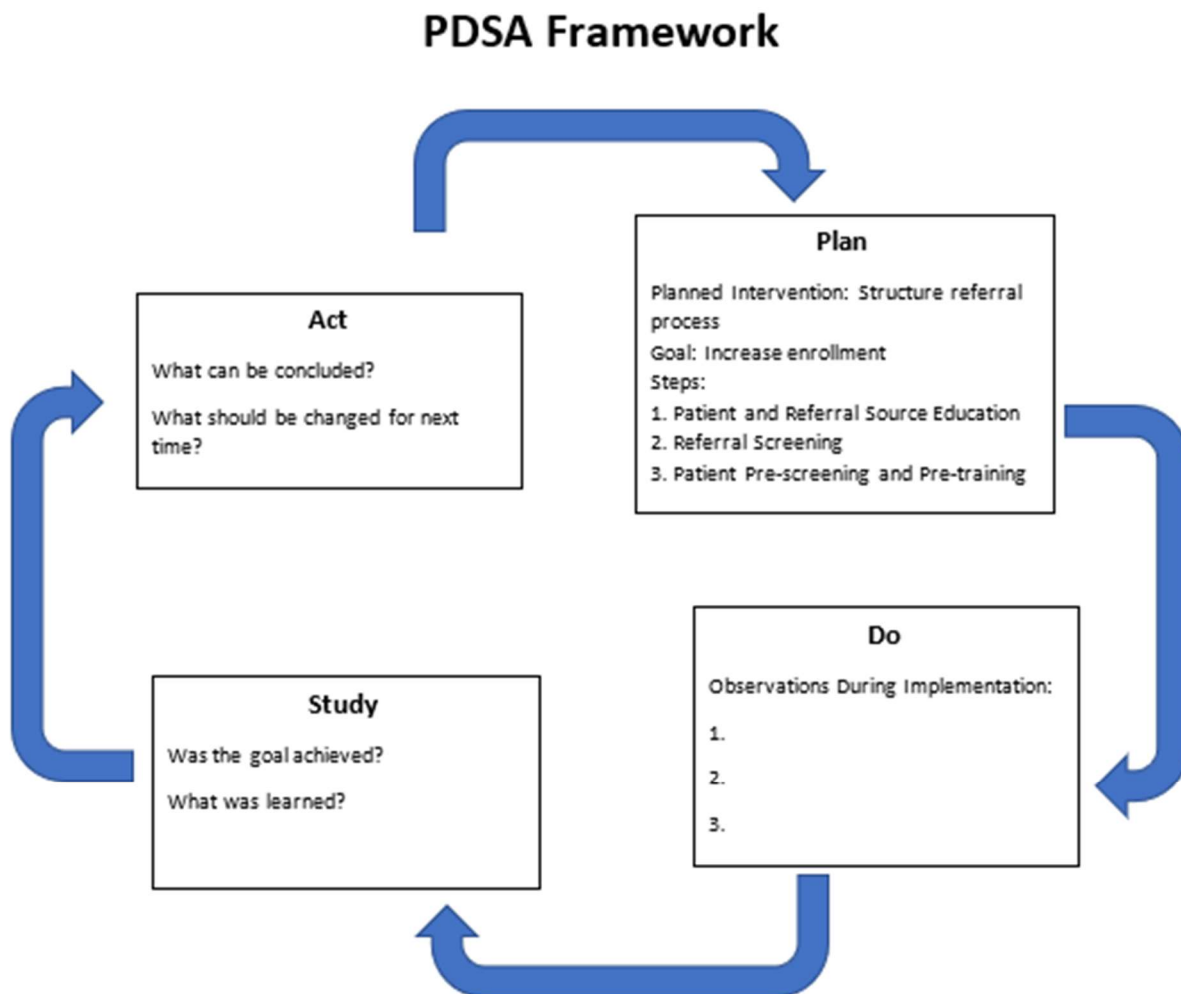
Figure 1: *PDSA Framework graphic*

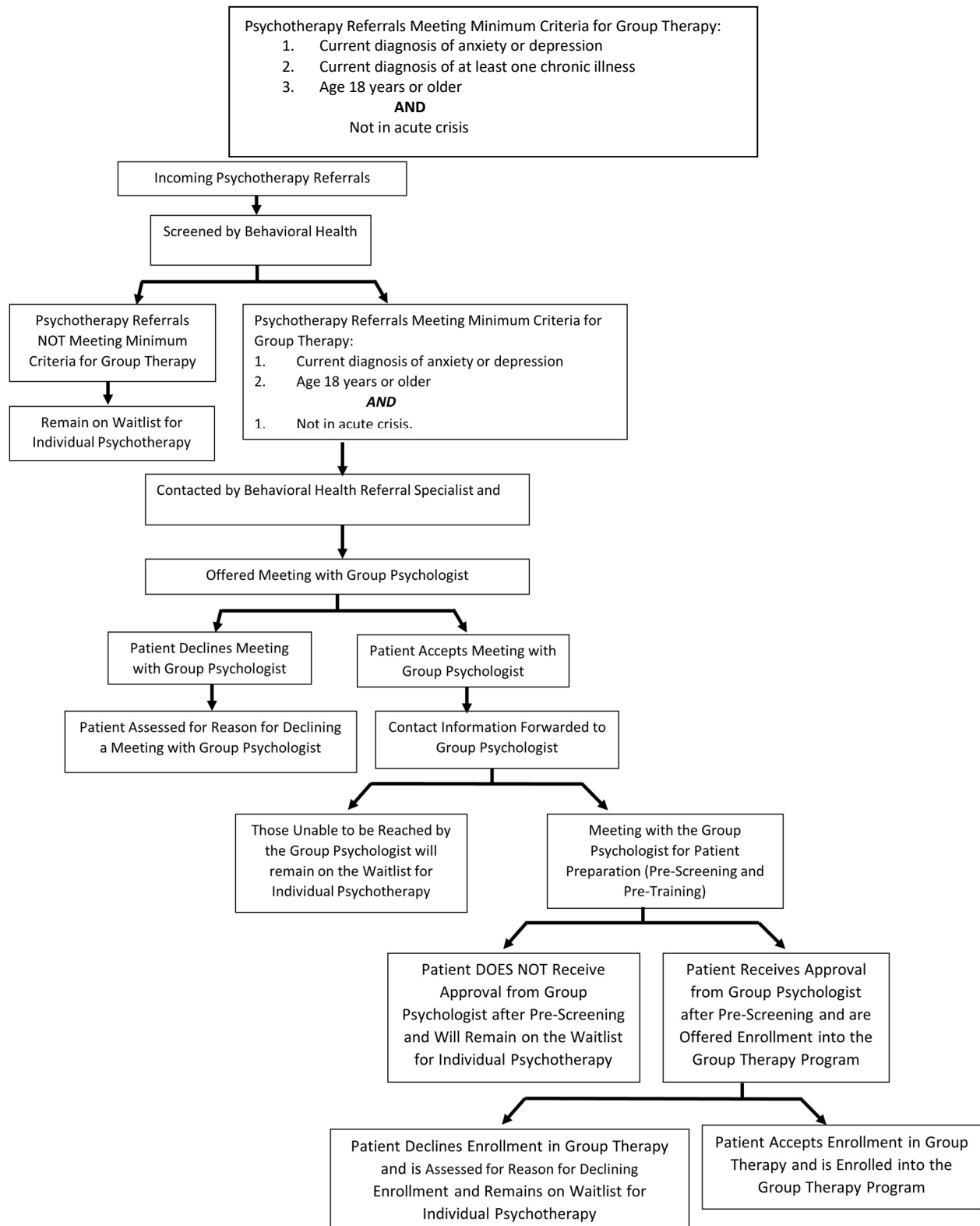
