



# Overcoming Challenges to Providing Quality Care in a Rural Health Clinic Setting



***Derrick Gruen, PT, DPT, MALOS, OCS  
Debbie Grice, RN, MPA***

Adventist Health Community Care (AHCC) (formerly known as Central Valley Family Health [CVFH]) opened our first rural health clinic in 1993. The rural health clinics are owned and operated by Central Valley General Hospital under the network of Adventist Health. In 2005, Central Valley General Hospital acquired an additional five clinics as a result of a consolidation of hospitals under Adventist Health, bringing the total to 12 clinics. Our patients are the medically underserved in Health Professional Shortage Areas (HPSA).

Presently AHCC consist of 18 licensed sites. Our operations are conducted in a 2500 square mile area of the central San Joaquin Valley of California. Each clinic provides a variety of primary and specialty medical services to the communities they serve. Our average visits per month exceed 29,500. In 2011, we are projecting 372,000 visits. This will be a 3% increase in visits over 2010 and a 3% increase in gross revenue. We plan to meet these growth projections by increasing specialist care, same store growth, and opening new clinics. We have plans to expand our clinic services into communities that we currently do not serve.

The central valley of California is underserved in both primary and specialist medical care. Oftentimes Medi-Cal or self-pay patients have to be referred to far away places like Los Angeles and San Francisco to receive care from medical specialists. This creates a great hardship on our patients, who are already dealing with transportation problems.

With a geographically dispersed clinic system, the challenge is how to provide leadership that is meaningful and connected to the staff. Another part of that challenge is the variability in the size of the clinic with the largest clinic seeing approximately 5,000 patient visits a month to our smallest clinic

that routinely sees 160 patient visits a month. What evolved over time has been Regional Director/Clinical Nurse Coordinator leadership teams in which the regional director is responsible for clinic operations, and the registered nurse is responsible for the nursing care provided by the back office staff. The Clinical Nurse Coordinator is a registered nurse.

Over the past four years, we have put an emphasis on developing the Regional Director/Clinical Nurse Coordinator relationship. We felt facilitating the growth of this relationship would enhance the leadership, quality of care, and consistency in our dispersed clinic system. To bring consistency and provide an increased focus on operations, the regional director position has been modified since its inception four years ago. Initially, the regional director's clinic responsibilities were determined primarily by geography and clinic volume. As the rural health clinic system has grown, over 30% in the past 4 years, the responsibilities and regions of the regional directors had to be modified. Today we have four Regional Directors and four Clinical Nurse Coordinators that work together as two person teams for AHCC. These two person teams work together on issues concerning clinical quality, clinic operations, staffing, and ultimately bring consistency and high quality performance to our clinic system.

When the consolidation occurred in 2005, there were many different forms and formats for the medical record, with everyone thinking their medical record was the best way to document care so a major ongoing challenge has been standardizing the documentation in the medical record. Added to this mix are the private physician practices that have been purchased and converted to rural health clinics. Many of the physicians in these clinics have been using the same medical records for their entire

career, and are unwilling to readily learn a new way. To meet the many challenges this brings, the ongoing standardized documentation committee reviews each form for how it will be used, what regulatory or other requirements apply, and what amount of documentation needed to capture the intended information in a format that is acceptable to providers and staff. This involves multiple iterations with trial runs providing feedback from providers and staff to get to a final form. This process can take time, however the end result is a form that is readily accepted and utilized. Included in the roll out process are directions on who is responsible for completing what areas as well as where the document is placed in the medical record. As we move towards an electronic medical record, the standardized medical record will ease the transition to the electronic format.

With approximately 400 employees comprised of advance practice providers, site managers, medical record clerks, receptionists, medical assistants and licensed vocational nurses, another challenge is ensuring the competency of the staff in each role. We have targeted support and education opportunities for each role, essentially connecting them to the experts in the field. The advance practice providers meet quarterly for education, business updates and networking with the advance practice provider (APP) Advisory Group determining the agenda for each of the meetings. Additionally the APP Advisory Group meets monthly and functions as the intermediary between administration and the rest of the advance practice providers. They also establish clinical pathways based on recognized standards for care, and provide group and/or one-on-one education during the roll out of the clinical pathways. There are ongoing monthly reviews of care based on the clinical pathways which is then reported through the medical staff committee process of the hospital.

The site managers have monthly meetings in which many topics critical to the successful functioning of the clinics are discussed. Additionally, the site managers participate in the Advanced Professional Management Program which provides education specific to running a successful health care business. The seminars that have been developed for this program are How Data Drives Change, Servant Leadership, Effective Communication, Critical Thinking/Role of Knowledge, Regulations, Leading with Confidence, Provider Relations, Budgeting

Process, Leading with Principles, and Interviewing. Pre and post tests assess the increased ability of the site manager. The goal is to have site managers who have extensive knowledge of the expectations and standards of management required for each clinic.

