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Strategic Community Healthcare Management

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Masters of Public Health

Abstract

Federally Qualified Health Centers(FQHC) and Community Health Centers are growing with the Affordable Care Act. This paper introduces literature that supports the need for Community Health Centers and management of low income patients with chronic illnesses. This paper also reviews the fieldwork experience at a FQHC. It reviews the goals, project, methods and findings of the fieldwork. This paper also elaborates on the scope of the project and a quality improvement report for the FQHC in observation. It discusses the future potential implementation of the recommendations and the benefits for both employees and patients. This paper concludes with follow up plans for whether the recommendations get implemented and the future success of the FQHC.

Introduction

Accessing basic needs and care can be difficult for many individuals when resources are in multiple places. This is even more difficult when individuals are low-income, immobile or have other issues. Davis Street Family Resource Center (DSFRC) aims at making things easier for citizens of the Eden area. The agency houses basic needs including a food pantry, subsidised child care, behavioral health services, dental and a primary care clinic. By having a comprehensive and holistic health center, DSFRC seeks to provide a "one stop shop" for homeless and low-income community members.

I was fortunate to complete my fieldwork at DSFRC. In this capacity, I experienced the basic operations of the agency. I eventually became responsible for assisting the primary care clinic with daily operations and later developed a quality improvement project. The project entailed observing and interviewing various staff members and departments to understand the operations of the primary care clinic. The gathered observations were utilized to provide a quality improvement report for management to review and implement changes. The purposes of the changes would improve the work environments for employees and the management of patient care.

This paper discusses the literature in support of community health centers and the need for management of of chronic illnesses especially in low-income populations. It also discusses the fieldwork goals, project and future recommendations for improvements within DSFRC. The paper introduces theoretical framework that supports the need and claims made in the quality improvement report. Lastly, this paper touches on the future success of DSFRC and the importance it serves to the community.

Background

Literature

FQHCs are medical centers that seek to provide care to underserved populations(HRSA). FQHCs also qualify for enhanced reimbursements from Medicare and Medicaid which aims to incentivise clinics to treat Medicare and Medicaid patients to reduce the amount of acute care emergency room visits(HRSA). FQHCS also must, "offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors(HRSA)." With the Affordable Care Act(ACA), FQHCs complement the primary prevention and chronic disease management model of the ACA.

The Eden area DSFRC serves has 43% of attributable deaths in 2010 to cancer and heart disease (Urban Strategies Council 2013). Mehta and colleagues (2016) asses the differences between diabetic health outcomes at free health clinics versus Federally Qualified Health Centers (FQHC). Free health clinics are a great resource to low-income communities, but Mehta and colleagues (2016) express the importance of primary care relationships for patients. The authors (2016) also add, when patients are educated about how FQHCs can help them improve their health, they are more likely to have higher retention rates and better health outcomes. For example the authors (2016) report, "Furthermore, we showed that 38% of individuals used the FQHC as their PCP, attending ≥2 appointments over the 9-month period" and "We observed a significant improvement in glycemic control as a decrease in mean HbA_{1c} among participants who attended ≥2 appointments at FQHCs." This finding supports the efforts of community health clinics, like DSFRC, recruit more Eden area community members to utilize the FQHC. As the literature suggest, through an affordable primary care prevention and disease management,

higher utilization of FQHC in a given community is associated with a reduction in mortality rates and longer life expectancy.

Operating a FQHC such as Davis Street Family Resources Center (DSFRC) can be difficult. As the literature suggests, these centers must engage and rely on the broader community to remain successful; and, indeed, this interrelationship with a continuous process. Work Friedburg and colleagues (2016) suggest, "The effectiveness of community clinics and health centers' efforts to improve the quality of care might be modified by clinics' workplace climates." With limited staffing, resources and budgets, community health centers workplace climates can really have a direct effect on quality measures and patient care. Friedburg and colleagues (2016) also mentions," The remaining 4 factors (staff relationships, quality improvement orientation, managerial readiness for change, and staff readiness for change) were highly correlated, indicating that these represented dimensions of a higher- order factor we called "Clinic Functionality." If Clinic Functionality is highly dependent on the four factors, a focus on staff is needed to ensure quality care. In all healthcare settings, it is important for staff to work as a team, but it is especially important when managing the primary care of low income community health center clients who may be dealing with other confounding factors.

In addition to the importance of community health centers workplace climates to effectively manage patients care, it is also important that staff members are trained to work with cultural sensitivity and low income populations. In Asgary's and colleagues' (2016) study, they discuss the importance of teaching homeless health care to medical students. The authors (2016) explain, "Students were taught to: elicit specific social history, explore health expectations, and assess barriers to healthcare; evaluate clinical conditions specific to the homeless and develop

plans for care tailored toward patients' medical and social needs; collaborate with shelter staff and community organizations to improve disease management and engage in advocacy efforts." By adding this curriculum component, the authors (2016) found statistically significant ($p<0.05$) improvements in medical students skills to evaluate mental health, substance abuse, and risky behavior.

In order to truly component of culturally competency, community health centers must work with their clients to understand the true needs of the community. As such, understanding and evaluating the community being served is essential for providing optimal care. Orratai Nontapet and colleagues (2008) add on the suggestion that effective primary care should follow four competencies consisting of interpersonal relationships, care management's, integrated healthcare services, and professional accountability.