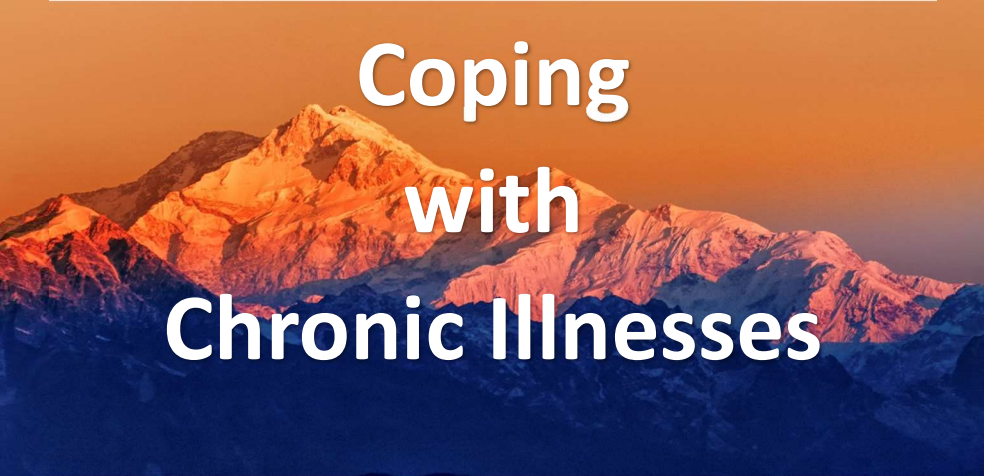
Figure 2: *Overview of Project Methods*

