

Ohio
State Office of Rural Health (SORH)
Rural Health Clinic Survey
NOSORH Capstone Project
2011

Abstract

The Ohio SORH focuses its efforts on mitigating the disparity in access to health care services created by rurality. We work in partnership with many internal and external partners to accomplish our goals and to develop programs and activities that meet the unique needs of a very diverse population. The SORH conducted a survey to determine next steps in assisting Rural Health Clinics (RHCs) in Ohio in improving access to health care for their communities.

Goals and Objectives

The overall goal for this project was to learn the needs of existing RHCs in Ohio and determine how the Ohio SORH can assist in meeting the identified needs of RHCs in Ohio, needs specifically related to quality, operational, and financial improvement.

Objectives:

1. By February 15, 2011, develop a survey for distribution in March 2011.
2. By April 18, 2011, collect all returned surveys.
3. By August 9, 2011, present findings to NOSORH Leadership Institute.
4. By December 30, 2011, develop a pilot project to address at least two of the identified needs related to quality, operational, and/or financial improvement.

Background

In the past year, the number of RHCs in Ohio has increased from 11 RHCs to 19 RHCs largely due to counties and areas being designated by our Primary Care and Rural Health Office as Governor's Certified Shortage Areas for purposes of RHC development. More specifically, the increase of 8 RHCs took place after this survey was conducted in April 2011. Currently, the SORH assist entities wanting to be designated as a RHC, but provide limited assistance to existing RHCs. The SORH is in the process of completing its Ohio specific Rural Health Clinic manual, has conducted annual RHC meetings for over 5 years, and plans to develop other programming for existing RHCs.

There are a few RHCs that are provider based and associated with critical access hospitals (CAHs). The few that are associated with CAHs have taken advantage of some of the quality improvement and patient safety tools that we provide to the CAHs through our Ohio Flex Program. Over the years we have developed and maintained a strong and comprehensive network to improve quality, operations, and finance management available to all of our 34 CAHs through the development of the Ohio Flex Network and the Ohio Flex Program. The process of designation as well as geographic isolation for the

RHCs is very similar to what the CAHs have been through in the past. The development of the Ohio Flex Network assisted the CAHs with overcoming their current barriers to communication with common partners and opportunities to network. Sharing ideas and resources are critical in times of scarce resources. It is the intention of the SORH to bring the RHCs together similar to the CAHs with the goal to create synergy and movement toward focused improvement regarding financial, operational, and quality improvement.

Methodology

The survey was developed and distributed via email to 11 RHC managers in February 2011. The managers received two reminders via email that the survey was due and that SORH would appreciate their participation. The due date to return the surveys was April 18, 2011 and three out of the eleven (27%) RHCs responded. The information was summarized and presented in September, rather than August, as planned to the NOSORH Leadership Institute participants. The SORH is seeking funding to support the top two education and training needs identified by the participating RHCs and will support all technical assistance and resource needs identified by providing referrals for information and resources through our quarterly SORH Newsletter.

Findings

According to the information provided by the three respondents, the type of services they provide are primary care, gynecology, obstetrics, mental health, radiology, peri-natal, pediatric, general and vascular surgery, pulmonary, intensive critical care, and laboratory. The RHCs indicated an average of 21.3 full time equivalent (FTE) staff and an average of 84.3 visits per day at each RHC. The majority of the services are billed as Medicaid at 37.6% and Medicare at 27.3%. The only existing partnership with any area health care provider was patient transfers. There were no partnerships indicated for training, peer review, community education, or health care education.

The RHC identified the following education and training needs (in ranking order of importance): quality improvement for patient care, staff recruitment, financial management, grant writing skills, operational management, staff retention, billing and coding, and customer service. Technical assistance needs were identified as follows in ranking order of importance: resources for grants/funding, regulations and legislative information regarding RHCs, training, patient education, staff training, financial management, and recruitment and retention of staff. When asked to rank their resource needs, the following needs were ranked in order of importance: computers, construction/building capital, physicians, medical supplies, networking capability, electronic medical records, nurse practitioners, assistant physicians, office supplies, translators, transportation for patients, and billing staff.

Conclusion

The areas of need identified were as expected and aligned with the goals of the Ohio SORH. However, the one barrier to fulfilling these needs is funding. The SORH is seeking federal and private sources of grant funding to meet the needs of the RHCs in Ohio. Additionally, the Ohio SORH is involved in a departmental reorganization that will shift the focus of the programs within the Primary Care and Rural Health Office to center around patient center medical home development activities. While implementing the RHC pilot project we will maintain the focus of our primary goals in SORH and added

responsibility to assist health care providers transition to patient centered medical home models. The pilot project (while improving quality, financial management and recruitment efforts at RHCs) will assist the RHCs that are interested in transiting to a patient centered medical home model as well.

Personal Leadership Experience

My personal leadership experience involved taking the initiative to research the needs of the RHCs in Ohio to determine how our SORH can assist them and develop a pilot project geared toward meeting those identified needs. The larger experience to be gained will be the further development of the pilot project goals, objectives and evaluation, and implementation of the project. A survey to establish the baseline needs of all 19 RHCs will be developed and implemented in November 2011. In an effort to gain 100% participation from the 19 RHCs in the development of the pilot project survey, the second survey will be distributed via U.S. postal mail and via survey monkey and followed up with phone calls to the managers.

Acknowledgements

I would like to acknowledge the RHCs that participated in the survey. Thank you to CAO of Scioto County Health Clinic, Fayette County Memorial Hospital, and Perry County Family Practice for taking the time out of your busy schedules to complete and return the survey. Secondly, but with no less regard, I would like to acknowledge my mentor for the NOSORH Leadership Institute Ms. Heather Reed. Heather is an excellent example of integrity, tenacity, and knowledge of health care. I am grateful to have been able to work with her for over a decade as one of her staff and be in the position to learn from her expertise. Thirdly, the Ohio SORH staff (Pam Hunt, Lucrecia Johnson, Jennifer Jones and Phil Styer) are *awesome* and encourage me to improve each day and I am honored to know them and work with them daily. Thank you NOSORH for this opportunity for improvement and learning experience. The NOSORH's effort and commitment are exemplary of a successful non-profit organization.

References

Ohio Rural Health Clinic Survey, April 2011

Ohio Department of Health, Medicare Health Care Providers, Rural Health Clinics

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