In addition to cultural competency, it is important to be aware of the economic situations of the patients community health centers typically serve. Patients dealing with multiple other social and economic forces can struggle managing their own complex health conditions. According to the Henry J. Kaiser Foundation (2010), 25% of of health centers visits were due to chronic illnesses compared to the 9% in private practices. Haynes and colleagues (2016) suggest management of complex chronic diseases are important for enhancement of health and efficiency. The authors (2016) found, "A shared care plan can align patients and providers by setting shared goals and developing a care plan around these goals." Patients with hypertension also need their medication closely monitored and regulated. It is unfortunate that Medicaid patients in private care offices are less likely to receive new medications for hypertension than privately insured patients (Fontil et. al 2016). Community health clinics offer an alternative

avenue treatment typically availing patients with these newer, more efficacious medication (Fontil et. al 2016). In fact, Fontil and colleagues (2016) concludes "Increasing physician use of fixed-dose combination drugs may be particularly helpful in improving hypertension control at CHCs where there are higher rates of uncontrolled hypertension." This result highlights the importance of patients from low socioeconomic backgrounds, such as those residing in the Eden area, have access to use a community health clinic, such as DSFRC, to help manage and care for their complex chronic conditions.

Given the high prevalence of chronic disease in low income communities, clinicians, researchers and public health practitioners must consider feasible mechanisms for disease management. In addition to FGHCs, there are other ways to manage and reduce patients chronic disease issues. Hughes and colleagues' (2016) study explores the effectiveness of the Community Health Worker (CHW) model. The literature suggests that CHWs can be effective in chronic disease management. For instance, Hughes and colleagues (2016) investigated an intervention where CHWs reached out to community members who were reported with type 2 diabetes and offered them diabetes management and prevention support. The authors found (2016), "The mean HbA1c decrease was 0.5 %. At follow-up, participants were less likely to be depressed, to forget to take their diabetes medications, and were more likely to report higher social support and score higher on an assessment of diabetes knowledge." A study in Israel also assess a community-hospital integrative model of healthcare to incorporate endocrinology services to the communities that need it most (Jaffe and colleagues 2015). The authors found (2015), "The demand for endocrinology services is growing worldwide, mainly due to the rapid increase of diabetes, obesity, the metabolic syndrome and osteoporosis and is particularly notable

among minority, immigrant and socioeconomically disadvantaged populations." Both studies recognize the need for support for those living with chronic diseases in lower income communities and the need for interventions to improve the health outcomes.

Regardless of disease management model, patients conditions may also improve with the increase enrollment in medical insurance and strong community referral programs. For example, Kahan and colleagues (2016) found, "Use of dedicated advanced practice nurses to link older patients in the ED with appropriate community services has been associated with lower hospital admission rates and repeated visits." If patients are actually being referred to primary care services, they can potentially have better disease and healthcare management. Bailey and colleagues (2016) also add, "The newly insured had 40 % increased odds of quitting smoking (aOR = 1.40, 95 % CI:1.24, 1.58), nearly triple the odds of having a medication ordered (aOR = 2.94, 95 % CI:2.61, 3.32), and over twice the odds of having $\geq$ 6 follow-up visits (aOR = 2.12, 95 % CI:1.94, 2.32) compared to their uninsured counterparts." Insurance is also key in retaining patients and DSFRC does assist patients to enroll in medical insurance which can potentially improve their retention rates and management of patients' chronic illnesses.

Overview of Project

Description of Agency

DSFRC is a non-profit community health and resource center that provides support to members of the Eden Area. The Eden area comprises the following communities in the San Francisco Bay Area: Ashland, Castro Valley, Cherryland, San Lorenzo, and San Leandro. DSFRC first opened it's doors in 1970 at the First Christian Church on Davis Street in San Leandro, CA. DSFRC began by offering subsidised childcare, a food pantry and a thrift store.

The organization has grown tremendously over the past 46 years. Today, DSFRC houses administrative offices, basic need services, dental, behavioral health, primary care, and free Rotacare clinic under on roof. In addition, the organization operates five off site subsidized child care centers. These operation are financed through several funding streams, including over 60 active and ongoing grants as well as private donors. Moreover, a new FQHC grant further supports behavioral health, dental and primary care services.

As a FQHC, DSFRC seeks to serve low-income clients of the Eden area. The Affordable Care Act specifically supports FQHCs by providing adequate funding to serve low-income Medicare and Medicaid patients and to reduce the amount of emergency room visits for acute illnesses. The Primary Care Clinic serves families, adults, and children and will soon launch their obstetrical program to provide prenatal care. They also serve many community members who are suffering from complex chronic conditions who utilize many of the services offered by DSFRC to manage and improve their overall mental and physical health. The basic needs department seeks to serve low-income clients as well as the homeless population. It offers food vouchers for clients twice a month, clothing, shoe and backpack giveaways, housing support, medical insurance enrollment assistance, subsidised childcare and other basic needs depending on funding. DSFRC overarching mission as a whole agency is to, "help people with low income of the Eden area and its surrounding communities improve their quality of life through short and long-term assistance (DSFRC)." Below describes my experience and contribution to achieving the mission of DSFRC.

Goals

The two goals were as followed:

1. Develop an understanding of how to create and manage a comprehensive community health and resource center.

2. Articulate several process improvement recommendation to help improve the organization and flow of the Davis Street Primary Care Clinic for efficient patient care management.