Figure 3: *Sample Informational Flyer for Patients*

Is managing your health causing you stress?
Does becoming healthy feel hopeless?
Then Join Us For:



**Coping
with
Chronic Illnesses**

New to Grace Health, *Coping with Chronic Illnesses* is a group therapy program focused on giving you the tools to cope with depression and anxiety related to your health.

Why Choose Group Therapy?

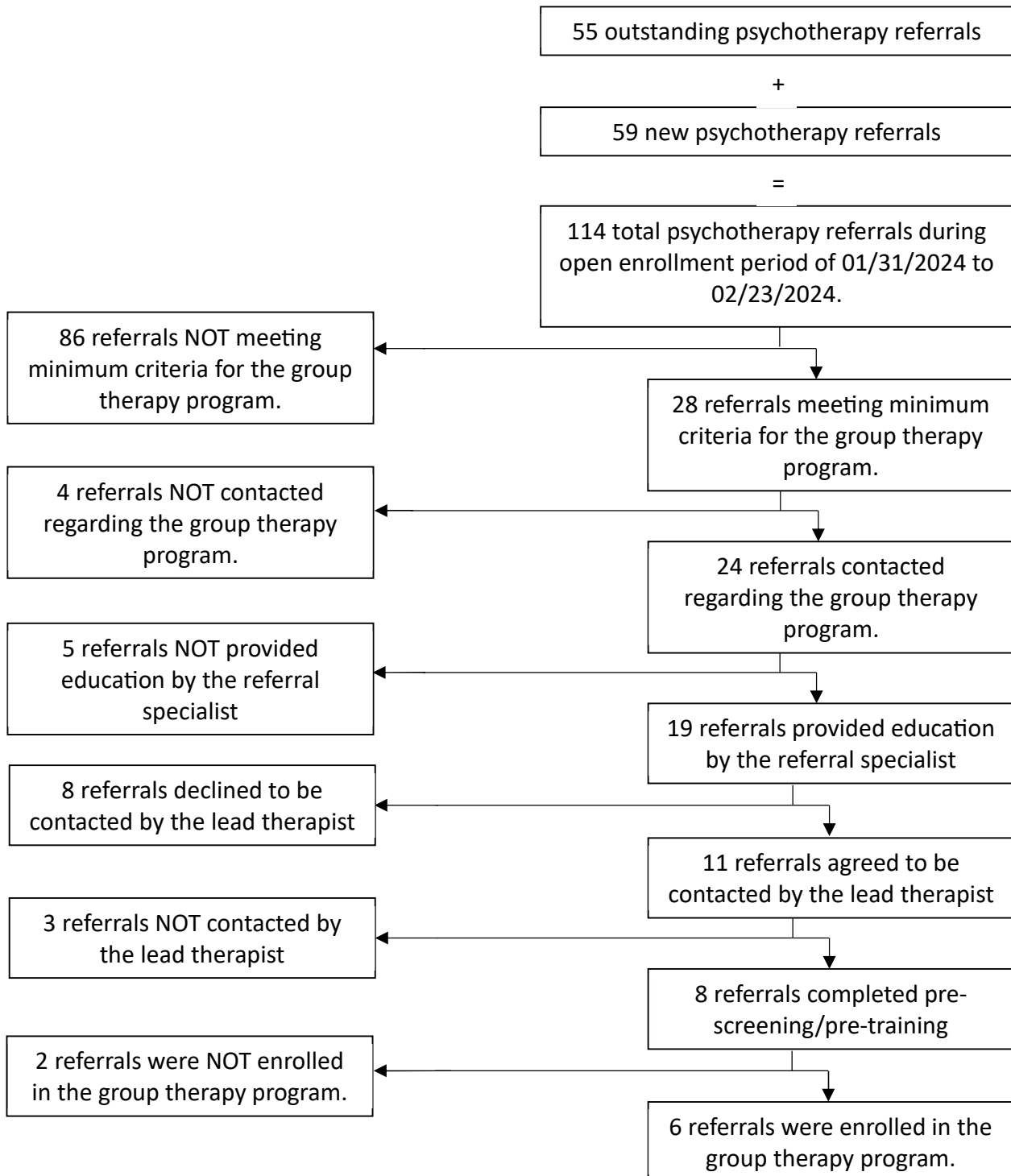
- *Gain Peer Support
- *Improve Communication Skills
- *Learn New Perspectives
- *Develop Health Boundaries

AND Skip the Wait List for Therapy!

