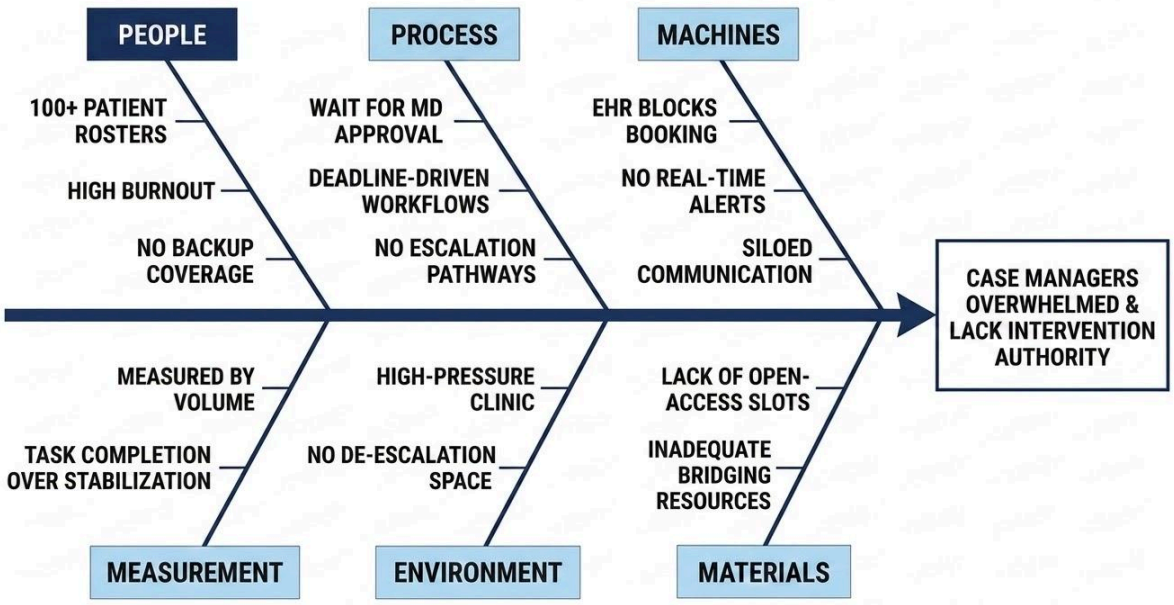

Root Cause Analysis: Ishikawa (Fishbone) Diagram

Project: Outpatient Psychiatric Clinic Workflow Optimization

Problem Statement

> **Case managers are overwhelmed by high caseloads and lack the administrative authority to intervene immediately when they spot early patient warning signs.**

Cause Categories (The Bones - 6Ms Framework)

The following analysis breaks down the root causes contributing to the central problem across the six standard Ishikawa categories. This structured approach helps identify systemic workflow and operational gaps rather than blaming individual staff members.

Category	Specific Root Causes
People (Manpower)	• Case managers are assigned excessive rosters (e.g., 100+ patients), stretching their capacity and causing fatigue. • High burnout rates leading to staff turnover and loss of long-term continuity of care. • Lack of designated backup coverage when a primary case manager is on leave or handling an acute crisis.
Process (Methods)	• Rigid clinic protocols require case managers to wait for attending physician approval before scheduling urgent interventions. • Administrative workflows are deadline-driven (e.g., standard 4-day default queue) rather than acuity-driven. • No protocolized escalation pathway exists for subclinical or early behavioral warning signs.
Machines (Technology)	• The EHR (Electronic Health Record) system physically blocks non-prescribing staff from booking emergency slots on a doctor's calendar. • Lack of automated alerts or real-time triage flags for deteriorating patients. • Siloed communication systems (EHR vs. NEHR vs. Private Clinics) mean case managers cannot always track external ER visits or medication lapses.
Measurement	• Staffing and performance are measured by total patient volume rather than the actual acuity or clinical risk-level of the roster. • Success is often measured by administrative task completion (e.g., checking the "voicemail left" box) rather than successful patient stabilization.
Environment	• A high-pressure, siloed outpatient clinic setting where doctors are booked back-to-back and inaccessible for quick curbside consults. • No dedicated physical space or triage team is designated for immediate, low-stimulation de-escalation of walk-in crises.

Category	Specific Root Causes
Materials	• A severe lack of available "open-access" or "buffer" appointment slots for immediate crisis management. • Inadequate temporary bridging resources (e.g., short-term medication overrides, immediate peer support tools) for patients while they wait for physician availability.

Key Insights & Prioritization

While all categories contribute to the bottleneck, the intersection of **People (High Caseloads)** and **Process/Machines (Lack of Override Authority)** forms the most critical breaking point. To solve this issue permanently, the clinic must decouple the case manager's surveillance ability from the physician's scheduling bottleneck by granting delegated scheduling authority to non-prescribing staff for urgent cases.