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# Increase Access to Community-Based Health Care for Underserved Individuals: A Quality Improvement Project

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GPNS 960: Doctor of Nursing Practice Practicum I

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## Abstract

**Background:** Health care access disproportionately affects certain populations. Health care opportunities for uninsured adult members of a rural community can be limited. Suwannee County is a rural community with a population of 43,814 of which 40.8 % live below the 200% poverty income level (WellFlorida Council, 2020). **Problem:** In 2016, 23.8% of adults in Suwannee County were unable to see a doctor in the past year due to the inability to pay and lack of insurance (Florida Department of Health, 2020). Community-based health care initiatives can address such issues by targeting underserved individuals, reducing barriers, and making health services more obtainable. **Setting:** This quality improvement project took place with an organization called Shepherd's Hands. The QI project was conducted at three separate locations in Suwannee and Madison County in Florida. Shepherd's Hands provides free health care to uninsured adult patients who meet the federal poverty guidelines. **Method:** The needs and specific interests of the stakeholders were identified, strategies for increasing visibility of the organization were developed and implemented using the Plan-Do-Study-Act framework. Strategies included an advertising campaign and patient satisfaction surveys. **Purpose:** The primary purpose of this quality improvement project is to implement a sustainable strategy to increase the visibility and patient volume of a community-based free clinic. The secondary purpose is to assess and measure the patient and volunteer perception of the available services with the purpose of improving the health service delivery. A look into the volunteers' perception of the services provided was useful in reaching potential populations.

*Keywords:* community health, underserved population, free clinic, community impact

## Background and Significance

Health care access disproportionately affects certain populations. Health care opportunities for uninsured adult members of rural communities can be limited. Suwannee County, Florida is a rural community with a population of 43,814 residents, of which 40.8% live below the 200% poverty income level (WellFlorida Council, 2020). The poverty guidelines are the measurement of the federal poverty levels, issued annually, and varies depending upon family size (U.S. Department of Health and Human Services, 2021). The guidelines are used to determine citizens' financial eligibility for certain state and federal programs.

In 2016, 23.8% of adults in Suwannee County were not able to see a primary provider in the past year due to the inability to pay (Florida Department of Health, 2020). The availability of a free health clinic did not improve this number of individuals by connecting them to free healthcare. Uninsured individuals use limited screening and prevention services, thereby increasing their chances of becoming sicker and developing more advanced conditions when compared to their insured counterparts. These individuals face several social barriers that limit their access to timely, quality, and affordable healthcare services (Office of Disease Prevention and Health Promotion, 2020). Social barriers refer to differences and inequalities that prevent or limit an individual's ability to access quality healthcare services. They include lack of health insurance coverage, lack of transportation means, poor health literacy, social stigma, and workforce shortage (ODPHH, 2020).

Maruthappi et al (2013) shares powerful sentiments, evoking the notion that access to healthcare in the U.S is a system mediated by health insurance coverage rather than a human right for all citizens. Healthcare in the U.S. is not a right given at birth or an entitlement, instead it is a granted privilege in exchange for money. Shepherd's Hands provides services to all

community members, regardless of ability to pay or citizenship status of which proof is not required. Medical services should ideally include health promotion, preventive, and palliative care regardless of their financial, educational, and geographical hardships (World Health Organization [WHO], 2018). Despite this direction from WHO, many Americans are disproportionately affected by health inequalities stemming from social factors like poverty. Furthermore, many of the individuals who are affected by these social inequalities are also individuals who are uninsured. To address the healthcare needs of such individuals, it is imperative to develop community-based care programs to address the unmet healthcare needs of uninsured individuals and those living below the 200% poverty level.

Shepherd's Hands is an outreach ministry of the Episcopal Diocese of Florida. This free health clinic is held monthly in three separate locations. The first clinic began operating in May 2015 in Live Oak, Florida. Additional clinics are in Madison and Greenville, Florida. All health services (primary and acute care, diagnostic testing, and medication provisions) are provided at no cost to all who qualify based on the federal poverty guidelines and are in need (see Appendix A).

**Description of the problem**

The United States Census Bureau (2020) reported that in Suwannee County, 34.6% of the population is living at or below the 200% income level are uninsured or without health care. The data presented by the Florida Department of Health (2020) indicated that 23.8% of the residents in Suwannee County did not see a provider because of the inability to pay for services, limited or no health insurance.

There is concern with visibility of the free health clinic services in the community. Shepherd's Hands is struggling with community visibility in the community. The uninsured

residents of Suwannee County, Florida are further marginalized with respect to the health care system. The free clinic and organization in general are concerned they have not successfully made their presence known to individuals who need the services they provide, resulting in low patient volume. In 2020, there is a mere total of 85 patient visits amongst the three clinics. Prior to 2020, on average 125 to 150 patients were seen each annually. Prior to utilizing the clinic, patients sought treatment through the local health department, emergency room, or abstained from seeking care. Providing access to care is one component of a reduction in health disparities. Incidence of hospitalizations and emergency room visits for non-acute conditions are higher among uninsured populations (FDOH, 2020).

A Quality Improvement project (QI) was designed by the project champion in coordination with the Director of Shepherd's Hands to examine and increase the visibility of a community-based free health clinic, to increase patient access to care, and identify the perception of services through satisfaction surveys. Increasing the visibility of health care services available to underserved populations provides the opportunity for health care access expansion and community-building, especially focusing on the overall health of an area, while attempting to bridge the health disparity gap. During a review of historical patient data from 2016 to 2020, it was noted that the organization does not currently have a method to track and coordinate care or measure and improve performance.

Areas examined as part of this QI project included the evolutionary process of improvement implementation of a community-based free health clinic. Another part of this QI utilized the experience of those participants who use the services provided by community-based free health service. This QI project evaluated the most and least effective strategies and elements of a community-based health care initiatives. Further, monitoring the performance of Shepherd's

Hands can help the stakeholders determine if the program is a social benefit (McDavid et al., 2019).

Health care professionals, based on their levels of training and expertise, are tasked with the responsibility of ensuring safe, timely, and quality healthcare services to all patients regardless of their gender, age, race, education, religious inclination, or ethnicity. Indeed, part of their duties revolve around civic participation that encompasses philanthropic and volunteer activities in community-based healthcare facilities such as the Shepherd Hand. Community-based volunteerism is important. It offers significant health expertise to the community and assists in improving the health and wellbeing of communities at large. Furthermore, such initiatives are critical as they help develop and sustain social trusts, especially in instances when the sector is under scrutiny. Lastly, engaging in volunteer work can assist healthcare providers to understand better the social context of health, a critical step in addressing the social determinants of health.