Ask your provider about *Coping with Chronic Illness* today!

**Managing your health can feel like
moving mountains; don't do it alone!**

Figure 4: Flowchart of Project Implementation



Appendix A

Letter of Support from Project Site



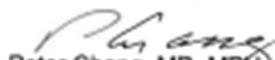
November 10, 2023

To the Michigan State University Internal Review Board,

This letter serves as confirmation of Grace Health's support for Janelle Wilkey, BSN, RN to perform her DNP project titled *Improving Enrollment in Outpatient Group Therapy at a Federally Qualified Health Center: A Quality Improvement Project*. This project is aimed at improving access to psychotherapy through implementation of a group therapy program, by addressing organizational, patient, and employee factors that have negatively impacted patient enrollment in the previous group therapy program.

We commit to supporting the implementation of this project within Grace Health, a Federally Qualified Health Center. We commit to providing on-site guidance, and appropriate resources (as applicable) for the project initiatives, including securing any needed approvals for data collection and storage in accordance with our local site requirements and institutional policies and procedures. We grant Janelle Wilkey permission to disseminate the project findings with Michigan State University to present her DNP project. Eric Macleod, Ph.D., L.P., Grace Health Behavioral Health Director, will serve as the site's organizational sponsor and is qualified to serve in this role due to his expertise in Mental Health and leadership of Grace Health's Behavioral Health Department.

Health care with grace,


Peter Chang, MD, MPH, CPE, FAAFP
President/CEO

Appendix B

IRB Determination Letter

**MICHIGAN STATE
UNIVERSITY****DETERMINED NOT "RESEARCH"
Revised Common Rule**

December 11, 2023

To: Janelle Wilkey

Re: **MSU Study ID: STUDY00010036**
Principal Investigator: Janelle Wilkey
Determination Date: 12/11/2023

Title: Improving Enrollment in Outpatient Group Therapy at a Federally Qualified Health Center: A DNP Quality Improvement Project

The activity described in this submission was determined not to be "research" as defined by the Common Rule as codified in the U.S. Department of Health and Human Services (DHHS) regulations for the protection of human research subjects.

Definition of Research

For DHHS, "Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research:

- (1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.
- (2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).
- (3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.



**Office of
Regulatory
Affairs**
Human Research
Protection Program

4000 Collins Road
Suite 136
Lansing, MI 48910

517-355-2180
Fax: 517-432-4503
Email: hrpp@msu.edu
www.hrpp.msu.edu

(4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions." [45 CFR 46.102(f)]

Determination

This is a Doctor of Nursing Practice Project designed to use current, best evidence to develop a process change for enrolling patients into group therapy at single FQHC. The project is not intended or designed to generate new knowledge or answer a research question. The project is in alignment with the operations of the institution with the purpose of identifying areas for care improvement in order to develop, implement and measure a quality improvement initiative. The implementation plan uses an evidenced-based quality improvement framework to measure outcomes and adapt interventions. The project's outcomes are not generalizable and dissemination is limited to the institution's behavioral health department and the College of Nursing for the purpose of degree completion.

Hence, the activity does not involve research.

Therefore, the federal regulations for the protection of human subjects would not apply to this activity and Michigan State University (MSU) Institutional Review Board (IRB) approval is not needed to proceed. However, please note that while MSU IRB approval is not required, other federal, state, or local regulations or requirements or ethical or professional standards may still be applicable based on the activity.

Modifications: If any of the activities described in this submission change, please contact the IRB office as the activity may involve human subject research and require IRB approval. For example, this determination is not applicable to activities that may be regulated by U.S. Food & Drug Administration (FDA), such as those involving drugs, medical devices, human food additives, color additives, electronic products, or any other test articles regulated by the FDA.

Modifications to Funding: Changes in funding may alter this determination. For example, MSU IRB review and approval is required if MSU receives an award through a grant, contract, or cooperative agreement directly from a federal agency, even where all non-exempt research involving human subjects are carried out by employees or agents of another institution. In addition, the new funding source may have additional or different requirements.

For More Information: See HRPP Manual Section 4-3, Determination of Human Subject Research (available at hrpp.msu.edu).