The goals were developed after a few weeks of working with the agency. During this period, DSFRC was preparing for their Human Resource and Service Administration (HRSA) inspection. In the meantime, I began analyzing my overarching goals and the need of the agency. Objectives and activities were then further developed to achieve the goals. See appendix 1.

Theoretical Model

Guiding the project and later creation of a quality improvement report was two theoretical models. The first model was Minnesota's Quality Improvement and Performance Management theoretical model. Minnesota's Department of Health defines Quality Improvement as, "is the use of a deliberate and defined improvement process and the continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality that improve the health of the community." They also follow four guiding principles which include develop a strong customer focus, continually improve all processes, involve employees, and mobilize both data and team knowledge to improve decision making (Minnesota Department of Health). The second theoretical model important to DSFRC and the report is the Organizational Development Theory mentioned by Glanz and Colleagues (2008). This model supports Minnesota's theoretical framework and focuses on organization performance and quality of worklife while, "...concerned

with members of organization, and organizational problems are diagnosed by gathering information directly from the members or workers, often through formal surveys or key informant interviews." Both models served as important guidelines in this project and emphasized the importance of employees being involved in quality improvement.

Implementation and Methods

In order to gain insight into the general operations of the agency, it was essential to shadow various departments and interview key staff members.

I shadowed the members of the following departments:

1. Eligibility Specialist

2. Medical Assistants

3. Providers

4. Intake Specialist

5. Client Navigators

6. Clinic Operations Director

7. Food Pantry

8. Nutritionist

I interviewed the following individuals:

1. CEO

2. Director of Behavioral Health

3. Dental Hygienist

4. Basic Needs Manager

5. Operations Director

Each staff member was informally interviewed face to face with the objective to find out their

history with DSFRC, their role, their daily workflow, how their department operates, future

expansions and/or improvements desired. Informants were given the opportunity to share

additional information that they felt was useful that I did not ask during the interview. The

departments shadowed involved hands on support and included some informal interviewing of

department leads. Notes were recorded from each interview and shadow experience for future

references and support for the next goal (See appendix 3 for some of the notes recorded).

In order to provide optimal recommendations and an efficient strategic healthcare

management plan, I shadowed and interviewed various staff members. The departments and staff

members included front desk, Client Navigators, Intake Specialist, Eligibility Specialist, Medical

Assistants, clinic station and providers. The observations were focused on the patient flow and

experience as well as current patient management. In addition, the observations were geared

towards improvements in the Primary Care Clinic with minimal recommendations on dental due

to the limitations of this report. Most of the information was from observations, but there was

some specific recommendations requested from anonymous staff members. Observation notes

were collected and used to create a large report of the condensed notes and recommendations

that can potentially improve the efficiency and happiness of employees as well as patients

healthcare management (See appendix 4 for report). Flow charts were used to also provide

visuals of the current operations and the newly recommended operations (See appendix 5 for

flow charts). When the report was completed, it was given to management for review and

possible implementation determined by management.

Findings

The finding of the first goal were really minor and were intended for personal knowledge to utilize for a future potential career in a community health center. Staff members were very helpful and insightful to all of the questions asked. Through the various interviews I was able to find out the benefits of FQHCs, how clients can utilize DSFRC and how the agency is funded.

The findings of the second goal were really essential in developing the quality improvement report. A major consistent finding was unsatisfied employees including the providers in the primary care clinic. DSFRC has tremendous staff who are motivated and passionate about serving the clients, but there were many additional consistent finding that contributed to their dissatisfaction. This included, but are was not limited to not enough staff, lack of Standard Operating Procedures and training documents, lack of leadership and communication, and technological issues that often interfered with work flows. Organization and guidelines were also lacking and often escalated staff arguments. The clinic is in serious need of an operations director, but staff should be able to function without one in a well developed organization. In addition, the unorganization of the primary care clinic has a tremendous impact on patients and providers. Patients are unhappy with the operations, availability of appointments, and wait times are long and appointment durations are unusual. In addition, providers are frustrated because they are having difficulty providing the best care and do not have trust in staff to help manage patients care. The conclusive finding was the organization is new and has potential to be an asset to the community, but there needs to be serious reorganizing and development in order to be successful. This conclusive finding is what the quality improvement report aimed to achieve (See appendix 4 for report).

Conclusion

DSFRC is a great long time local organization that thrives to provide comprehensive services for the clients of the eden area. It houses a new Federally Qualified Health Center that achieves to serve low income, uninsured and Medicare/Medicaid patients. The literature supports the need for community health clinics and their important role in managing chronic illnesses. DSFRC aims to be a health home for the local community, but the newly FQHC operations needs quality improvements. The scope of the project conducted observations and interviews with staff members to derive the recommendations later given in a quality improvement report. The report is currently under review by management and changes from the recommendations will hopefully be implemented soon. However, DSFRC is a very successful organization that will overcome the obstacles faced by all new FQHCs and will hopefully be a role model for future FQHCs.

