AmeriCares

U.S. Medical Assistance Program

Case Study of Quality Improvement in The Free Clinics, Inc.

Hendersonville, North Carolina

May 2014

Improving No-Show Rate

About the Clinic

Name of Clinic: Henderson County Free Medical Clinics, Inc. d/b/a The Free Clinics

Type of Clinic: Free Clinic

Location: Hendersonville, NC

Year Founded: 2001

Budget: $776,098

Unduplicated patients: 1,613 (2012-2013)

Patient visits: 8,884 (2012-2013)

Paid staff: 5 full-time, 10 part-time

Volunteers: 250

Services:

- Acute care: dental clinic and medical clinic
- Chronic and Specialty care: diabetes life management program, endocrinology clinic, eye clinic, orthopedic clinic, physical medicine & rehabilitation clinic, community case management (with referral to 92 off-site practices/partners), other clinical services
- Mental Health Care: counseling, psychiatric care navigation, psychiatric clinic
- Pharmaceutical services: prescription assistance program and community pharmacy
- Patient Education and Wellness: smoking cessation, diabetes education

Leadership: 18-member Board of Directors; medical director; dental director; staff leadership team consists of executive director, clinical services director, and assistant director; clinical services committee consists of two board members (MD & FNP) and two nurse volunteers in addition to Executive Director and Clinical Services Director and medical and dental directors

For further information:

Judith Long, Executive Director
jlong@thefreeclinics.org

Jacquie Rose, Clinical Services Director
jrose@thefreeclinics.org

Summary of Quality Improvement Project

The Problem: High no-show rate

The Approach: The Free Clinics (TFC) created a new no-show policy, which suspends services for a period of 90 days for any patient who fails to show up for an appointment twice within a 90-day period without previously calling to cancel or reschedule the appointment. The clinic provides each patient with a written copy of the no-show policy during the eligibility visit. In addition, the eligibility volunteer verbally explains the policy to the patient. The final step requires the patient to sign a no-show contract upon enrollment and annual re-enrollment.

PDSA in Action:

The free clinic carried out PDSA cycles for two related quality initiatives: (1) to monitor compliance among staff and volunteers with new procedures established for communicating the no-show policy to patients and (2) to determine patient compliance with the new no-show policy.

Plan 1: To ensure that 95% of new patients sign TFC's no-show contract.

Do 1: The clinic developed a no-show policy, created a no-show contract, and trained volunteer eligibility workers about the importance of the policy and how best to explain it to patients.

Study 1: The clinic tracked the percentage of new patients signing the no-show contract for two quarters following the adoption by the Board of Directors of the new policy in September 2009. An eligibility specialist reviewed each new patient chart for the required signature and noted charts with missing signatures. Review of these data showed 100% compliance.

Act 1: Feeling confident that systems were in place to assure that patients were aware of the new policy, the clinic was ready to enforce the policy.

Plan 2: The clinic established two goals: (1) Less than 10% of patients will have a no-show during a quarter and (2) Less than 5% of patients will have two no-shows during a quarter.

Do 2: After reviewing the first quarter results and in an effort to improve its communication methods, the clinic engaged in one-on-one volunteer training and mentoring with their eligibility volunteers about communicating the policy.

Study 2: The clinic tracked the percentage of patients who were no-shows for one year. A simple query report of the patient database indicated how many patients had one or two no-shows during the 90-day period. Their results improved throughout the year with regard to the percentage of patients who had one no-show: first quarter 18%, second quarter 12%, third quarter 6%, and fourth quarter 6%.

Act 2: The clinic implemented the policy permanently.

Q & A[i] with Judith Long, Executive Director, The Free Clinics

Quality Improvement Efforts at Your Clinic

Q: What was the impetus for deciding to initiate improvement at your clinic?

A: The Free Clinics (TFC) completely changed leadership (i.e., executive director and clinical director) in summer/fall 2005.