Contact Information: If we can be of further assistance or if you have questions, please contact us at 517-355-2180 or via email at IRB@msu.edu. Please visit hrpp.msu.edu to access the HRPP Manual, templates, etc.

Appendix C

Budget

The costs of this project included the cost of human resources and material resources. Human resources included the time spent by the behavioral health referral specialist reviewing and contacting referrals, the time spent by the psychologist pre-screening/pre-training referred patients, and the time spent by the project coordinator running the project and collecting and analyzing data. The labor costs were estimated using the national average hourly rate for each position from the U.S. Bureau of Labor Statistics (U.S. Department of Labor, 2022). Since the referral process for the referring providers is a part of their existing workflow, it was not included in this project's budget. The cost of material resources was estimated using the average cost from the local print shop to produce the printed materials. Funding for this project came from the Behavioral Health department at the FQHC and was expected to be reimbursed through revenue from the group therapy program. Reimbursement for this program was based on the average Medicaid reimbursement rate for group therapy (Zhu, Renfro, Watson, Deshmukh, & McConnell, 2023). The budget for this project was subject to changes in human resources, market fluctuations, and insurance reimbursement, but was estimated as accurately as possible (see table A1).

Table A1: *Predicted Budget*

	Item(s)	Rate	Cost
Expenditure			
Referral Specialist Referral Review and Tracking	1 x Behavioral Health Referral Specialist for Approximately 1 hour (20-30 second review and tracking of 100 referrals)	\$17.20/hour	\$17.20

Referral Specialist Contact with Referred Patients and Tracking	1 x Behavioral Health Referral Specialist for Approximately 7 hours (Up to 5 minutes per phone call and tracking of 80 referred patients)	\$17.20/hour	\$120.40
Pre-Screening/Pre-Training by Psychologist	1 x Ph. D., L.P.C. for Approximately 14 hours (Up to 20-minute meeting per patient with 40 referred patients)	\$44.00/hour	\$616.00
Project Coordinator	1 x DNP Student	\$0.00	\$0.00
Patient Education Flyers	250 copies	\$0.10 per copy	\$25.00
Psychologist leading the Group Therapy Program and Session Documentation	1 x Ph. D., L.P.C. for Approximately 9 hours (1 hour group + 30 minutes for documentation for 6 sessions)	\$44.00/hour	\$396.00
Total Expenditure		\$1,174.60	
Revenue			
Group Therapy Reimbursement (6 sessions)	Maximum of 10 patients at each session	\$25.59 per patient per session	\$1,535.40
Total Revenue		\$1,535.40	
Total Budget (Total Revenue - Total Expenditure)		+\$360.80	

The final budget after implementation at the project site is detailed in Table A2.

Variations to the budget include: less time than planned was utilized to make the required phone calls (reducing cost), the student project coordinator completing the pre-screening/pre-training sessions (reducing cost), and only 50% of the intended enrollment (decreasing revenue).

Ultimately, the project's budget remained in the black.

Table A2: *Final Expenditures and Revenue*

	Item(s)	Rate	Cost
Expenditure			
Referral Specialist Referral Review and Tracking	1 x Behavioral Health Referral Specialist for Approximately 1 hour (20-30 second review and tracking of 114 referrals)	\$17.20/hour	\$17.20
Referral Specialist Contact with Referred Patients and Tracking	1 x Behavioral Health Referral Specialist for Approximately 2.5 hours (Up to 5 minutes per phone call and tracking of 28 referred patients)	\$17.20/hour	\$43.00
Pre-Screening/Pre- Training by Psychologist	1 x Ph. D., L.P.C. for Approximately 2 hours (Up to 15-minute meeting per patient with 8 referred patients)	\$44.00/hour	\$88.00 (Not included in total as this was completed by the Student/Project Coordinator)
Project Coordinator	1 x DNP Student	\$0.00	\$0.00
Patient Education Flyers	250 copies	\$0.10 per copy	\$25.00
Psychologist leading the Group Therapy Program and Session Documentation	1 x Ph. D., L.P.C. for Approximately 12 hours (1.5 hours group therapy + 30 minutes for documentation for 6 sessions)	\$44.00/hour	\$528.00
Total Expenditure		\$613.20	
Revenue			
Group Therapy Reimbursement (6 sessions)	5 patients at each session	\$25.59 per patient per session	\$767.70
Total Revenue		\$767.70	
Total Budget (Total Revenue - Total Expenditure)		+\$154.50	