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Appendix

1. Goals and Objectives
    1. Develop an understanding of how to create and manage an integrative community health center (personal learning goal)
        a. Objective: Develop a detailed report to use for future references
        b. Activities: Interview and shadow various Staff/Departments
            i. Desired departments/staff:
                1. CEO
                2. CFO & Other key financial staff(Medical biller)
                3. CMO(Primary Care Clinic)
                4. Operations Director
                5. Director of Behavioral Health
                6. Basic needs & childcare subsidies
                7. Food Pantry manager
                8. Dental
                9. Nutritionist
        c. Start/End: Anticipated start 6/13 and end by 7/08
        d. Who is responsible: Stephanie
    2. Clinic Staff Needs Assessment & Organizational Plan
        a. Objective: Improve the organization and flow of the clinic in order to improve patient care.
        b. Activities:
            i. Survey Staff
                1. Interview Clinic Staff members for qualitative data
            ii. Organize data
            iii. Outline employees roles, task and responsibilities
            iv. Develop a report of quality improvement recommendations
        c. Start/End: Anticipated start 6/13 and end 8/11
        d. Who is Responsible: Stephanie (leader) and participating Clinic Staff

2. Competency Inventory

USF MPH Competencies Proposed Activities	Number of Hours (Estimated)	
1. Assess, monitor, and review the health status of populations and their related determinants of health and illness.	Reviewed chart noes and clinical reports on demographic illnesses	3

2. Demonstrate the ability to utilize the proper statistical and epidemiologic tools to assess community needs and program outcomes.	N/A	
3. Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	Done in my paper	8
4. Specify approaches for assessing, preventing, and controlling environmental hazards that pose risks to human health and safety.	Suggested improving on patient follow up to prevent dangerous chronic conditions being left untreated	1
5. Apply theoretical constructs of social change, health behavior and social justice in planning community interventions	Used in theoretical framework section of my paper	2
6. Articulate the relationship between health care delivery and financing, public health systems, and public policy.	Commented on the importance of using budgets wisely and retaining patients while increasing numbers in my report	40
7. Apply evidence-based principles to the process of program planning, development, budgeting, management, and evaluation in public health organizations and initiatives.	Observations done for my report to provide evidence based reasoning	40
8. Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects.	Same as 7	40
9. Identify and apply ethical, moral, and legal principles in all aspects of public health practice.	Reminded staff not to blame patients for being late because we have to sensitive of why they might be late	30
10. Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.	N/A	

11. Effectively communicate public health messages to a variety of audiences from professionals to the general public.	Through my report, I kept a consistent message of improving the quality of care for the health of the patients and the public	60	
12. Advance the mission and core values of the University of San Francisco.	Reminded staff when they are frustrated that their purpose and to be sensitive to the confounding factors	300 **CEPH Core Knowledge Areas** **Proposed Activities**	**Number of Hours (Estimated)**

Biostatistics	Assisted operations director with quantitative reports for the agency board	10	
Epidemiology	Worked with staff on data to see who needed women's health screenings	16	
Social and Behavioral Sciences	Utilized theoretical models to guide the overall project	N/A	
Environmental Health	Assisted with making sure all medical supplies were disposed correctly	N/A	
Public Health Administration and Leadership	Developed a report for quality improvement	60	
Cross-Cutting/Interdisciplinary Values Proposed Activities	**Number of Hours (Estimated)**		
Communication and Informatics	Recommended better forms of communication for employees and patients	8	
Diversity and Culture	My whole fieldwork experience was in a diverse and culturally sensitive area	300	
Leadership	When there was conflict moments, I used my leadership skills to try to suggest alternatives	300	
Professionalism	Working with patients and management required contestant professionalism	300	
Program Planning	N/A		
Public Health Biology	N/A		
Systems Thinking	N/A		

3. Interview Notes

CEO

- Hemer Richardson-Pastor who started DSFRC with food and childcare support
- Official CEO in 1991

- Important to always conduct a community needs assessment
    - Ask people what they need! Initial needs:
        - Safety not services for residents
        - Healthcare
- Free clinic in 1992-took 3 years to open
- Always have a strategic plan
- Role
    - Juggle, multitask and follow through
    - Understand everything
- Reliable source of funding is important

Basic Needs Manager

- Only serves Eden area
- Food twice a month & on income base
    - 1 time emergency available
- Clothing-emergency available
- Housing-binder at the front desk with housing options
    - Start with binder
    - Case management(sometimes)
    - Long wait list and restricted income requirements
- Homeless task force funding
    - Homeless-moving into San Leandro
    - Help with back pay of bills
- No longer job assistance, but still can help
- Can help sign clients up for medical insurance (only if part of DSFRC and appointment based only)

Director of Behavioral Health

- Use to be long time independent organization and joined with DSFRC
- Intern base and only 2 licensed psychologist
- Good director
    - Understanding all the components (fiscal, employees, clients, etc)
    - Experience working in all the roles being directed
    - Supporting staff

Dental Hygienist

- Needs a lot more help to keep up with expected numbers
- Needs front desk with dental experience

- High demand for dental, but not enough to supply to support demand

Operations Director of the agency
- IT oversight
- Grant oversight
  - Grant writing
  - Grant correspondence management(Data reporting)
- Facilities management
  - Ordering supplies
  - New technology, etc
- HRSA grant compliance
4. Report

 August 10th, 2016

Dear Davis Street Family Resource Center,

Thank you for the opportunity to complete my fieldwork requirement and allowing me to be a part of such a great organization. DSFRC does an excellent job at serving its clients and the community greatly appreciates the hard work of this long time organization. As a member of the local community, I have watched DSFRC grow tremendously and continue to work towards expanding the amount of services offered under one roof. The passion and ambition of the leaders of this organization are responsible for the tremendous growth and the community is very lucky to have such advocates.