In the fall of 2006, TFC initiated the process to become a deemed clinic under the Federal Tort Claims Act (FTCA), which would provide full coverage and thus malpractice immunity to our clinical volunteers. As part of our application for the FTCA coverage, TFC was required to adopt a Quality Assurance (QA) policy. TFC leadership (staff, board, volunteers) takes policies and organizational processes seriously. We were not the kind of organization to adopt something like QA in name only and merely give lip service to the concept. Once we adopted a QA policy, QA was integrated into all aspects of TFC.

Q: When did you first start focusing on improvement?

A: Explicitly we began focusing on improvement in fall/winter 2006 upon adoption of the QA policy, as motivated by application for FTCA coverage. Implicitly a focus on quality (and by extension improvement) is inherent in the very fabric of TFC.

Our clinic has a very different model than most free clinics; we explicitly do not provide primary care. Part of the reason for this model is that in our community, primary care is not the gap that needs to be filled; we have an FQHC, a residency training program with a generous sliding scale fee, a rural health center, and a health department providing primary care for women and children. But far more significant to the culture of TFC is the quality issue inherent in our model. We do not provide primary care in a volunteer-based free clinic setting because, as understood by our medical director

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[i] Questions were taken or adapted from Houck, S. (2004). *What Works: Effective Tools and Case Studies to Improve Clinical Office Practice*. Boulder, CO: HealthPress Publishing.

and volunteers, it does not provide the highest quality care. Ideally, primary care should entail a relationship whereby a patient gets to know his/her provider. Primary care in a volunteer setting means that patients usually have a different provider at each visit, thus the provider relationship is not established and there is not always continuity of care. I explain that regarding our model as a way to express that our emphasis on quality and improvement is embedded into the very DNA of our clinic, our formation, and our model.

Q: How were you able to achieve staff/provider/volunteer/organizational buy-in to your QI initiative?

A: I think the single most influential dimension of obtaining the buy-in of board, staff, volunteers, etc. was the focus on quality.

Our founding steering committee, as well as our volunteer medical director, emphasized the importance of quality to our founding board of directors, who carried the message to subsequent boards. During our first year, the board focused on start-up issues—do we have enough money, what is our eligibility process anyway, how do we recruit volunteers, etc.? But remarkably, less than one year after the first clinic, the board began to focus on larger/broader issues, including "how do we ensure quality healthcare?" Discussions of assurance of quality have continued to today.

With respect to provider buy-in, both our volunteer medical director, Dr. Crane, and our volunteer dental director, Dr. Richards, are local leaders in their respective fields, respected by their peers and regularly engage in professional development in order to improve their own provision of quality care. Dr. Richards and Dr. Crane embraced the QA and Peer Review systems and introduced them as matter of course for TFC in order to ensure to the community that we were providing the highest quality care AND continually seeking to improve that care. With these two as the lead voices among their peers, obtaining provider buy-in was relatively painless.

Q: What activities have been especially important to sustaining improvement?

A: I think the activities most important to sustaining improvement have been showing the results of what we have accomplished previously. The fact that we could demonstrate improved patient care in an area, better patient relations and fewer no-shows, over time heightened our engagement and improved stakeholder buy-in, both of which contribute to sustained improvement. Board, staff, volunteers, leadership could see tangible results from the activities; it was a true commitment to improvement, not just paperwork for paperwork's sake.

Another activity important to sustained improvement is that the staff has a tremendous voice in identifying organizational challenges and what needs to be done to address those challenges. We have an annual staff retreat. One goal of the retreat is team-building, but most of the agenda of the retreat is evaluation of the past year—program area by program area. We explore areas that staff assess as weaker and craft new QI goals to improve those areas. Staff recommendations then are submitted to the Clinical Services Committee for discussion. The Committee adopts most staff suggestions, with some modifications and occasional additions of prior year goals or deeper/nuanced exploration of a prior year goal. Then the final goals are presented to the board. Giving the staff voice is a significant dimension of sustaining their engagement with quality improvement.

Q: Was leadership important to your improvement efforts? How so?

A: Leadership was very important, especially the medical director and dental director. Physician volunteer leadership and physician commitment to obtaining the FTCA immunity coverage was also a significant driver in beginning our explicit improvement efforts. Board leadership was important, certainly, but the board's commitment came in response to the physicians.