The back office staff — both Licensed Vocational Nurses (LVN) and Medical Assistants — attends a rural health specific orientation for 3 days, which includes phlebotomy training done by a laboratory phlebotomist and injection training. Additionally, all back office staff are required to do an annual clinical marathon and skills lab, which are set up in stations that address the high volume, high risk procedures for the staff. The components of the clinical marathon/skills lab are determined from a variety of sources including staff and provider input, occurrence reports, and new regulatory requirements. The clinical marathon is all of the theory and/or background with procedure education and is done prior to the skills lab. The attendee must bring the completed and scored pre-test as the entry into the skills lab which is all practical hands-on training done by subject matter experts.

Each clinic site has a designated clinical lead who is responsible for ensuring the delivery of safe patient care. A monthly clinical lead meeting is held in which any patient care related topic may be addressed. Routine speakers include experts in risk management, accreditation, pharmacy, and infection control. The expectation is that the clinical leads report back all information to their sites. The Clinical Nurse Coordinator for that clinic can then ensure that any changes to practice have been implemented. In addition, the Clinical Nurse Coordinators provide medical emergency response training twice a year at each clinic site. All staff and providers are expected to participate in the exercise, which are conducted in a similar way to a Mock Code Blue in the hospital setting. A “patient” is found non-responsive with the staff and providers responding in their assigned roles, utilizing the emergency supply cart which has an Automated External Defibrillator, a nebulizer, and specific medications and other supplies.

Medical Records clerks participate in quarterly meetings sponsored by the HIM Director in which issues pertinent to the medical record management are discussed. There is one remaining gap from the staff perspective and that is training for the front office/receptionist group. The plan for this year is to develop an orientation for the front

office/receptionist that encompasses all aspects of scheduling and registering patients so that vital patient information is collected and maintained appropriately. The other plan for this year is to conduct quarterly Medical Director meetings so that there are routine updates and interactions between them and rural health administration.

One of the challenges for the clinics was the ability to maintain survey readiness for the site, staff and providers. Many of the programs, and many of the insurers along with state and federal regulators require site visits with specific criteria expectations. To ensure that each clinic is ready for survey all of the time, reference guides for both the site managers and clinical leads were developed to use on a routine basis for ongoing preparation and to use during the actual site survey. The reference guide for the clinical leads, called the Master Audit Tools Crosswalk, contains the source of the requirement, what the exact criteria is with critical items in red, and references. The references can be links to specific policies, documentation requirements, or actions that need to be taken to meet the criteria. Some of the general topics included in the Crosswalk are medications, infection control and hazardous waste, emergency response, medical records, and equipment. The various survey tools used by surveyors in the clinics were used as sources of information during the development of the Crosswalk. Additionally, all applicable regulations were reviewed as part of the development. The site managers have the Manager and Supervisor Reference Guide which can be used as an additional tool during site manager orientation as well as for ongoing survey readiness. The topics covered include human resources, hospital resources such as plant operations and clinical engineering, marketing, finance, quality, and clinic operations. Each item has a link to specific policies or procedures. The idea that drove the development of these resources was to have a standardized approach applicable in all clinic sites in which the clinic leadership could meet expectations for performance during surveys. Additionally, each month the Clinical Nurse Coordinator conducts a facility safety review in which many of the survey readiness issues are assessed. The areas assessed each month are medications, emergencies, infection control, point of care, and safety. This also is an opportunity to provide ongoing one-on-one education specific to regulations as applied in the clinics. A compliance

score is calculated and action plans are required if the score is less than 90%. The site managers and clinical leads are encouraged to utilize this tool for their own clinic assessments on a weekly basis. Since the inception of these facility safety reviews, the site manager and clinical lead understanding of regulations has increased significantly, leading to better compliance and survey readiness.

The Adventist Health Central Valley Network adopted Lean/Six Sigma methodology for performance improvement in 2008. Performance improvement in the clinics is a challenge because of differing levels of engagement in the process. The first project for the clinics utilizing Lean/Six Sigma was focused on medication inventory control. This project was chosen because of the high cost of medications used and the underutilization of control processes for the medication inventory. By standardizing the inventory processes and the establishing a formulary, the result was a savings of \$61,500.00 through 2010 and a sustained decrease of 7% in costs. The standardized labeling of the medication drawers was identified as a best practice by the Joint Commission and can be found on their best practice site. The labeling includes route of administration of a medication, which is identified by the color of the paper and the picture associated with the administration (e.g. syringe for intramuscular injections), tall man lettering, black box warning and look alike/sound alike notices in addition to the trade and generic names. This has decreased the number of medication errors and increased patient safety.

While there have been many strategies employed to overcome challenges in providing quality care, it really comes down to communication and standardization. Giving the site managers and clinical leads the information necessary for the efficient operation of a rural health clinic, and setting the expectation for performance at a level where safe patient care is delivered, the rural health clinic patients benefit by having quality care without having to travel out of the area. Standardization has created the ability for staff to work in any one of the clinics with the expectation that processes and procedures will be the same resulting in staffing that can be more efficient. Overall, we continue to look for new ways to improve the experience for our patients.