I came to DSFRC intrigued by the holistic Public Health Center and wanted to help the organization while also growing my knowledge of how to operate a well developed center. During my time here, I was able observe and shadow staff to develop an understanding of the basic operations. From those observations, I was able to create and notate some of my personal recommendations.

Attached is a report of the current operations and my recommendations on how to improve the operations including, but not limited to staff training, patient flow and experience, and quality improvement to retain and increase patients/clients. Please note, this report is entirely based on my observations and discussions with various staff members. Therefore, some information or recommendations may be limited or subjective. This report also only primarily focuses on the Primary Care Clinic.

During my last few days I am happy to provide additional support and elaborate on any recommendations I've made. I really hope for continued success for DSFRC and I am confident DSFRC will achieve its goals for the Primary Care Clinic.

Thank you,

Stephanie Penrod
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(510)495-5439

Overall Organization and Development
Staffing, Job Capacity and Duties
 DSFRC has tremendous staff who are smart, passionate and eager to serve the clients of this community. I believe they have the capacity to be cross trained and perform more with the proper training and support.

Primary Care Clinic

Current Staff		Staff Needed and Positions Posted	
Front Office	Back Office	Front Office	Back Office
2 intake staff 1 Full time day Client Navigator 1 Part time night Client Navigator 2 Eligibility Specialist	3 MAs 2 part time NPs(1 going on maternity leave) 2 part time MDs 1 Clinic Coordinator 1 Chief Medical Officer Registered Nurse	Eligibility Specialist Intake Specialist Call Center Operator	Clinic Operations Manager Certified Medical Assistant 1 Full time Family Nurse Practitioner 1 on call/per diem-Family Nurse Practitioner

Dental

Current Staff		Staff Needed	
Front Office	Back Office	Front Office	Back Office
1 Dental Assistant	2 Dentist-Part time 1 Full time Dental Hygienist		Full time Dental Assistant(not posted)

 Front Desk/Client Navigators:

There are currently 3 seats at the front desk of the agency and all 3 seats should be filled with Client Navigators who are fully trained to triage clients and patients who walk through the front doors with whatever they need. I believe the desk area is even big enough to potentially to a 4th seat in the future. Shifts can be staggered throughout the day to cover all hours, but it is important to have at least 2 Client Navigators during the busiest Clinic hours. Listed below are examples of Client Navigators roles at the front desk:

1. Triage all basic needs questions (In depth questions are already set up for appointments with basic needs staff)
2. Check in existing patients for all departments(especially feasible with ECW merge)
    a. Dental, Behavioral Health and Clinic
3. Provide New Patients with packets and prepare them for the Intake Specialist
4. Prepare New Patient paperwork
5. Schedule follow up appointments when needed
6. Direct phone calls when needed (More explanation in technology section)

Client Navigators should also primarily be the greeters for DSFRC, but should be able to answer phone calls and schedule for all departments. This may not sound feasible, but I am confident with proper training this will work really well and provide adequate support for all departments and DSFRC clients.

Intake Specialist:

There are 3 Intake offices and they should all be filled with Davis Street Intake Specialist. During observations of busy clinic hours, patients were being delayed because they were waiting for someone to complete their intake. Intake should also be the primary contact for scheduling existing patients over the phone.

Eligibility Specialist:

The Eligibility staffing seems to be well developed and organized. However, staff would like clear cut protocols and for those to be consistently followed. Only the Eligibility staff should be the ones to complete intake for all new patients and schedule all new patients over the phone. For walk ins, Intake can still help, but Eligibility should only be the ones to check their insurance.

***These two positions actually seem to blur together at times. It almost seems more efficient to have one title/position that can complete all intake for new patients, check eligibility, and only help established patients when they need the SFS/HPE or schedule appointments over the phone. I personally think these positions should be reevaluated and staff members working in those positions should work with management to consolidate and create an efficient and feasible work flow. Dental also does not need their own Intake/Eligibility Specialist(especially with ECW merge) and can actually utilize the help of the Dental Assistant in the back office. Once the

patient is registered in ECW, Intake/Eligibility Specialist can notify the dental department to call the Patient for an appointment.

MAs:

MAs should primarily be in charge of helping providers room and see the patients throughout the day. They should be responsible for taking care of the same patient from the time they room them all the way to discharging them and completing all necessary behind the scenes paperwork. When the MAs are not seeing patients they should be performing the administrative duties for the patients they helped that day.(explained in more depth later). It would be beneficial for management to work with MAs to create more efficient work flows and expectations.

RNs:

The RNs should primarily be triaging patients calls, assisting with managing patients care, and helping MAs with rooming patients when they are behind/need help. Managing patients care is included to, but not limited to referrals, prior authorization, lab tracking, and follow up care calls. The RNs can also be useful in working with MAs to develop workflows and responsibilities for ordering supplies, administrative work, etc.

Call Center Operator:

I see there is a posting for this position and that is great. I think it would be very beneficial if the Call Center Operators can do some scheduling, but mostly triage phone calls and create patient cases for all departments (especially medical). This position should be the gatekeeper and reduce the amount of unnecessary phone calls to clinical staff.