The driving forces were the medical and dental director, the volunteer physicians, and the executive director and clinical director. The physician volunteers were enthusiastic endorsers of the FTCA application, including willing participants in developing the policies/procedures required (i.e., more extensive privileging, peer review, QA). They also verbalized their desire to be involved with a program that could/would demonstrate quality to the community.

The clinical director (now retired) and executive director provided key staff leadership to the program, giving it form and day-to-day direction.

Q: Do you have an ongoing team that leads improvement in your organization? If so, please describe who is on it, how often they meet, and the structure for initiating improvements.

A: Our board's Clinical Services Committee (comprised of board members, leadership staff—clinical director and executive director, and several key volunteers with quality experience/backgrounds) is the leadership team that leads improvement at TFC. All members are clinicians except the executive director. Membership always includes at least two providers and at least two volunteer RNs. Membership has sometimes (when we can find someone to serve) included a pharmacist and a dentist. The organization's medical and dental directors are nominal members of the Committee, though they are rarely able to make meetings in person and instead give their suggestions/thoughts via email or phone conference. The Committee meets quarterly (or more often if needed) to review the quarterly QI data. The Committee reports its findings to the board on a quarterly basis.

In addition, the clinical staff teams meets monthly to discuss multiple topics, including more recently the newer PDSA process for QI, which was implemented 6-9 months ago under the auspices of a new effort led by the North Carolina Association of Free Clinics.

The process for initiating improvement efforts was described above, beginning with staff evaluation of program areas and determination of key areas to explore. Those suggestions are then taken to the clinical services committee who modifies, adopts entirely, and/or suggests new topics as appropriate.

Q: How do you track and post results or outcomes? (These include operational, clinical, satisfaction, and financial.) How do you select which metrics to use? Have you found it important to limit the number of metrics used? What metrics do you use?

A: The method for tracking results varies with the outcome being measured. Over the past eight years, we have measured 45 different outcomes, some of which are process-related, some board-related, some relational (as in visiting partnering practices) and some focused on patient outcomes. For each measure, we determine the best tracking system and means of utilization of the data available to us. We try not to create questions for which there are no data (though in early years we did make that mistake), forcing us to create complex systems and administrative busywork simply to answer our own questions. Our Clinical Services Director is the staff person responsible for obtaining, tracking, and reporting the data. She works with various staff persons to determine the best metrics. In recent years, TFC has benefitted greatly in this effort from the services of a volunteer who is highly skilled in programming, and who has created systems for data retrieval from the three programs used (patient records, pharmacy, prescription assistance) and written queries (at our direction) to analyze a more complete picture of our work with any/all patients.

Quarterly outcome results are tabulated and reported first to the clinical services committee, then the board of directors and the staff. There are occasions when we will also present outstanding results to the community via a newsletter article.

We do not yet have an EMR. At present, we simply use MedServices for our patient database.

Q: What lessons have you learned during the QI process? If you were starting your improvement work now, what would you do differently?

A: One of the key lessons we have learned is to determine the "how" for data collection when we create the goal, not after the fact. There were a few occasions early on in our process when we created a goal and then wondered how we were going to possibly measure/report on it.

Another lesson is that we do not collect data for data's sake or because we have to do something but rather to answer the larger questions: what are we learning that will have lasting impact on our patients, the care we provide, and our community safety net?

What would we do differently: I would hope that we would focus on the larger questions at the beginning of the QI process. For the first year, we were more focused on finding answers to a question, not looking to the vision of using the process to gain understanding of how to improve our overall clinic, practice, and care. I don't think in the beginning we understood how to use the process to truly further our vision and goals of quality. We started the process without any formal training on QA/QI. It took a year of trial and error to gain understanding as to how to use the process for our clinics' overall benefit. I think it would have been useful to have some training for our leadership staff on QA/QI processes and methodology.

Q: What advice do you have for other clinics that are new to QI?

A: I would advise them to embrace the process, not to fear or dread it. It can and does lead to real positive change/improvement in your clinic and thus ultimately to better health outcomes for your patients—which is the whole point of what free clinics are about.

