

## LEAN Evaluation of Glaucoma Clinic Workflow



Nish Patel BS<sup>1</sup>, Casey Scavone BS<sup>1</sup>, John Musser BS<sup>1</sup>, Leslie Niziol MS<sup>1</sup>, Abhilash Rao MS<sup>2</sup>, Elizabeth Olin MS<sup>2</sup>, Amy Cohn PhD<sup>2</sup>, Shivani Kamat MD<sup>1</sup>, Manjool Shah MD<sup>1</sup>, Paula Anne Newman-Casey MD, MS<sup>1</sup>

<sup>1</sup>Department of Ophthalmology & Visual Sciences, University of Michigan Medical School, Ann Arbor, MI <sup>2</sup>Department of Industrial and Operations Engineering, University of Michigan School of Engineering, Ann Arbor, MI

## Background

- Glaucoma is a leading cause of irreversible blindness, affecting over 70 million people worldwide, with 10% of these people suffering from blindness in both eyes.<sup>1</sup>
- The current leading treatment is eye drops that lower the intraocular pressure (IOP), inhibiting the progression of glaucoma.<sup>2,3</sup>
- Adherence to glaucoma medication regimens is estimated to be as low as 30-80%<sup>4,5</sup>; this poor adherence has been correlated with more severe vision damage from glaucoma.<sup>6</sup>
- Counseling and educational information tailored to each patient's needs have been the most successful in combating poor adherence. However, these interventions are time-intensive.
- Although providers believe there is not enough time for additional counseling during a clinic visit, many glaucoma patients complain about long clinic wait times.

## Objectives and Hypothesis

- We hypothesize that there is considerable time during a glaucoma clinic visit when patients are not engaged in value added activities.
- We aimed to quantify these wait times to identify times that could be used for educational interventions.

### Methods

#### **Time Studies**

- A purposive sample of new visit (NV) and return visit (RV) patients, across different providers and days of the week, seen at the Kellogg Eye Center glaucoma clinic were included over 4 months.
- Patients were followed through their clinic visit and length of time spent within each component of their visit was recorded using a stopwatch.

#### **Lean<sup>8</sup> Observations**

 Clinic flow (Figure 1) was observed, paying attention to bottlenecks, long wait times, queuing of patients, and miscommunications. Clinic staff and patients were asked for their opinions regarding these issues.

#### **Lean Analysis**

- Value-stream mapping<sup>8</sup> was used to analyze the clinic process and assess for improvement.
- Observations were recorded in an A3 format.9

Figure 1. Clinic visit process

|              |               | Wait        |                 | Wait                          |                                   | Wait                                |                              | Wait        |                   | Wait             |          |
|--------------|---------------|-------------|-----------------|-------------------------------|-----------------------------------|-------------------------------------|------------------------------|-------------|-------------------|------------------|----------|
| Process Step | Check-In      | <del></del> | Tech<br>Work-Up | <del></del>                   | Ancillary<br>Testing              | <b></b>                             | Resident<br>/ Fellow<br>Exam | <del></del> | Attending<br>Exam | <b></b>          | Checkout |
| Location     | Front<br>Desk | Reception   | Exam<br>Room    | In-Process<br>Waiting<br>Area | Visual<br>Field/<br>Photo<br>Room | In-Process Waiting Area & Exam Room | Exam Room                    |             | Checkout<br>Line  | Checkout<br>Desk |          |

#### Results

#### **Current A3**

<u>I. Background</u>
 Patients are frustrated with how much they have to wait in clinic especially for visits that are perceived to be short: return visits. Approximately 85% of clinic visits in the past year were return visits.

#### II. Current State

Table 1. Visit times, stratified by new patients and return visit patients

| Variable              | N  | Mean   | SD    | Min   | Max   |
|-----------------------|----|--------|-------|-------|-------|
| New Patients          |    |        |       |       |       |
| Total time (min)      | 29 | 187.4  | 44.2  | 120.0 | 331.0 |
| Process time (min)    | 29 | 126.1  | 27.7  | 78.9  | 173.2 |
| Wait time (min)       | 29 | 61.4   | 31.5  | 25.5  | 185.0 |
| Percent Wait time     | 29 | 31.9%* | 9.4%  | 13.1% | 55.9% |
| Return Visit Patients |    |        |       |       |       |
| Total time (min)      | 47 | 102.5  | 45.0  | 31.5  | 203.9 |
| Process time (min)    | 48 | 49.4   | 24.8  | 15.5  | 131.8 |
| Wait time (min)       | 48 | 52.6   | 31.6  | 8.9   | 129.1 |
| Percent Wait time     | 47 | 49.4%* | 14.7% | 20.4% | 78.7% |

\*The percent of wait time to total visit time was significantly larger on average for RV patients (49.4%) compared to NV patients (31.9%), p<0.0001, 2-sample t-test