Providers:

Fortunately, DSFRC's providers are very patient and understanding of the development of the clinic. However, providers during my entire fieldwork experience are constantly being interrupted with non urgent questions or task that can be handled by clinical staff. I notice this often delays or slows down provider from seeing patients on time. Providers should only be seeing patients and assisting with managing their care.

Staff Accountability:

I think it would be beneficial for management to work with staff to define what they are accountable for, what is their daily required task, and what is not urgent but needs to be completed by certain deadlines. For example, MAs are in charge of uploading all patients documents to their charts for the patients they helped that day before they go home.

Development of Standard Operating Procedures(SOPs) and Training Documents

Staff are quick at learning their jobs, but less mistakes could potentially be made during staffs' training periods if there were SOPs and training documents available to them. The SOPs differ from DSFRC's policies and procedures as they are more specific to guidelines for staff to follow when operating on a daily basis and training documents they can reference. Some of these examples include, but not limited to:

1. Scheduling rules(a condensed sheet of basic rules)
2. Directions of where to seat patients for certain appointments
3. Which rooms to use for certain patients
4. How and when to send prior authorizations
5. How to send referrals

Here is a link to a workflow assessment guide that can be valuable in guiding those SOPS and training material creations (also attached).

http://healthinsight.org/Internal/REC_Event_Resources/MU_Boot_Camp_Materials_Resources/Workflow%20Questionnaire.pdf

Training binders for each front and back office position should be created with these materials and given to all new staff. I highly recommend this because staff expressed their desire for this type of materials and again, I think it will help prevent mistakes. I think the Clinic Coordinator should be in charge of this and can work with lead staff members in each position to create the most effective materials.

Changes

Although management has the ultimate decisions, staff or leaders(discussed below) should be involved in process and workflow changes. There are often abrupt changes being made and staff are confused and frustrated because the changes are frequent and sometimes not beneficial to them. When changes are being made with multiple departments involved, there should especially be multiple formal meetings between leaders of those departments to discuss how it would work best for everyone. An example is the reorganization of the front office.

Leadership

There are definitely some great natural leaders in both the back office and front office. Therefore, I think there definitely needs to be some staff members appointed as leaders to reduce the amount of questions being directed to the CMO, Clinical Operations Director, and Providers. I really like the idea of the nurse being the back office leader, but I think their should also be a MA lead(when the nurse is out) and a front office leader/supervisor. The front office staff and back office staff leaders should work together to manage providers and patients schedules and only consult with providers or management when issues escalate beyond their authority.

Team Communication

The front office teams and back office teams need to communicate more and should be comfortable with each other. Although the offices are in separate locations, the clinic is one big team and they need to work together to provide patients with the best care. Staff should only consult with management when there are conflicts and issues beyond their authority. Otherwise, they should communicate among each other. Hopefully with more leaders, this will improve.

Organization and Patient Management

Patient Flow

       Current Flow: Please see attached

       Suggested: Please see attached

***I made some recommendations on how to improve the flow, but I think this still could use some focus. It is great the clinic is already working on getting the patient's back and seen at the time of their appointments. However, when I was observing the front desk, patients are constantly being moved around and sent to different people for different things. I noticed many patients seemed frustrated and confused because the check in process was so many steps. The check in process really should be more smooth and only require a patient to move once.

Chart preparing at Front Desk & Back Office

This is really important! Mistakes are being made because charts are not being prepped the day before. Providers are constantly asking the MA to upload the patient's labs right before their appointment and they shouldn't have to worry about that. I am not sure who to assign this to, but both front desk and MAs should be preparing for the next day. New patient paperwork should be prepared, labs should be in charts, staff members should be assigned to providers or patients, etc. This could also be a tool for catching scheduling mistakes before the patient arrives.

Documents and Document Uploads:

It would be extremely beneficial to have a medical records clerk, but unfortunately that is a luxury that can come later with an increase in budget. However, for now the staff needs to be in charge of uploading documents to patients charts. The current system really is not working and there is a constant backup of patient documents. My recommendations are:

1. Eliminating unnecessary documents. The registration form is not needed if staff are doing intake electronically. The statement at the end where patients initial can be added to the payment policy.
2. Staff who help the patient should be in charge of uploading the documents to the patients charts. This goes back to accountability and working with staff to figure out deadlines for when this should be completed. Uploading documents to a folder and instructing them to work on scans when they are available will never work especially without accountability.

Using the EMR to Track Patients

Referrals and labs are currently being tracked by paper. However, I believe the EMR has a system to set task and reminders to track patients care. When patients are given lab orders, the clinical staff should set an alarm in the EMR to check if the patient went to the lab. It is also always best to check with the lab or place referred to if the patient went before calling the patient. It is really important to track patients especially those living with complex chronic illnesses and need constant follow up.

HIPPA

During my observations, I encountered some major HIPPA violations. All staff should be reminded to always turn over documents with client information. Client names especially last names should never be spoken out loud in open areas between staff members. Patients should be called back by their first name. In all EMR systems patients have ID numbers and staff should use them at all times in open office areas when the information is available. An example of ways

the front office can avoid using names when calling the back office is, "Dr. Coats 9am is 5mins late, can we still see her?"

Technology

Note: I recognize some of these recommendations below are a simple fix, but some maybe a long term goal due to limited budgets.

Phones:

Every staff member should have a personal extension that is grouped together with their department extension. For example, the front desk where the Client Navigators sit should have an extension number that rings all Client Navigators' phones. Whoever is available will pick up the phone. This should be the same for the MA station, Intake Specialist, and Eligibility Specialist. The unanswered calls by the Call Center Operator can overflow to the Client Navigators.