I would advise them to identify two to three key leaders who are going to "own" the process and embody the "quality vision." Ideally these leaders (or at least one of them) should have authority within the clinics—not necessarily the authority that comes with position or supervisory authority, but more the authority that comes with respect of their peers. If they embody the quality vision, these leaders will have the greatest impact upon their peers.

I would advise other clinics to encourage staff ownership. It will likely not come right away. Most staff will inherently resist additions to their busy workloads. But with slow encouragement, staff will come to embrace the QA/QI process. Begin slowly, have a staff retreat, and talk about the work and the patients—what's working and what's not. Don't frame in terms of a "Quality Improvement Plan/Initiative." Rather frame it as: "let's look at what's working and what's not and how we can make things better." Start small—perhaps start with patient no shows for appointments (a common free clinic issue given our patient population). How might we try options to reduce no-shows? Brainstorm. Then make it an exploration for a year—what exactly (not anecdotal but actual) is our no-show rate? Then use the staff wisdom to try a solution. Test it. Measure again. Repeat. Ideally by the end of the first year, you see an improvement/reduction in patient no-shows. After that first year, THEN explain that they just engaged in a QA/QI process AND their collective effort just made a difference in how care is provided to patients. Once the staff gets a taste of how their shared exploration of a question and brainstorming for solutions (which are tested and tried) makes a big difference in patient care, they are far, far more willing to embrace the process.

I would also advise them to use the information they glean to actually make improvements. Make changes based on the information gathered.

Start small, but use the process to explore the "larger questions" of how to do your business and how to improve care for patients.

Always determine how you are going to gather the data to answer your question before you adopt the measure for the year.

Q: What are the benefits and drawbacks of engaging in a QI process?

A: The benefits are many:

- Improved care for patients
- Improved patient outcomes
- Improved utilization of resources—funds, volunteers, donated goods, etc.
- Staff satisfaction—both due to ownership of the process and due to improved care and outcomes for patients
- Increased respect among healthcare community; QI is part of doing business in hospitals, FQHCs, etc. Our embrace of QI heightens our respect among our partners

I can't think of any drawbacks if it's implemented well with staff ownership and strong leadership. If it's implemented top-down and imposed on staff without their ownership/embrace, it will not work.

Quality Improvement Initiative:
No-Show Rate Policy

Q: Can you give us a "before" and "after" portrait of the problem you wanted to address?

A: Like many free clinics and other safety net providers, TFC had a real problem with patient no-shows. This happened with our diabetes program regularly, as well as most of our other clinics. It was frustrating on many levels—the patients were not getting the care they needed, the volunteers felt coming to the clinics was a waste of their time, the staff person was unable to connect with the patients who needed us. We tried (multiple) reminder calls, reminder postcards, and free bus passes to alleviate the cost of transportation for those for whom it was an issue. Nothing seemed to make a difference.

Simultaneous to the challenges we had with many of our clinics and programs, we had the absolute opposite experience with our dental extraction clinic. We rarely had no-shows with that clinic. We examined the differences between the dental clinic and our other programs to see if we could determine what made the difference. For instance, the dental extraction clinic operates with a same-day, phone-in procedure. Patients are not scheduled ahead of time but rather must call at 10 am the morning of clinic to schedule an appointment for that evening. Patients with other clinics are scheduled ahead of time, sometimes weeks before their appointment. Was the timeliness of the clinic appointment the deciding factor? Of course, the dental clinic is often about relieving immediate pain of an infected or broken tooth, whereas our other clinics were rarely treating issues of such an acute nature. Was that the deciding factor? Finally, there was the no-show policy for the dental. With dental, we instructed patients at the time that they called for their appointment that if they did not show up that evening, they would not be seen at the clinic for 30 days. If they called, they could reschedule as soon as next week. We explained that we understood that "life happened" and sometimes events were beyond their control, but they needed to call us rather than not show up. As we explained, if they called, a) they would not end up on the "do not see list" for 30 days and b) we could call someone from the waiting list.