Shepherd's Hands became a member of the National Association of Free and Charitable Clinics (NAFCC) in the spring of 2021. The mission of NAFCC is to ensure underserved individuals with a medical need have access to affordable quality health care (NAFCC, 2020). Organizations that are part of NAFCC follow a standardized set of seven measures to ensure quality and continuity of care. According to the NAFCC, the standards of care include the following: administrative oversite, access and continuity of care, the ability to identify, support and manage patient populations, provide community resources, track and coordinate care, and measure and improve performance (NAFCC, 2020).

**Purpose**

Shepherd's Hands is struggling with community visibility and a resulting decrease in the number of patients accessing health care services. The purpose of this QI project was to improve the process and delivery of care to the individuals who seek care at Shepherd's Hands. This QI project took a comprehensive approach to assess the patient and volunteer perspective of services offered at Shepherd's Hands.

## Literature Review

A literature review was performed using the following databases: PubMed, Embase, Cochrane Database of Systematic Reviews, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Each database was searched using the following key terms, "community health," "underserved population," "free clinic," "community impact," "health outcomes". Additional terms used in the search include "community-based setting," "patient satisfaction," and "primary health care". Peer reviewed, evidenced-based articles from 2008 to 2020 were selected. Articles published prior to 2015 were chosen based on theories and clinical outcome significance. Articles were chosen based on setting, patient outcomes, patient satisfaction, access to care, and cost effectiveness of the intervention. The design of the study, role of the community health care workers, and the aims and objectives were included in the selection process.

The literature review was structured according to the level of evidence, quality rating and alignment with aims and objectives of the QI project. The total number of articles found was 44. Of the 44 articles obtained 24 were reviewed and 19 were included in the literature review. The literature selection was based on the alignment with quality standards, patient perception and satisfaction of community-based health care. The ability for the facility to provide community-based primary and acute health care was included in the selection criteria.

## Literature Synthesis

### *Quality Standard*

Quality measures are helpful in establishing interventions designed to improve the quality of care received at free health clinics. The Model for Improvement, also known as the Plan Do Study Act, illustrates the steps involved in a quality improvement project. The rationale for identifying and measuring quality inclusive of sharing the steps undertaken enables project leaders to put interventions which lead to improvements into practice. Burger et al. (2020) presented a study where six quality measures were examined in relation to four quality improvement interventions and the impact on preventative care in a free clinic. The result of the study showed outcome measures exceeding the national average. Like Shepherd's Hands, the project was completed at a free clinic providing comprehensive health care services to low income individuals with no health insurance (Burger et al., 2020). One intervention included the introduction of an electronic medical system with the purpose of targeting appointment reminders, quality measure reports**,** and diagnostic testing. The results of the study showed an increase in screening rates for breast and colon cancer, and urine protein for patient with diabetes (Burger et al., 2020). Improvement in diabetes and HTN control was not indicated as an outcome in the study.

A collaborative community approach composed of adequate resources, stakeholder trust, engagement, and inclusion, evolved as a common factor for the success of a community-based initiative. Major factors, such as the inability to pay for health care services and the lack of health insurance have influenced the location and setting of patient care. Recommendations to decrease inequalities in health care include collaborative partnerships and community engagement (Boelens, 2019). The result of the study presented by Boelens et al. 2019 indicated a

collaborative community approach affected the understanding of project expectations and development of interventions to impact quality standards. At present, there is limited knowledge of how community collaboration can successfully impact health inequalities. Further, it is unclear as to which factors determine the success of community-based health and programs such as Shepherd's Hands (Boelens et al., 2019).

Boelens et al. (2019) completed a mixed method study wherein the relationship of socioeconomic inequalities and health care were explored. In the study, socioeconomic conditions were defined as the quality of the neighborhood, parenting, family life, and the emotional development of youth (Boelens et al., 2019). The rural mental health project and the promising neighborhood program were implemented as collaborative community projects to promote health and well-being. Boelens et al. (2019) found that multi-disciplinary collaboration, establishing trusting relationships, community engagement with inclusion and adequate resources were identified as facilitating factors of the success of the program.

The impact of free health care and its role to improve access to health care for vulnerable groups of people was examined in a study by Yaogo (2017). Direct payment for health care services in the African country Burkina Faso had a negative effect on the health outcomes for women and people living in poverty (Yaogo, 2017). The method of direct payment for services was established in the 1980s. In the 1990s, the negative effects of the direct payment policy were demonstrated and triggered by the health care location. The policy was changed to ensure that fee exemptions were provided for both select groups of people and medical conditions (Yaogo, 2017).

The purpose of the study performed by Yaogo (2017) was to outline the impact of removing the direct payment method to promote the use of health care services and equity of

access to care. The premise of the policy change was to remove financial burdens attributed to accessing care. However, the intervention revealed other constraints for health service users. Indirect costs associated with food, travel, and shortage of drugs was not accounted for in the creation of the policy (Yaogo, 2017). The downfall of the policy change was a direct reflection of poor planning and preparation. The needs of the people, staff, and health structures were not included in the final decision. In retrospect, the action to change the policy was well-meaning; however, people residing in remote locations were not taken into consideration in the policy-making decisions. Community-based health care sites should be located within areas that will directly impact the availability and delivery of care to the necessary and patient populations in need.

In a study presented by Kamimura et al. (2016) which focused on uninsured patient's perception of free health services, participants indicated that health care providers should focus on changing behaviors and not rely solely on increasing knowledge (Kamimura et al. 2016). Difficulty implementing learned health-related knowledge into behavioral changes was noted. Health outcomes from health education programs indicated promoting interventions for self-efficacy in areas like diabetes would be effective for patients who receive care from a free clinic.

Cockerham et al. (2017) introduced an article outlining the impact of social determinants on quality measures. Findings obtained from "minority or underrepresented groups" indicated the quality of care delivered was lower. Social factors inclusive of the outcome include reports of discrimination, mistrust, underutilization of health services, and poor communication with health care providers. (Cockerham et al., 2017, p. 9). The risk of exposure, degree of susceptibility and the outcome can be determined by the social context of a person's life (Cockerham et al., 2017).