Call Center Operator:

Again, all calls should be taken through the Call Center Operator and the front desk. Back office clinic staff should not be directly transferred calls unless the nurse is available for advising. The MAs do not have the capacity to have calls directed straight to them. I've never called or been to a medical office where I got directly transferred to my nurse or provider without being screened and/or triaged by front office staff.

Automated reminders:

With the increase in patients and technology grant, it would be beneficial for DSFRC to have an automated reminder system that would do reminder calls instead of having staff manually call 48 hours ahead. This can be beneficial for patients who speak other languages since some of the staff conducting reminder calls do not speak Spanish. This is probably a distant goal, but should definitely be kept in mind for the future.

In office communicator:

Often people are unavailable to answer calls and it would be beneficial to have an in office communicator system where staff can effectively communicate if they are unable to reach each other by phone. This is important for the agency because there are many different departments who meet with Clients. This also would be separate from Apricot because it would allow for dialogue to be communicated privately and efficiently.

Scanners:

Intake and Eligibility Specialist need in office scanners and/or copiers. If they have scanners, there is no need to make copies of patient's information. This can also reduce the amount of clinic scans needed to be attached to charts, because that information scanned by the Intake Coordinators can be directly uploaded to the chart shortly after scanning them. If individual scanners are not in the budget, then maybe front desk(Client Navigators) should make copies of patient's information before sending them to Intake Coordinators. This will speed up the intake process.

Monitors:

The front office is in desperate need of at least 1 wide screen monitor. It would be even better to have 2 monitors per desk to ensure patient information is being transcribed accurately.

Back office work stations:

The 3rd MA already does not have an adequate workstation, so I think it is important to get the medical staff more work stations.

5. Flow Charts

Patient Walks in

Someone greets the patient and ask if they are here for a medical appointment

— Yes → Did a Client Navigator greet them? — No → Patient waits for Client Navigator

Did a Client Navigator greet them? — Yes → Is it a new patient?

Is it a new patient? — Yes → CN gives new pt. ppwk & instructions, triggers Intake, starts check in and informs pt. to have a seat.

Is it a new patient? — No → Established patient?

Established patient? — Yes → CN ask patients name and starts check in for EMR

CN ask patients name and starts check in for EMR → Do they need SFS or HPE?

Do they need SFS or HPE? — No → CN verifies info on file is correct

Do they need SFS or HPE? — Yes → Triggers Intake Specialist

CN verifies info on file is correct → Inputs into Appricot

CN verifies info on file is correct → Does pt. have a co-pay?

Does pt. have a co-pay? — Yes → Pt. pays with Cashier

Does pt. have a co-pay? — No → Finishes check in EMR and directs pt. to Clinic waiting area

Arrival Times:
New Patients: 45mins early
Established Patients with SFS or HPE: 30mins early
Established Patients: 15mins early

CN gives new pt. ppwk & instructions, triggers Intake, starts check in and informs pt. to have a seat. → Pt. waits for Intake & completes packet

Pt. waits for Intake & completes packet → Intake calls pt. into office and completes Intake

Intake calls pt. into office and completes Intake → Pt. waits while Intake makes copies of info

Pt. waits while Intake makes copies of info → Does the pt. have insurance?

Does the pt. have insurance? — No → HPE or SFS?

Does the pt. have insurance? — Yes → Does pt. have a co-pay?

Does pt. have a co-pay? — Yes → Intake verifies info and walks pt. to cashier office

Does pt. have a co-pay? — No → Finishes check in EMR and directs pt. to Clinic waiting area

Triggers Intake Specialist → Pt. waits for Intake Specialist

Pt. waits for Intake Specialist → Intake calls pt. into their office

Intake calls pt. into their office → HPE or SFS?

HPE or SFS? — SFS → Intake verifies info and walks pt. to cashier office

HPE or SFS? — HPE → Intake verifies eligibility

Intake verifies info and walks pt. to cashier office → Pt. pays with Cashier

Pt. pays with Cashier → Finishes check in EMR and directs pt. to Clinic waiting area

Intake verifies eligibility → Finishes check in EMR and directs pt. to Clinic waiting area

Finishes check in EMR and directs pt. to Clinic waiting area → Pt. waits for MA to be roomed

Pt. waits for MA to be roomed → Does EMR say pt. is ready?

Does EMR say pt. is ready? — No → Waits for pt.

Does EMR say pt. is ready? — Yes → MA calls pt. to back office

MA calls pt. to back office → Child or Adult?

Child or Adult? — Child → New or established?

Child or Adult? — Adult → New or established?

New or established? (Child) — New → MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc.

New or established? (Child) — Established → MA gets height, weight, reason for visit, & vitals, etc. (eye exam for physicals)

New or established? (Adult) — New → MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc. (eye exam per provider request)

New or established? (Adult) — Established → MA gets height, reason for visit, & vitals, etc.

MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc. → MA rooms pt. in room 7 ONLY

MA gets height, weight, reason for visit, & vitals, etc. (eye exam for physicals) → MA rooms pt. in room 7 ONLY

MA gets height, reason for visit, & vitals, etc. → Is it a Pap?