As a staff we talked about the issues and wondered what the key element might be that indicated the significant difference between the lack of no-shows at dental and the high prevalence of no-shows at all our other programs. We decided to make no-shows a QA indicator and test various dimensions of the issue and try a solution. After much discussion, we created a no-show policy for our programs. We were thoughtful, drawing on our experience with our dental program. We required patients to call, and we imposed a penalty for no-shows. If they did not call to cancel/reschedule twice within a 90-day period they would be suspended from ALL TFC services for 90 days. TFC operates a dispensing pharmacy for the community, providing medications and diabetic supplies at very little cost ($3 per prescription, which can be waived).

While we could not recreate the acuity of the dental experience—the alleviation of pain as an incentive to not no-show—we could enact a penalty that would be significant to most of our patients; by not showing up they are denied affordable access to their needed medications and supplies. [If a person is suspended, our pharmacy phones in the prescription to the pharmacy of their choice so that the patient still receives his medication, but at far greater cost.]

This was a new policy, so we needed to introduce it to patients as well as test its application. Patients would receive a paper copy of the policy during their eligibility appointment and the policy would be verbally reviewed by the eligibility volunteer at that time. They would also be required to sign the No-Show Contract upon enrollment. Ongoing patients are re-enrolled once each year to verify their eligibility. Thus, while all new patients would receive the policy immediately upon enrollment, we knew it would take a full year from adoption to ensure that every ongoing patient received a copy and explanation of the policy.

To ensure that each patient received explanation, we adopted a QA goal during the 2009-2010 year that stated, "95% of new patients/clients will sign TFC's no-show policy contract." We initiated this QA measure to ensure that we developed appropriate systems to get the policy into patients' hands and minds, including training the volunteer eligibility workers about the importance of the policy and how to best explain it to patients. The QA measure was initiated in June 2009 and adopted by the Clinical Services Committee in July 2009; however, the board had not yet adopted the policy. Thus, we did not track the measure during the first quarter because the policy was not adopted until September 2009. We tracked the measure for the 2nd and 3rd quarters and achieved 100% compliance. We did not track the measure in the 4th quarter because we felt confident that our systems were in place.

We then tested patient compliance with the policy in 2010-2011. We created two separate outcome measures:

1. Less than 10% of patients will have a no-show during a quarter and
2. Less than 5% of patients will have two no-shows during a quarter.

The first measure really explored how well we explained the policy to patients, teaching them to understand the importance of communication with their medical provider and to be good patients for TFC. The second measure explored how many patients were suspended from services due to 2 no-shows.

As we tracked our results for the year, we found that the penalty worked. Less than 1% of patients had 2 no-shows during a quarter and were suspended from services. Yet, we also learned that while our systems were in place to get the policy into patients' hands, we needed to improve our communication methods. We engaged in one-on-one volunteer training and mentoring with our eligibility volunteers on communicating the policy. Our results improved throughout the year with regard to the percentage of patients who had one no-show: first quarter 18%, second quarter 12%, third quarter 6%, and fourth quarter 6%.

By the end of the two-year process, we felt confident that we had sufficiently addressed our no-show issue. Patients attended their scheduled appointments or they called to cancel/reschedule. Thus, patients received the care they needed. Volunteers felt better about the use of/respect for their time. And patient outcomes improved because they received the care they needed.

Q: What did you need to change?

A: Due to our experience with the dental clinic, we recognized the need to change our methodology for teaching the importance of communication. Rather than encourage ("we really want/need you to call"), our new tactic employed the threat of loss of something they needed/wanted. For dental, it was access to alleviation of pain and for the rest of our programs, it was access to their medications/supplies.

Q: What tools/templates/worksheets/diagrams/instruments/charts/data/metrics did you use in your improvement efforts (in each of the PDSA stages)?

A: We did not use any standard tools or templates. The data used was drawn in the first year from the eligibility specialist's review of all new patient charts and re-enrolled patients charts for full documentation, including signature of the no-show contract. In the second year, the data were drawn from the patient database record of no-shows on appointments. The data collected was tabulated by the Clinical Services Director and then reported to the Executive Director and the Clinical Services Committee.