Socio-economic status can determine health outcomes over time; socioeconomic disadvantages lead to poor health whereas, socioeconomic advantages lead to good health.

***Patient Satisfaction***

Randall et al. (2017) conducted a systematic review of 15 studies with 3965 participants focused on the impact of a nurse-led community-based clinic and patient satisfaction. Patient outcomes, access to services, and cost effectiveness were inclusive. In the study, the effectiveness of nurse-led community-based clinics in managing patient care was noted. The role of the community-based clinic evolved from blood pressure and blood sugar checks. Today, community-based clinics provide primary care and support to patients with conditions such as cancer, diabetes, heart disease, skin conditions, and sexually transmitted diseases (Randall et al., 2017). Limitations identified in the study included the lack of a formal process to evaluate the impact of the community-based clinic. The conclusion of the study revealed that nurse-led clinics have a positive impact on patient outcomes, patient satisfaction, access to services, and cost effectiveness of care.

In studies reviewed by Randall et al. (2017), six of the studies used the Likert scales to examine patient perceived satisfaction of care and qualitative data from the patient's perception of services provided to individuals seeking care. Patients reported a high level of satisfaction and a sense of security, comfort, respect, and trust and indicated that they would recommend the services to friends and family members. Negative findings included "unfilled expectations" and "feeling controlled and exposed" (Randall et al., 2017, p. 31). Patient outcomes included improved self-management of symptoms or chronic disease, and general well-being (Randall et al., 2017).

The patient's perception of the health care services received is the foundation for building an effective relationship with community health care workers who provide care (Asanad et al., 2018). The study presented by Asanad et al. (2018) illustrated the delivery of health care services through patient satisfaction surveys. Demographic data, satisfaction survey responses, and patient outcomes were analyzed. Patients reported a high level of satisfaction with the overall service provided at the sites included in the study. The feedback from patient satisfaction surveys is used to assess and improve access to care, and the quality of services provided.

The study presented by Kamimura et al. (2016) illustrated the experience of uninsured socioeconomically disadvantaged patient's experience and perception of when receiving free community-based healthcare. The study was performed at a free clinic where routine health maintenance and preventative care is offered to uninsured individuals living below the federal poverty level. Unlike Shepherd's Hands, the clinic has six paid fulltime employees, 300 active volunteers and the clinic is open 5 days a week. In contrast to the QI project, the patients were given $20 cash for participating in the patient satisfaction survey. Thirty-five patients participated in the survey. The survey results included an overall satisfaction with services, dissatisfied with long wait times, the number of services available, and phone communication (Kamimura et al. 2016).

***Community-Based Care***

For this QI project a free clinic is for an individual without insurance who is living below the government established federal poverty level. Patients who access health care through a free community-based clinic suffer from a variety of chronic and acute medical conditions, poor physical health, and mental disorders (Kamimura et al., 2016).

Treatment of Ambulatory Care Sensitive (ACS) conditions in a hospital setting is indicative of poor access to primary care (Hutchinson et al., 2018). Untreated health conditions lead to unwarranted hospitalization for chronic conditions such as asthma and diabetes. Hutchinson et al. (2018) defines ACS conditions as chronic illnesses and treatable acute conditions. Preventable hospitalization for ACS conditions exceeds 30 billion dollars annually (Hutchinson et al., 2018). Limited access to primary care for treatable conditions can lead to poor health outcomes such as respiratory distress, uncontrolled diabetes, and a stroke. Low income, uninsured adults are more likely to be hospitalized for unmet medical needs.

The impact of free clinics on hospitalizations for ACS conditions was examined in the study presented by Hutchinson et al. (2018). Patients of free clinics showed an improvement in chronic disease management, reduced HgbA1c, lower BP and lower LDL (Hutchinson et al., 2018). The premise of the study which consisted of 270,035 uninsured individuals was to determine if free clinics in North Carolina reduced the number of ACS hospitalization. The results presented by Hutchinson et al. (2018) showed that a free clinic reduced the odds of hospitalization for an ACS by 8%. In addition, management of a chronic illness resulted in a 9% reduction of hospitalizations.

Free clinics are in counties with a statistically high number of uninsured hospitalizations. Inclusion of the structural environment during the planning and preparatory phase when developing a free clinic is important as discussed earlier in the stud presented by Yaogo (2017). Hutchinson et al. (2018) indicated that proximity to the free clinic reduced the odds of hospitalization for ACS. Free clinics in North Carolina are meeting the needs of the uninsured adults and contribute significantly to decreasing the number of ACS hospitalizations (Hutchinson

et al., 2018). This article further solidifies the necessity of programs like Shepherd' hands given the positive outcomes yielded by the free clinics.

The study presented by Foo et al, (2020) highlighted the challenges and difficulties of sustaining community health care delivery. Limited capacity to provide care and technology, lack of coordination and communication were examples given. Lack of care accessibility, expertise, resources, and infrastructure to manage complex patients were also emphasized. Recommendations included taking a "whole-of-society" approach, policy formulation and community care planning (Foo et al., 2020).

Boehmer et al. (2019) identified and addressed the gaps in delivery of community-based health care to patients with chronic conditions. The impact of implementing a community health team on health outcomes was observed. The AIDED Model (Assess, Innovate, Develop, Engage and Devolve) was used to identify implementation gaps and provided more flexibility in addressing environmental context. The strength of the community health team derived from the ability to provide tangible resources like transportation to the clinic which can impact a patient's health outcome.

The literature reviewed identified challenges and positive correlations between patient outcomes and community-based health care initiatives. The literature reviewed indicated the importance of including structural needs, patient and volunteer perspective, the impact of strategic interventions as well as the implementation of quality measures was explored.

## Guiding Framework

The Johns Hopkins Evidence Based Model (JHEBPM) was applied to the literature review for this QI project. The JHEBP Model was designed as a problem-solving approach to clinical decision making and is based on three core elements: a practice question, evidence, and

translation (Dang & Dearholt, 2018). The three components of the JHEBPM were used to assess the latest research findings and best practices. The structured approach of the JHEBPM model begins with the question and the search for and appraisal of relevant evidence (Dang & Dearholt, 2018). The evidence is translated into patient care and evaluating the outcome. In this QI Project the objective of each study was identified and assessed. The most common method utilized in the studies included a pre- and post-services study design with an educational evidenced based intervention. Studies based on statistical significance and those which are evidenced-based can be used by nurses and facilities to develop best practices.