#### Table 2. Wait times for each process step for return visit patients

| Wait Variables (min) | N  | Mean | SD   | Min | Max  | Median |
|----------------------|----|------|------|-----|------|--------|
| General reception    | 48 | 14.7 | 9.7  | 0.2 | 47.9 | 11.9   |
| In-process waiting 1 | 14 | 12.3 | 11.3 | 3.1 | 43.5 | 7.4    |
| Photo                | 9  | 11.9 | 12.8 | 3.5 | 40.5 | 4.4    |
| In-process waiting 2 | 18 | 12.7 | 12.1 | 1.0 | 47.6 | 8.9    |
| Resident             | 35 | 11.0 | 9.6  | 1.0 | 35.2 | 7.1    |
| Attending            | 38 | 22.1 | 19.8 | 2.3 | 70.1 | 13.7   |
| Checkout             | 21 | 2.0  | 2.3  | 0.0 | 7.7  | 1.6    |

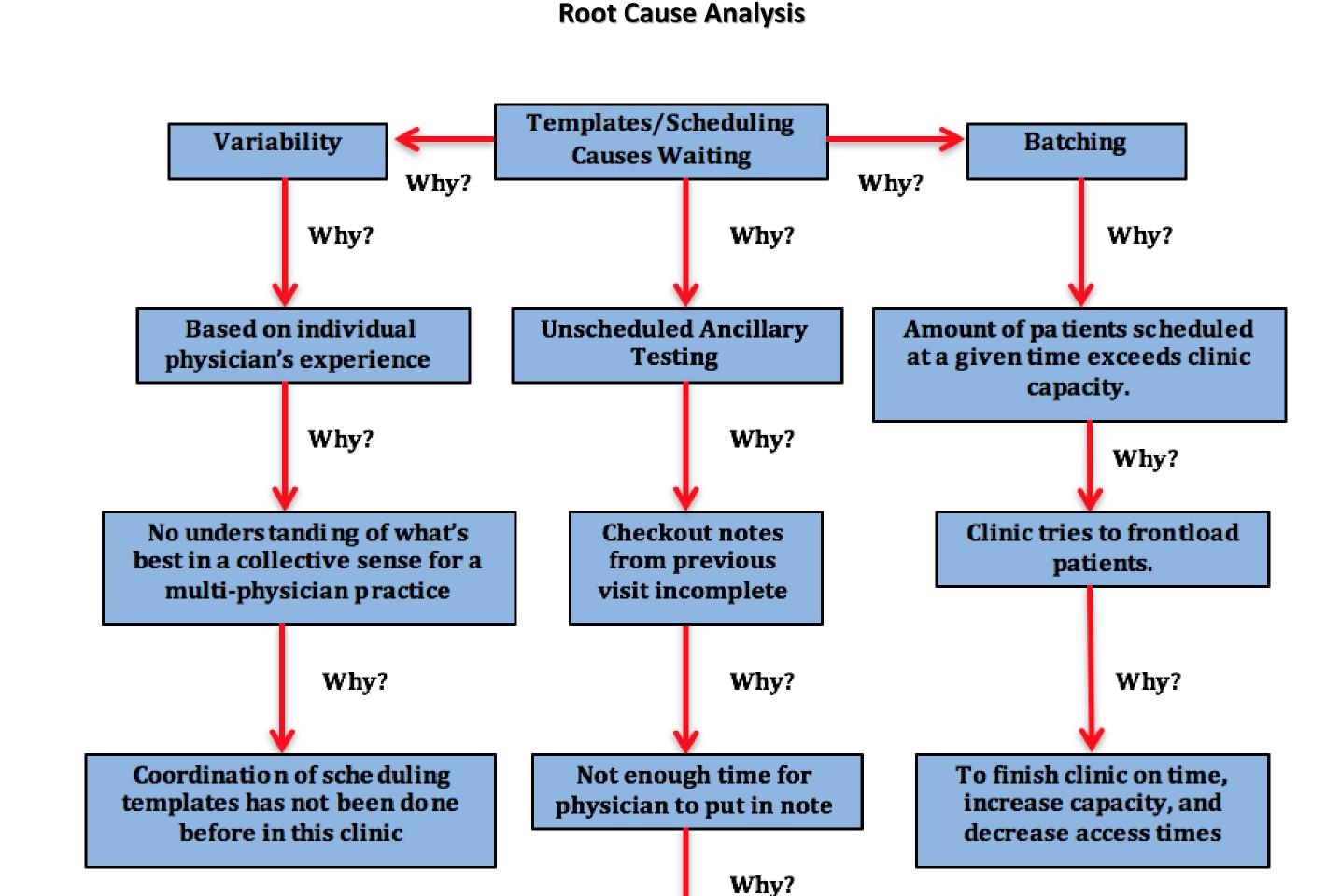
#### Table 3. Frequency of wait time blocks, overall and stratified by new versus return visit patients