Is it a Pap? — No → MA rooms pt. in any room besides room 7

Is it a Pap? — Yes → MA rooms pt. in room 6 or 8 ONLY

MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc. (eye exam per provider request) → MA rooms pt. in any room besides room 7

MA rooms pt. in room 7 ONLY → MA informs provider pt. is ready, the room number and waits for provider to see pt.

MA informs provider pt. is ready, the room number and waits for provider to see pt. → When provider is done they inform MA next steps for pt.

When provider is done they inform MA next steps for pt. → Does the pt. need a Vaccine?

Does the pt. need a Vaccine? — Yes → MA administers vaccine

Does the pt. need a Vaccine? — No → Does the pt. need an appt.?

Does the pt. need an appt.? — Yes → MA schedules appt. at MA station

Does the pt. need an appt.? — No → MA discharges patient

MA schedules appt. at MA station → MA discharges patient

Patient Walks in

Someone greets the patient and ask if they are here for a medical appointment

Yes — Did a Client Navigator greet them? — No — Patient waits for Client Navigator

Removing this can reduce the amount of delays and people the pt. interacts with. See solution in staffing section.

Arrival Times:
New Patients: 45mins early
Established Patients with SFS or HPE: 30mins early
Established Patients: 15mins early

Can be reduced to 30 if Intake is done directly into EMR over the phone

Yes

CN gives new pt. ppwk & instructions, triggers Intake, starts check in and informs pt. to have a seat.

Yes — Is it a new patient?

No

Pt. waits for Intake & completes packet

Established patient? — Yes — CN ask patients name and starts check in for EMR — Do they need SFS or HPE? — No — CN verifies info on file is correct — ◇ ◇ ◇ — Inputs into Appricot

Intake calls pt. into office and completes Intake

Yes

All of these steps can be consolidated and a lot faster if intake is completed entirely over the phone(see phone flow sheet) & Intake only needed to make sure new pt. ppwrk was complete, verify info, & deiced if pt. is using insurance, SFS, or HPE. It would also be more efficient if CNs made the copies of documents before sending pt. to Intake or if Intake had personalized scanners and could scan info directly.

Triggers Intake Specialist

Pt. waits while Intake makes copies of info

Pt. waits for Intake Specialist

Does the pt. have insurance? — No

Intake calls pt. into their office

Does pt. have a co-pay? — No

HPE or SFS?

Yes

Does pt. have a co-pay? — Yes — Pt. pays with Cashier

SFS

Intake verifies info and walks pt. to cashier office

HPE

Intake verifies eligibility

Finishes check in EMR and directs pt. to Clinic waiting area

No

Pt. pays with Cashier

Pt. waits for MA to be roomed

Does EMR say pt. is ready? — No — Waits for pt.

MAs should be calling CN if pt. is not ready 5mins before appt. to check on ETA

Yes

MA calls pt. to back office — This should be done at least 10mins before appt. time

Child or Adult?

Child — New or established?

Adult — New or established?

MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc. — New

New — MA gets height, weight, reason for visit, Vitals, eye exam, intake-pharmacy, med hx, etc. (eye exam per provider request)

Established

Established

MA rooms pt. in room 7 ONLY

MA gets height, weight, reason for visit, & vitals, etc. (eye exam for physicals)

MA gets height, reason for visit, & vitals, etc.

Is it a Pap? — No — MA rooms pt. in any room besides room 7

When provider is done they inform MA next steps for pt.

MA informs provider pt. is ready, the room number and waits for provider to see pt.

Yes

MA rooms pt. in room 6 or 8 ONLY

Does the pt. need a Vaccine? — Yes — MA administers vaccine

No

Does the pt. need an appt.? — Yes — MA schedules appt. at MA station

All of this should be done inside of the room for HIPPA privacy and efficiency before discharge. By the time the pt. is ready to leave the room and exit the clinic, they should have everything they need.

No

MA discharges patient

Patient Walks In

Is it a new patient?

No → Follow main flow sheet

Yes

If pt. is willing to wait, CN will get first & last name and trigger an Intake Specialist

If pt. can't wait or Intake not available, CN will get pts. name & phone number and will inform pt. Eligibility Specialist will contact them for appt.

Pt. waits for Intake Specialist

CN will let provide ES with Pt. info and ES will follow new pt. telephone process

Intake Specialist calls pt. into office and gathers all on their information, scans/makes copies of info, has ES check their insurance, schedules their Initial Health assessment consult & provides the pt. with all the required info needed at appointment & arrival time.

Arrival time is dependent on completion of paperwork. If information is missing pts. should still arrive 30mins before appt.

New pt. is set for appointment

Patient Calls DS

Is it a new pt.? → No → Directs to Intake Speicalist

Yes

Transfers to Eligibility Specialist's Line

If all information is gathered over the phone, there is no need for the registration form the day of the appt. and patients can arrive 30mins early instead of 45mins. If anything is missed, Intake can gather information on day of appt.

Eligibility Specialist completes intake entirely, gathers insurance information, checks insurance and schedules initial health consult

Still arrive 45mins early in case not HPE eligible & need to complete SFS

Does the pt. have insurance? → No → Eligibility informs pt. of HPE & SFS options, instructs them to bring required docs for both & arrive 45mins early to complete new pt. ppwk

Yes

Eligibility informs pt. of any co-pays, instructs them to bring the required documentation and arrive 30mins early to complete new pt. ppwk

New patient is set for appointment