The Logic Model was used for planning and development of the project. The Logic Model provided the stakeholders with a visual description of the project and its intended effects. Along with a clear roadmap to the anticipated outcomes. Through development of the model, project leaders were able to understand the strength between the activities and outcomes. The components of the module included the target population, underlying assumptions, challenges, activities, outputs, and outcomes (Hayes et al., 2011). The Logic Model was used as a communication tool to help stakeholders and volunteers understand the relationship between the resources, activities, outputs, outcomes, and the overall impact of the project (see Appendix D).

The Model of Improvement, Plan-Do-Study-Act, was used for the identification and implementation of suggested changes to the health service delivery process at Shepherd's Hands. The PDSA is composed of four recurring stages: plan, do, study, act. Application of the framework started in the planning stage. In the planning stage, needs of Shepherd's Hands were identified with the contributions of the site coordinator and stakeholders (See appendix C).

## PICOT

The existing problem led to the question: How does process improvement implementation of a community-based free health clinic evolve? What is the effectiveness of a community-based health service on an underserved population? What are the effective and least effective strategies and elements? Based on these inquiries the Project champion (PC) developed the following clinical question:

Will improving the visibility of the Shepherd's Hands community-based health care services and identifying patient and volunteer perception of services increase patient volume? Among uninsured adults with at least one chronic disease or acute illness, living below the federal poverty guideline (P) would a strategy to increase program visibility and identify patient and volunteer perceptions of service (I), increase patient volume, and improve patient health outcomes in 12 weeks as compared to uninsured adults who seek non-acute health services at the emergency room.

P: Uninsured adults with at least one chronic disease or acute illness, living below the federal poverty guideline.

I: Modified strategies to improve visibility, and access to community bases health care services.

C: Compared to uninsured adults who seek health care in the emergency room for non-acute illnesses.

O: Increase patient volume and improve patient and perception of services

T: Over 12 weeks

## Aims and Objectives

In this QI project the objectives are targeting a mixed approach. The alignment of a quantitative and qualitative approach is critical toward achieving increased validity and attaining a successful project. Data collection for each objective's data element will include information extracted from observations, clinic frequency tracking sheets, data extracted from charts, survey response, clinical measurements pre/post access to services. The aims and objectives include:

**Aim1:** Examine Shepherd's Hands alignment with the National Association of Free and Charitable Quality Standards 6 and 7 which include the ability to track and coordinate care while simultaneously measuring and improving performance.

***Objectives:***

1. Analyze Standard 6 and 7 of the National Association of Free and Charitable Clinics and Shepherd's Hands processes.
    i. Identify the process to perform and track follow up appointments at Shepherd's Hands.
    ii. Identify the process to communicate normal and abnormal lab results to patients who access care at Shepherd's Hands.
2. Identify current Shepherd's Hands clinical programs and offerings.
3. Identify alignment and gaps with providing health care services at no charge.

**Aim 2:** Implement structured strategies to use Shepperd Hand's community-based services and evaluate the perception of community health and the visibility of Shepherd's Hands clinic services.

***Objectives:***

1. Invite participants to complete a survey to determine the perception and visibility of Shepherd's Hands services

    i. Identify barriers to health care services within the community.

    ii. Identify additional needs identified by focus group participants.

    iii. Identify how underserved individuals find information about community services and resources.

    iv. Analyze how underserved individuals used the community services and resources

b) Invite volunteers with Shepherd's Hands administration team to participate in a survey to determine the perception and visibility of Shepherd's Hands services

    i. Identify perceived barriers to health care services within the community.

    ii. Identify additional perceived needs identified by focus group participants.

    iii. Identify perceptions of how underserved individuals find information about community services and resources.

c) Determine the social value of Shepherd's Hands through patient and volunteer perceptions.

**Aim 3:** Measure the effectiveness of the community-based health care services by increasing patient volume with at least one chronic disease or acute illness, who receive care from Shepherd's Hands clinics.

Objective

1. Measure the effectiveness of the services used and patient care experience through the perspective of the individual seeking care and the health care system providing the care.
2. Increase the number of new patient visits by 10%.

## Expected Outcomes

Successful interventions continued as a part of the program and are subject to re-evaluation as indicated by the number of patients who utilized the services.

1. Alignment with the National Association of Free and Charitable Quality Standards 6: track and coordinate care and Standard 7: Measure and improve performance
2. Increase knowledge through patient and volunteer perspective surveys
3. Increase visibility of Shepherd's Hands clinic services
4. Work with Shepherd's Hands administrators to reduce identified barriers, consider additional needs, and refine advertising and communication of services
5. Increase patient volume at Shepherd's Hands clinic by 10% from the baseline within 12 weeks of implementation of the project

# Methods

## Setting and Population

The QI project was conducted at three locations in Suwannee and Madison County in Florida. Each clinic location provides free primary and acute medical services to uninsured adults who met the federal poverty guideline. A survey was conducted of new and returning patients as well as former and current volunteers. The survey is available for patients and volunteers during each clinic for 12 weeks. Survey results are used to identify the perception of patients and volunteers regarding access to care and satisfaction with services at Shepherd's Hands.

The consensus among stakeholders was the need to increase patient volume by increasing the visibility of Shepherd's Hands. The stakeholders also requested data indicating the perception of the volunteers and patients, regarding the services provided. The use of surveys,

advertising strategies, and necessary resources were identified with respect to individual and team responsibilities. The versatility of the PDSA method was noted during the project. Additional advertising strategies were proposed and integrated into the process during week 4 of the project.

## Intervention and Implementation

The project occurred over 12 weeks from June 2021 to August 2021. An additional week was added in September because of inclement weather and poor patient turnout. The project champion is also a volunteer with Shepherd's Hands and is therefore not only invested in the outcomes associated with the QI, but also in Shepherd's Hands and its community-health effectiveness. The project leaders initiated a variety of print media in English and Spanish, radio, and social media advertising strategies. Appointment reminders, visual media, and community resources were also initiated.