Q: What did you propose to do (want to change) to address the problem?

A: We wanted ultimately to change/reduce the number of quality of the patient's care and health outcomes AND to increase the satisfaction of our volunteers. If we lose our volunteers, we simply cannot provide care.

Recognizing that we cannot change the reality of our patient's complex and often crisis-ridden lives, we needed to change their communication with us about their lives. We needed to enforce that they must communicate with us.

Q: How did you go about testing the change(s)?

A: Our objective was to change our patient's communication style with regard to needing to cancel/reschedule appointments due to crises in their lives.

We predicted that reminder phone calls and postcards weren't enough to warrant a change in patients' behavior. Given the extensive utilization of our pharmacy and patients' need for medication/supplies, we predicted that fear of loss of access to that service (and thus higher costs through another pharmacy) would motivate patients to communicate with us.

We engaged in a two-year process to implement and test the change. Our enrollment process (or re-enrollment) occurs annually. It was one full year after adoption/implementation of the new policy before all patients were educated about it and had signed the contract. During the second year, we tested their response to the change by tracking both the % of patients who "no showed" one time and the % of patients who "no showed" two times and thus were suspended from services for 90 days. Using the patient scheduling module of our patient database, we simply recorded no-shows. Then a simple query report produced the data we needed. The Clinical Services Director ran the reports, tabulated the information and reported to the Executive Director and Clinical Services Committee. She also communicated to the entire staff those few patients who were suspended from care for a 90-day period, including when their suspension would be lifted.

Because we were examining our entire patient population, we tested all patients. During the 2009-2010 year, this was a review by the eligibility specialist of 1,658 charts. During the 2010-11 year, it affected 1,843 patients. Appointments are scheduled for the following programs: psychiatric clinic, counseling, diabetes clinic/program, eye clinic, dental clinic, endocrinology clinic, PMR clinic, orthopedic clinic, prescription assistance program, and community case management program. These programs affect approximately 2/3 - 3/4 of our patient population in any given year.

Q: What were the results of your intervention?

A: The results were dramatic. We went from having significant no-shows in all of our appointment-based programs (except dental) to having 6% no-shows by the end of 2010-11. Patients still sometimes canceled appointments, but they called to do so rather than be a no-show. And more frequently, by calling to speak to the appropriate staff, we were able to assist them in finding a solution to the barrier/obstacle to their appointment.

We refined one dimension during the second year. We found after the first quarter or so that we needed to train our eligibility volunteers better about how to communicate our expectations to patients and how to encourage/teach them to communicate with us. The refinement of our teaching occurred during the first six months of our test year so we had another six months of data. We have not formally measured compliance to our no-show policy again, however, we continue to enforce the policy. Our Clinical Services Director continues to run a monthly report tracking 2nd no-show within a 90-day window and suspend those patients from TFC services for 90 days. At any given time, there are fewer than five patients on this list—which is significantly less than one percent.

Q: How did you spread the change? What are the lessons learned?

A: The no-show policy was for the entire organization. It was a Board-approved policy in September 2009. It is reviewed every year and remains intact and unchanged. That policy was then crafted into a patient no-show contract. Eligibility volunteers are trained on how to present the policy to new patients (and at re-enrollment).

One lesson learned is that sometimes with challenging patients, the way to leverage good behavior is through threat of loss of access to desired care. For us this has been true with both the dental clinic specifically and our entire appointment-based programming. Another lesson is that change sometimes takes a long-term perspective; this entire process was two full years. Sometimes there are unintended (positive) side-effects, in that this policy resulted in better communication between patients and the clinic about other dimensions of their lives.

Q: What have been the implications of your QI initiative(s)?

A: With respect to the no-show initiative, the implications have been even stronger staff engagement with the QI process because they see concretely how examining a problem, taking concrete action, then testing/studying and making modifications can bring tremendous results. Patients come to their appointments, get the care they need, and their health outcomes are better because they get that care. Volunteers are happier. And often patients are learning to communicate with our team in new and different ways, which also enhances their experience and their outcomes.