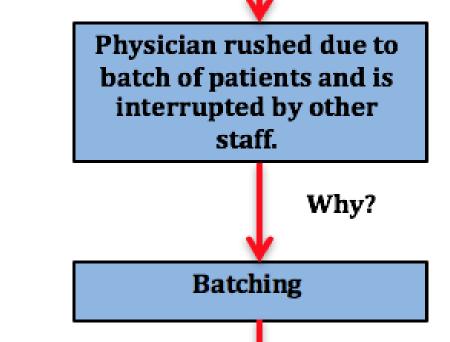
| Useable Wait Times | Overal | Overall (n=77) |    | ent (n=29) | Return Patient (n=48) |        |  |
|--------------------|--------|----------------|----|------------|-----------------------|--------|--|
|                    | #      | %              | #  | %          | #                     | %      |  |
| 5+ minutes         | 77     | 100.0%         | 29 | 100.0%     | 48                    | 100.0% |  |
| 10+ minutes        | 71     | 92.2%          | 29 | 100.0%     | 42                    | 87.5%  |  |
| 15+ minutes        | 57     | 74.0%          | 24 | 82.8%      | 33                    | 68.8%  |  |
| 20+ minutes        | 42     | 54.5%          | 13 | 44.8%      | 29                    | 60.4%  |  |
| 30+ minutes        | 22     | 28.6%          | 5  | 17.2%      | 17                    | 35.4%  |  |

#### III. Goals/Targets

- · Return visit patients spend almost as much time waiting as they do being served.
- Goal: Reduce return visit wait times by 50%.

#### IV. Analysis





SCHEDULING

TEMPLATES

Why?

# Conclusions

- Return visits have a higher percentage of wait time, on average.
- •The root causes identified for wait times through lean evaluation were scheduling issues which lead to patient batching and increased wait times.
- Educational interventions that can be delivered in 10-15 minute blocks may be best integrated into clinic flow.
- Clinic efficiency should be improved to decrease five-minute wait times as they are unlikely to be useful for education.
- Patient and provider movement will be monitored in the future using passive RFID technology<sup>10</sup> to assess process and wait times on a larger scale and to assess the effectiveness of any countermeasures.

## References

Weinreb RN, Aung T, Medeiros FA. The pathophysiology and treatment of glaucoma. *JAMA* 2014; 311(18): 1901-11.

Kass MA, Heuer DK, Higginbotham EJ, et al. The Ocular Hypertension Treatment Study: a randomized trail determines that topical ocular hypotensive medication delays or prevents the onset of primary open-angle glaucoma. Arch Ophthalmol 2002; 120: 701-713. Discussion 829-30

- Kass MA, Heuer DK, Higginbotham EJ, et al. The Ocular Hypertension Treatment Study: a randomized trail determines that topical ocular hypotensive medication delays or prevents the onset of primary open-angle glaucoma. Arch Ophthalmol 2002; 120: 701-713. Discussion 829-30.

  Leske MC, Heijl A, Hussein M, et al. Factors for glaucoma progression and the effect of treatment: the early manifest glaucoma trial. Arch Ophthalmol 2003; 121: 48-56.

  Olthoff CM, Schouten JS, van de Borne BW, Webers CA. Noncompliance with ocular hypotensive treatment in patients with glaucoma or ocular hypertension an evidence-based review. Ophthalmology 2005; 112: 953-61.
- Schwartz GF, Quigley HA. Adherence and persistence with glaucoma therapy. Surv Ophthalmol 2008; 53(Suppl 1): S57-68.
   Newman-Casey PA, Weizer J, Heisler, et al. Systematic review of educational interventions to improve glaucoma medication adherence. Semin Ophthalmol. 2013; 28(3): 191-201.
- Newman-Casey PA, Dayno M, Robin AL. Systematic review of educational intervetnions to improve glaucoma medication adherence: an update in 2015. In Press.
   Yusof MM, Khodambashi S, Mokhtar AM. Evaluation of the clinical process in a critical care information system using the Lean method: a case study. BMC Medical Informatics and Decision Making 2012; 12: 150.
   Shook, J. Managing to learn: Using the A3 management process to solve problems, gain agreement, mentor, and lead. Cambridge, MA: Lean Enterprise Institute, Inc. 2008.
- Shook, J. Managing to learn: Using the A3 management process to solve problems, gain agreement, mentor, and lead. Cambridge, MA: Lean E Min D, Yih Y. Fuzzy logic-based approach to detecting a passive RFID tag in an oupatient clinic. J Med Syst 2011; 35: 423-432.

**Grant Support** 