A team-based approach was used to increase the visibility of Shepherd's Hands through community-focused advertising initiatives. Location of flyers included local convenience stores, churches, food pantries, laundry mats, post offices, supermarket bulletin boards, and restaurants. Flyers were also distributed to residents in the community. In addition to providing medical services, each organization operates a food pantry which is open to the public twice per week. An announcement with clinic information was added to each bag of food provided to an individual or family. Flyers were emailed to local radio stations and the local newspaper. A total of 50 postcards were mailed to patients who previously accessed services at the Madison County Clinic. The postcard detailed the new location in Madison County. In addition, the scheduled clinic dates, and locations of the clinics in Suwannee County and Greenville, Florida were listed on the postcard. New and returning patients received appointment reminder cards after receiving

services that indicated the date and the location. Additional advertising campaigns included visits to local Spanish churches and speaking with the pastor and local congregation regarding available health services at Shepherd's Hands.

A patient satisfaction survey and volunteer survey consisting of eight questions was used to obtain qualitative data. To clarify, when speaking about access to care and obstacles, the author refers to the patient's perspective on the quality of services provided and their opinion as to what is needed to improve program visibility and access to care. Patients were approached with the opportunity to participate in the survey following their intake and registration. Willing participants were escorted to a private location in the waiting room to complete the survey independently or with the assistance of a volunteer. The survey was delivered in English and available in Spanish if requested.

**Data Collection**

Qualitative and quantitative data collection for each objective's data element will emerge from the following: direct observations, patient utilization of services tracker, volunteer attendance tracker, clinical assessments, survey responses, and client satisfaction surveys.

The project champion compiled medical staff and volunteer hours during the 12 weeks of the project. The investigator designed qualitative tools were implemented to obtain the patient and volunteer's experience with Shepherd's Hands. Patients and volunteers were invited to complete the corresponding surveys during scheduled clinic hours. The survey completed by the patients consisted of eight questions. The focus of the survey included the following: information pertaining to program awareness, reason for continuing to utilize the services, barriers to using the services, what the program does best and what the program is missing.

The client satisfaction survey and participant tracker provided descriptive data to include the following demographic characteristics: gender, race, age, ethnicity, primary source of care, new patient and returning patient.

An investigator designed quantitative tool (participant data tracker) was used to collect the following data: race, sex, location, new or established patient and completion of survey, for each patient. A retrospective review was completed utilizing established patient clinic data from 2016 to 2020. An excel spreadsheet was designed to compile a random sample of clinical data.

The retrospective review included the following clinical data: race, age, sex, weight, BP, Hemoglobin A1c, chief complaint, diagnosis and follow up recommendation. Appendix E illustrates, the systolic and diastolic blood pressure for 47 patients during 9 clinic visits. For a given visit, the average of the systolic and diastolic were taken independently. The decrease in the average mean systolic and diastolic BP at the start and end of the project (2016, 2020) indicates that the measures which are currently in place to promote follow up appointments and return visits are working and benefiting the patients. Each record reviewed contributed to the aggregate and was assigned a sequential identifier to maintain confidentiality.

## Data Analysis

The purpose of this QI project was to answer the following question: Will improving the visibility of the Shepherd's Hands community-based health care services and identifying patient and volunteer perception of services increase patient volume? Data from intake and registration served as the primary source of information for new and established patients. Data from the retrospective review was used to identify patterns and relationships with clinical findings. Evaluation of the data revealed encouraging results.

Initially, 24 patients and 27 volunteers participated in the corresponding surveys. Each respondent was interviewed and chosen based on their affiliation with Shepherd's Hands; criteria included patient or volunteer. Content analysis was used to analyze survey responses. Descriptive analysis, including mean and percentage, was used to summarize data and find patterns. The mean illustrated the numerical average of a data set, and the percentage represented the value of a group within a larger group.

## DNP Project Results and Findings

### Aim 1: Utilization of Services

Based on the investigator designed patient tracker, during June 2021 to August 2021, 83.3% of the patients were Caucasian and 16.6% Hispanic. The patient population was spilt with 50% being male and 50% being female. The average age during the project was 60.5. Twenty-nine percent of the patients who accessed services were new patients and 70.1% were established patients. Overall, 100% of the patients reported Shepherd's Hands as their primary and only source of care, reporting 100% satisfaction with clinic services.

### Quality Standards

Based on investigator observations during the project, there is no method in place to track and follow up with appointments. This created a misalignment with the National Association of Free and Charitable Clinics, Quality Standards 6 and 7. Clinic services offered through Shepherd's Hands includes primary and acute medical services, diabetes and hypertension management, medication for chronic and acute illness, diagnostic studies, radiology services, referrals for mammograms, and other services are provided to the patients at no cost. There was no method in place to track appointments, initiate appointment reminders, measure the quality of care, or diagnostic testing. There was no alignment with standard age-based annual screenings

and vaccines. There was limited adherence to provider recommended follow appointments and diagnostic testing.

### Aim 2: Patient Satisfaction and Perception

Patient and volunteer survey results included the identification of the following barriers: language, transportation, community visibility, social stigmas. A total of 24 patient satisfaction surveys were completed. Clinic needs identified through the patient satisfaction survey: 3 out of 24 survey responses indicated a need for doctors who specialize in oncology, 8 out of 24 indicated a need for increased advertising in the community. The remainder of the surveys indicated no additional needs.

### Community Perception

Community perception of Shepherd's Hands as evidenced by the following statements included the following:

*"Is it really all free," Do I have to believe in "their religion," "Never heard of the free clinic," "I'm not poor this service is for poor people," "what will people think if they see my car outside of the clinic," "I work at night and the clinic is only offered in the evening."*

### Barriers

| Identified Barriers | Survey Response (%) |
|---|---|
| Homelessness | 4.16 |
| Transportation | 25 |
| Accessibility | 16.6 |
| Memory and Emotions | 4.16 |
| No barrier identified | 45.8 |

To identify how underserved individuals find information about community services and resources, patients were asked, "How did you hear about the program?" Responses include a church member, local provider in the community, sign on the front of the building, people who currently volunteer at Shepherd's hands, NAFCC clinic website, Facebook, and coworkers.

**Community Visibility**

Survey responses to community visibility included the following: Eight percent of the patients reported learning about the clinic through Facebook or a coworker. Two out of 24 patients returned to the clinic because of the postcards received in the mail or posters displayed in the community. Four patients reported seeing a large "free clinic" sign in front of the building. One patient reported finding information on the following website: National Association of Free and Charitable Clinics. Nine patients reported learning about the clinic from current volunteers.

