HCH Performance Improvement Committee Meeting Minutes

Date of Meeting:	6/19/19	Time:	8-9am
Location:	421 Fallsway, 3rd Fl Large Conf. Room	Minutes prepared by:	Ziad Amer

Attendees

Z. Amer, C. Brocht, A. Darby, J. Diamond, B. DiPietro, J. Ferdous, M. Flanagan, E. Goldberg, S. Golden, T. Gray, K. Healy, M. Johnston, K. Leisner, A. Richert, T. Russell, J. Tate, G. Thacker, A. Trustman, L. Williams, M. Williams

Agenda and Notes, Decisions, Issues

Topic	Discussion
Agenda note	The agenda item of "PDSAs in-depth" was moved to the July PI Committee meeting due to technical difficulties with the conference room computer.
Monthly Dashboard:	
BP Control	Special cause variation at 64% in May, jumping out of the control limits but still under our goal of 65%.
BMI	Continuing our 8 month streak being above our goal of 75%. Currently at 82% in May.
Child Weight Screening and Counseling	Continuing to track our baseline data. We will begin our PI Committee Meetings next week to identify improvement opportunities.
Pediatric Dental Varnish	3 months in a row above our goal of 50%. Currently at 55% in May.
Incident Reporting	The large uptick in April to 34% (above our goal of 25%), was likely due to our increased discussion and advocacy around Incident Reporting, not a result of any testing or implementation of changes. This also explains the unsustainability of that rise as we have not committed any changes to the agency. We currently sit at 17% in May.

Provider Communication	• Without the release of the most recent Client Experience Survey data, we still show 80% (goal = 83%) from November 2018.
	• Subcommittee work has revealed that provider communication challenges are not only provider-client but provider-provider communication as well. Providers don't know how to accurately guide clients to other services within the organization.
	• The subcommittee has identified root causes, identified and prioritized change ideas, and presented these ideas to the E-Team.
	• Key Change Ideas:
	  ○ Communicating wait times to clients using whiteboards and CAAs
	  ○ Protocol for communicating staffing changes timely
	  ○ Addressing long medical wait times
	  ○ Formal training for staff on communication best practices
	• Each of these ideas target specific root causes we have identified.
	• A wait time study was conducted on 6/12 AM session to evaluate the current state of our clients' wait.
	  ○ Average Non-Medical Wait: 2 minutes (56 clients tracked)
	  ○ Average Medical Wait: 17.5 minutes (39 clients tracked)
	• Clients also have to wait to check out after being released by their provider
	• We will also be including staffing changes into Kevin's weekly all-staff emails to incorporate any staff changes from the week prior
	• We will also explore a procedure for communicating with clients when their provider leaves the agency
	• Thus far we have learned:
	  ○ The need for internal communication on procedures, workflows, staff changes, etc.
	  ○ Client frustration in waiting areas is related to lack of wait time communication
	  ○ Clients and staff do not know how to access all of the services we provide
	• The Subcommittee's next steps:
	  ○ Continue to explore clinic workflow
	  ○ Review change ideas with CRC in July
	  ○ Develop formal training for staff and new hires on customer service
	  ▪ Discussions on the use of grant funding for training purposes
	  ○ Begin to test using whiteboards to display wait times
	  ○ Discuss creating a procedure for communicating staff changes to clients.

	Questions:
	• How are the wait times being calculated?
	  ○ The study was done by manually tracking clients who enter the waiting area and when they are called back to their appointments. This information was then referenced in the EMR to determine actual wait times that ran over the appointment times and how long the client was *actually* waiting.
	• How will the whiteboards accommodate the clients when we are short staffed?
	  ○ At this point in the study, we are only looking at current wait times and whether or not a whiteboard would improve "satisfaction" in our clients. The complexity of our schedule should not significantly impact the estimated average wait time that is being communicated to our clients.
	• Will there be a difference in how this is communicated to walk-in clients?
	  ○ Yes. Walk-in clients will be told by the CAAs that there are a certain number of other clients ahead of them in the queue and we estimate a certain wait time; ensuring that this is a separate wait time than a scheduled appointment.

Missed Appointments	• As of May we are still hovering at 25% with a special variation, towards our goal of 20%.
	• Since we last met:
	  ○ The subcommittee has continued to test the delaying of no-showing a client until the end of the sessions
	  ○ The CAAs on the 2nd floor have begun to implement the reminder calls to clients, based on care teams, prior to their appointments
	  ○ Identified clients who frequently miss their appointments
	• In developing the change idea of delaying no-showing clients until the end of the session we discovered that there was no clear procedure shared by all providers to no show their clients – this left the discretion of whether or not a client is seen up to their provider
	  ○ Part of this change idea is to standardize the process of no showing clients across all providers
	• Our first 3 PDSA cycles revealed that the assumption that, if clients are allowed to be seen no matter how late they are will result in abuse of the scheduling system, is not true
	  ○ PDSA cycle 1 tested for one day, showed avg. of 1 client per session was late and could be seen with no workflow interruptions

	- PDSA cycle 2 reflected the same results even with an expanded test period of one week - PDSA cycle 3 revealed significant workflow concerns shared by all who participated (full medical team) with an avg. of 1.5 clients who came in more than 15 minutes late and were still seen. - Clients who were seen at the end of the PM session left providers without support staff and lab staffing as these positions end at 4pm. - We targeted the top 20 clients for missed appointments and revealed that their no show rate can be as high as 68%. 30% of our clients in a 6 month audit period missed 3 or more appointments; 3% of our clients in the same period missed 10 or more - This top 20 group that we pulled demonstrates an enormous volume of appointments per client, as high as 182 appointments in 6 months – we want to find out why - Aisha and Laura have been looking into some of the clients specifically to determine what these clients are being scheduled - The reminder calls have also shown through collected Yellow Team data that clients who are reached by phone have a 17% no show rate vs. clients who are not reached who have a 54% no show rate. - Similarly this is dependent upon the accuracy of phone numbers on file. - Dental, Orange, Magenta, Jade, Yellow, Green, Purple, Steel and all non-care team providers are implementing this practice - Lessons Learned: - Average of 1 medical client does come in after 15 minutes late - How will delaying no-showing clients impact providers' access for walk-ins and same day appointments - Reminder calls result in a significant decrease in missed appointments - A certain group of clients have a very high number of scheduled appointments that also result in high numbers of missed appointments, as high as 68% - Next Steps: - Continue to test current change ideas - Implement successful ideas - Determine and test change ideas to address clients who frequently miss appointments

Discussion: Professional Development	• There continues to be a ton of opportunities relating to PI, IHI and quality that are available for staff.
	• How do we communicate these opportunities to staff?
	  ○ Make it a part of the Performance Evaluations for Supervisors
	  ○ Encourage the use of Professional Development now, in the middle of the year rather than late
	  ○ Distribute opportunities far in advance as medical staff are booked 5-6 weeks out

Next Meeting:

Wednesday, June 19th, 2019
8am – 9am
3rd Floor Large Conference Room