Patients indicated the services offered by Shepherd's Hands were used for primary and acute care. Twenty four patients were asked if Shepherd's Hands was not an option where would you go? One out of 24 patients responded my only option would be the cemetery, twenty patients responded they would seek care at an emergency room or health department. Three out of 24 patients indicated they would not seek care.

**Volunteer Perception**

Volunteers with Shepherd's Hands were invited to participate in a survey to determine the perception, barriers, and visibility of Shepherd's Hands services within the community. A total of 27 volunteers responded to the survey. 18.5% of the volunteers indicated concerns involving work/life balance and community awareness, 62.9% of the volunteers indicated low patient turnout, keeping volunteers motivated and community visibility. 18.5% of the volunteers indicated that low patient turnout was discouraging.

Additional clinic needs identified by volunteers: 37% of the volunteers indicated a need to increase the number of clinics offered each month and 18.5% of the volunteers suggested providers who specialize in cardiology and oncology services. Three volunteers suggested implementing a service to transport patients. When asked how the volunteers learned about the clinic, twenty volunteers indicated they are current members of the churches providing the clinic space. Information pertaining to Shepherd's hands was posted in church bulletins and advertised church sponsored events. One volunteer learned about the service from a coworker. Two volunteers indicated their knowledge of the clinic was obtained at a local pharmacy and a local emergency room.

**Aim 3: Community Benefit**

For this project, the social value of Shepherd's Hands was measured through the perspective of the people affected by the organization and clinical data. 37.5% of the respondents reported that Shepherd's Hands is filling in the healthcare gap in the community. 25% of the survey responses indicated that Shepherd's Hands provides medical treatment to a population which no one cares about. 14.8 percent of the volunteers implied there are no other options for health care in the community for people without insurance or money. 11.1% of the volunteers stated, "it helps people who need help".

Follow up clinical data from 2016 to 2020 were available for 47 established patients during 9 clinic visits. Mean baseline blood pressure across all visits was 128.3 and 81.8. Initial visits average BP 136.5 and 85.75. Final average BP is 121.5 and 83.5. For each visit, the average of the systolic and diastolic pressures was taken independently. This evidence illustrates a 15 point decrease in the SBP and a 2.25 drop in DBP (see Appendix E). A total of 11 patients were seen during the project timeline resulting in 24 patient encounters. The number of new

patient visits increased by 118% June to August 2021. In 12 out of 24 patient encounters during the project most common chronic disease identified included HTN and DM.

## Ethical Considerations

Institutional Review Board approval was obtained and documented prior to conducting this project to affirm the project was quality improvement. No potential risks or harm associated with administering the satisfaction survey to patients or volunteers was identified. Participation was voluntary, participants were informed about the project and its purpose. Surveys were conducted in a private setting at clinic location by the project champion or site coordinator. Surveys were available in English and Spanish. A translator was on site during each clinic. The survey was administered before the patient received services. Patients were given the option of reading the surveys and answering the questions or assistance with the survey from the project champion. Results of the surveys will be transferred to spreadsheets. Patient and volunteer surveys will be shredded after data is transferred.

## Summary

Project aim 1 objective was met, examine the alignment with the National Association of Free and Charitable Clinics, Quality Standards 6 and 7. There was no method in place to track appointments, initiate appointment reminders, measure the quality of care or diagnostic testing. There was no alignment with standard age-based, annual screenings and vaccines. The previous two issues have now been resolved. Implementation of appointment reminder cards and direct mail postcards is currently increasing patient volume.

Project aim 2 objectives were met. Patient and volunteer perception of services resulted in the identification of barriers: language, transportation, and community visibility. Volunteers voiced concerns regarding low morale and motivation due to low patient volume. Patients and

volunteers expressed satisfaction with services. There has been an increase in the volume of patients with a chronic disease who accessed services through Shepherd's hands.

Project aim 3 objectives were met. During the project a total of 11 new patients were seen establishing an increasing the number of new patients by 118%. Established patients with 3 or more visits experienced a decline in their systolic and diastolic blood pressure.

## Interpretation

Patient survey results indicated self-initiated refrainment when seeking care. Participants noted refraining from seeking immediate care for acute and primary health issues because of limited information, inadequate understanding of clinic services, associated worries, lack of accessibility and accommodations. Volunteer survey results indicated a concern regarding the relationship between poor volunteer morale and low patient volume. Volunteers and patients advocated for specialty providers and additional clinic hours.

## Limitations

There are two key limitations identified in this QI project. First is the limited number of project participants. Second, providers do not have access to patient assessments or treatment plans developed for patients by providers at a neighboring Shepherd's Hands clinic. An electronic medical record software is not available at the organization. Since the QI project explores only community-based free healthcare agencies, it may be difficult to generalize or replicate the project findings in for-profit and other forms of healthcare organizations. Medical providers and staff are unpaid. There is no contract or obligation to continue providing volunteer services. Lastly, there is limited literature on the community-based healthcare organizations involved in social support systems.

## Conclusion

Free clinics improve access to care for individuals without insurance living at or below the federal poverty level. Increased community visibility and appointment reminders result in an increase in patient volume. Quality improvement initiatives increase educational opportunities for volunteers and stakeholders. Communities ranked with poor health outcomes should support and develop free clinics. The sustainability measures resulting from this project will ensure the future of Shepherd's Hands will include the following:

- Additional clinic in a neighboring county is under development
- Agenda for Shepherd's Hands 2022 is in the planning stage
- Additional volunteer and provider hours are being sought in anticipation of an increase in patient volume
- For the first time, planning for a community event to recognize and fundraise for Shepherd's Hands
- Partnership are being established with the Coalition for Rural Health Disparities, Coalition for Rural Women's Health, Mobile Dental Clinic
- Partnership with Cancer Care and Urology of North Florida under development.

Sustainability is dependent upon community visibility, recognition, accessibility, and access to health care services provided by Shepherd's hands.

## Recommendations

Communities ranked with poor health outcomes should support and develop free clinics. A quality improvement process should be implemented to track and coordinate care. A formalized clinical data collection or management process should be established to measure and improve performance. Shepherd's Hands could benefit from a designated person or team to

perform quality improvement initiatives. Site coordinators and committee members could integrate patient and volunteer perspectives to enhance the delivery care process. Additionally, Committee members can propose a stipend or monetary compensation for medical providers and volunteers.

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## Appendix A

**Table 1.** *2021 Federal Poverty Level Guidelines*

**2021 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA**

| Persons in family/household | Poverty guideline |
|---|---|
| For families/households with more than 8 persons, add $4,540 for each additional person. | |
| 1 | $12,880 |
| 2 | $17,420 |
| 3 | $21,960 |
| 4 | $26,500 |
| 5 | $31,040 |
| 6 | $35,580 |
| 7 | $40,120 |
| 8 | $44,660 |

**Note*. Federal Poverty Guidelines

Source. U.S. Department of Health and Human Services (USDHHS). (2021). HHS Poverty Guidelines for 2021 prepared by Office of the Assistant Secretary for Planning and Evaluation (ASPE). https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

## Appendix B

**Table 2.** *Model for Improvement: Plan-Do-Study-Act*

| **Model for Improvement: Plan-Do-Study-Act** | |
|---|---|
| **Assess** | Increase clinic visibility in the community<br>Increase patient volume<br>Increase access to services<br>Determine the social benefit through patient and volunteer perceptions |
| **Analyze** | Number of patients before project implementation compared to after |
| **Develop** | Advertising campaign, patient satisfaction and volunteer survey |

## Appendix C

**Table 3.** *Community-Based Initiative Logic Model*

| | | | OUTCOMES | | |
|---|---|---|---|---|---|
| Inputs | Activities | Outputs | Initial<br>0-3 months | Intermediate<br>3-9 months | Long-term<br>9 -12 months |
| Location:<br><br>First Baptist Church, Greenville Methodist Church, St. Luke's Episcopal Church<br><br>Staffing:<br><br>Volunteers<br>Medical Director<br>Nurse Practitioners<br>Nursing Director<br>Case Managers<br>Clerical Support<br><br>Community Resources:<br><br>Pharmacist: Cheek & Scott<br>Laboratory: Quest Laboratory<br><br>Partnering Organization:<br><br>Florida Association of Free & Charitable Clinics | Free Primary and Acute medical services provided<br><br>New prescriptions and medication refills<br><br>Laboratory requests<br><br>Healthy Food distributed through the food pantry<br><br>Medical Services offered 2 hours per week, 5:30 pm to 7:30 pm, 2nd Tuesday of every month, 3rd & 4th Thursday of each month.<br><br>Advertising campaign<br><br>Patient satisfaction survey<br><br>Volunteer perspective survey | Total number of patient visits<br><br>Total number of patients who received primary care services<br><br>Total number of patients who received acute care services<br><br>Total number of patients who received a MH referral.<br><br>Total number of non-clinical volunteer hours<br><br>Total number of clinical volunteer hours | Patient volume increases<br><br>Increased visibility in the community | Patient and staff initiated follow ups increase<br><br>Increased access to disease and medication management<br><br>Maintain visibility in the community<br><br>Integrate findings from patient and volunteer surveys | System in place to track and coordinate care.<br><br>System in place to measure performance and coordinate care.<br><br>Additional facility added for medical services<br><br>Number of clinical hours offered increased to 8 hours per month for each clinic<br><br>Increased patient access to disease and medication management<br><br>Maintain visibility in the community<br><br>Transition to an electronic health record<br><br>Hospitalization rates decrease<br><br>Elevated blood pressures decrease<br><br>Elevated Hga1C levels decrease |

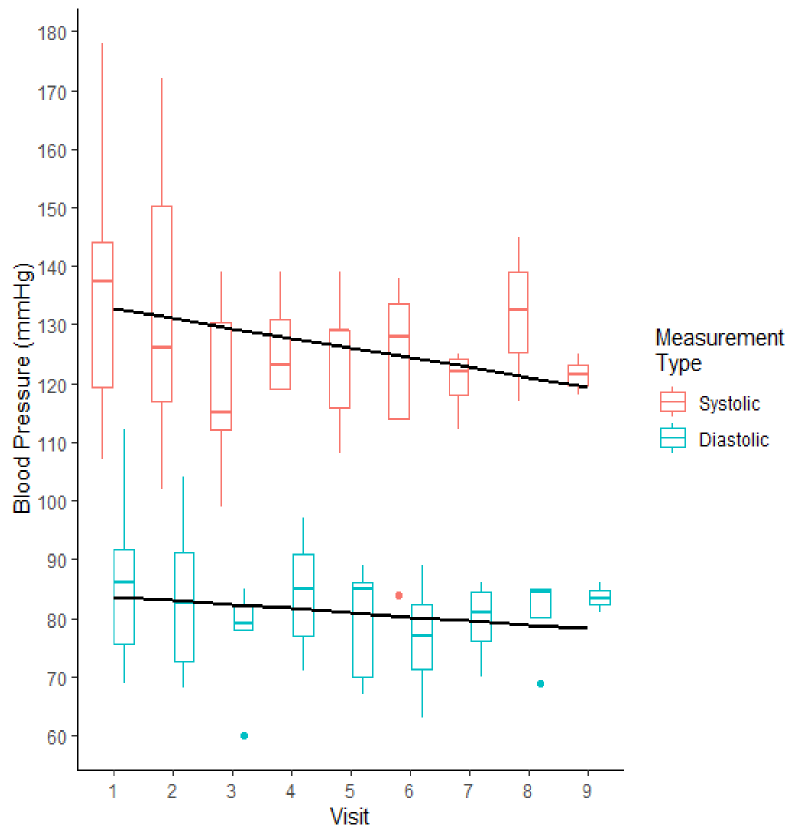
## Appendix D

**Table 4.** *Service Utilization and Demographics*

| **June 2021 to August 2021** |
| --- |
| **First time at Shepherd's Hands:**<br>New Patient 29 %<br>Established patient 70.1 %<br><br>Primary source of healthcare: 100%<br>Only source of healthcare: 100%<br>Satisfied with services: 100%<br><br>Race: White 83.3%<br>Hispanic 16.6% |

# Appendix E

**Graph 1.** *Blood Pressure Boxplot*



## Appendix F

**Table 5.** *New and Established Patients*

# Data

Volunteer and Medical Provider hours, May, June, July, August 2019,2020,2021

Number of established patients and new patients, May, June, July, August 2019,2020,2021

Utilization of Service Tracker, May to September, 13 weeks (1 additional week added because of inclement weather)

| Clinic Dates | New Patient | Returning Patient | Patient Survey Completed |
|---|---|---|---|
| June 8 | 1 | 5 | 6 |
| June 22 | 0 | 0 | 0 |
| June 24 | 0 | 2 | 2 |
| July 13 | 2 | 3 | 5 |
| July 27 | 3 | 1 | 4 |
| July 29 | 1 | 0 | 1 |
| August 10 | 0 | 1 | 1 |
| August 24 | 0 | 0 | 0 |
| August 26 | 0 | 0 | 0 |
| September 14 | 0 | 5 | 5 |
| Total | 7 | 17 | 24 |

August 10 (Inclement Weather)

**Volunteer Demographics**

| Sex | Race |
|---|---|
| 14.8% males | 14.8% black |
| 85.1% females | 85.2% white |

Total number of volunteer surveys completed 27

Volunteers: 4 males, 23 females, 4 Black, 23 White, all over the age of 55 except 1 female.

**Patient Demographics**

| **Race** | Black-0 | White- 15 | Hispanic-3 |
|---|---|---|---|
| | | | |
| **Gender** | Male-9 | Female-9 | Undetermined-0 |

| Patients |
|---|
| Total number of female patients 50% |

| Total number of male patients 50% |
|---|
| New Patients 7 |
| Established Patients 17 |

| **Patients** | |
|---|---|
| New Patients | 33.3% |
| Established Patients | 66.6% |

| **Race** | |
|---|---|
| White | 83.3% |
| Black | 0 |
| Hispanic | 16.6% |

*January to May 2021, 4 to 5 patients each month, telephone inquiries increased

| **Shepherd's Hands Free Health Clinic 2021** | **110 Volunteer Hours** | **Medical Staff Hours** | **Total Hours** |
|---|---|---|---|
| *Live Oak, June* | 16.5 | 16 | 32.5 |
| *Greenville, June* | 19 | 6 | 25 |
| *St. Mary's, June* | 13 | 7 | 20 |
| *Live Oak, July* | 6 | 9 | 15 |
| *Greenville, July* | 17 | 5.5 | 22.5 |
| *Madison, July* | 19.5 | 10 | 29.5 |
| *Live Oak, August* | 6.5 | 6.5 | 13 |
| *Greenville, August* | 13 | 6.5 | 19.5 |
| *Madison, August* | 20 | 5.5 | 25.5 |
| *Live Oak, September* | 8 | 8 | 16 |

| **Shepherd's Hands Free Health Clinic 2021** | **Number of new Patients** | **Number of Repeat Patients** | **Total Patients** |
|---|---|---|---|
| *Live Oak, June* | 1 | 5 | 6 |
| *Greenville, June* | 0 | 2 | 2 |
| *Madison, June* | 0 | 0 | 0 |
| *Live Oak, July* | 2 | 3 | 5 |
| *Greenville, July* | 1 | 0 | 1 |
| *Madison, July* | 3 | 1 | 4 |
| *Live Oak, August (bad weather)* | 0 | 1 | 1 |
| *Greenville, August* | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| *Madison August* | 0 | 0 | 0 |
| *Live Oak, September* | 0 | 5 | 5 |
| ***Total*** | **7** | **17** | **24** |

| **Shepherd's Hands Free Health Clinic 2020** | **110 Volunteer Hours** | **Medical Staff Hours** | **Total Hours** |
|---|---|---|---|
| *Live Oak, June* | 6 | 4.5 | 10.5 |
| *St. James, June* | 25.5 | 7.25 | 33.75 |
| *St. Mary's, June* | 8.5 | 6 | 14.5 |
| *Live Oak, July* | Cancelled | Cancelled | Cancelled |
| *St. James, July* | Cancelled | Cancelled | Cancelled |
| *St. Mary's, July* | Cancelled | Cancelled | Cancelled |
| *Live Oak, August* | 8 | 10.5 | 18.5 |
| *Greenville, August* | Cancelled | Cancelled | cancelled |
| *St. Mary's, August* | 20 | 5.5 | 25.5 |
| *St. James, July* | Cancelled | Cancelled | Cancelled |

| **Shepherd's Hands Free Health Clinic 2020** | **Number of new Patients** | **Number of Repeat Patients** | **Total Patients** |
|---|---|---|---|
| *Live Oak, June* | 0 | 4 | 4 |
| *St. James, June* | 0 | 0 | 0 |
| *St. Mary's, June* | 1 | 3 | 4 |
| *Live Oak, July* | Cancelled | Cancelled | Cancelled |
| *St. James, July* | Cancelled | Cancelled | Cancelled |
| *St. Mary's, July* | Cancelled | Cancelled | Cancelled |
| *Live Oak, August* | 0 | 3 | 3 |
| *Greenville, August* | Cancelled | Cancelled | Cancelled |
| *St. Mary's, August* | Cancelled | Cancelled | Cancelled |
| *St. James, July* | Cancelled | Cancelled | Cancelled |

| **Shepherd's Hands Free Health Clinic 2019** | **Number of new Patients** | **Number of Repeat Patients** | **Total Patients** |
|---|---|---|---|
| *Live Oak, June* | N/A | N/A | N/A |
| *St. James, June* | N/A | N/A | N/A |
| *St. Mary's, June* | N/A | N/A | N/A |
| *Live Oak, July* | 2 | 9 | 11 |

| | | | |
|---|---|---|---|
| *St. James, July* | 2 | 0 | 2 |
| *St. Mary's, July* | 0 | 3 | 3 |
| *Live Oak, August* | 2 | 5 | 7 |
| *St. James, August* | 1 | 0 | 1 |
| *St. Mary's, August* | 1 | 4 | 2 |

| **Shepherd's Hands Free Health Clinic 2019** | **110 Volunteer Hours** | **Medical Staff Hours** | **Total Hours** |
|---|---|---|---|
| *Live Oak, June* | N/A | N/A | N/A |
| *St. James, June* | N/A | N/A | N/A |
| *St. Mary's, June* | N/A | N/A | N/A |
| *Live Oak, July* | 27.25 | 20 | 42.25 |
| *St. James, July* | 21.5 | 7.25 | 28.75 |
| *St. Mary's, July* | 21 | 8.5 | 29.5 |
| *Live Oak, August* | 22.25 | 22 | 44.25 |
| *St. James, August* | 10.5 | 2 | 12.5 |
| *St. Mary's, August* | 18.25 | 12.75 | 31 |