# *FINAL REPORT*

## *Mother & Child Community Health Services Project Santiago de María (AmeriCares Family Clinic)*

***Volunteer's at work.***

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## I. Executive Summary.

This report summarizes AmeriCares' implementation of USAID - AmeriCares Agreement (Award No. 519-A-00-01-00213-00) in the town of Santiago de María, State of Usulután, El Salvador, Central America. The agreement, signed September the 27th 2001, concluded the 30th of September 2004.The project, anticipated improving access to primary health care for the inhabitants of Santiago de María and surrounding areas though the construction of an ambulatory outpatient Clinic. AmeriCares initial role was to build and equip the Clinic and hand it to a local NGO. When the construction phase was almost finalized (March 2003) it became clear that further involvement of AmeriCares was needed to optimize the initial investment and secure future resources.

Through an agreement modification, AmeriCares assumed as of September 2003 sole responsibility for running the clinic. Once under AmeriCares direct oversight, the clinic *(Clínica Integral de Atención Familiar, in Spanish)* operated using proven modern hospital management principles which included the following premises: a) the provision of accessible ambulatory clinical primary health and diagnostic services can be achieved by carefully selecting well trained staff. In our model, staff motivation was enhanced through continual education and through the involvement of our staff in all decision making stages of administration, hence ensuring staff had ownership of the clinic and took responsibility for service delivery in all its aspects; b) if presented with the option patients from very low-income sectors of developing countries are willing to pay for good quality health services. Patients value high quality and compassionate care provided in a modern facility at affordable and subsidized prices; c) private sector and modern hospital managerial techniques, including utilization of current information technology tools, increase productivity, allow for close monitoring of day to day operations and help non-for profit health institutions provide services to a broader segment of the society; d) non-for profit private health institutions can successfully work in coordination with public sector institutions and such collaborative efforts strengthen health systems.

The number of patients using the clinics' services rapidly increased. In its first month, the clinic treated 69 patients; and the number of monthly patient visits averaged about 1,800 by the end of the Agreement. To keep pace with the demand, new Saturday hours were to be implemented as of November 2004. Our volumes are impressive. In less than a year, more than 6000 Electronic Medical Records were opened. Over 9700 medical office visits (patient visits), over 2700 nursing procedures, over 650 Social and more than 7000 diagnostic procedures and over1190 dental procedures were registered since the November 2003 opening.

The AmeriCares Family Clinic's team of dedicated professionals offered and will continue to offer patients a wide range of high-quality medical services including general medicine, pediatrics, gynecology, dentistry consultations and clinical laboratory, ultrasound, X-ray & mammogram, and pharmacy services.

## II. Progress towards achievements

Initial plan envisaged that AmeriCares Foundation Inc. a non-for profit Connecticut based organization was to build the Clinic and pass it to a local NGO (original agreement, signed on September 27, 2001). As the project evolved, and when the building process was reaching completion, it became clear to AmeriCares that the complexity of the project would require further direct involvement in the Clinic's operation. Considering the level of expertise and further economic support required running a clinic set with modern medical equipment and technology, discussions between the NGO and AmeriCares took place, resulting in a modification of the Agreement requested by AmeriCares to USAID. The modification was signed September 12, 2003 and gave AmeriCares sole responsible for the Clinic's operation.

Once under AmeriCares direct oversight, the clinic *(Clínica Integral de Atención Familiar, in Spanish)* progressed towards the realization of its objective (health service delivery) through the implementation of carefully planned and executed organizational steps and presenting patients with high quality services rendered with respect and potential donors with accountable operations.

***Receiving a donation from Friends of Children.***

### A. Organization standards

***Staff Training.***

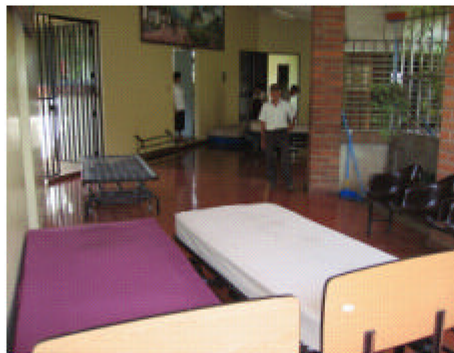
By accepting that the provision of accessible ambulatory primary health and diagnostic services could be achieved in low-income semi-urban/rural settings, we centered our efforts in two key factors:

a) engage carefully selected staff and b) keep staff's levels of motivation high. Continual education and involving staff in all management decision-making stages were crucial incentives for success. Extensive preparatory training took place prior to

opening our doors to the Public. All our Staff (gardener, door man, clinicians) participated. Ensuring staff's ownership of the clinic resulted in staff taking responsibility for service delivery in all its aspects. In addition, we utilized other private sector and modern hospital managerial techniques, including utilization of current information technology tools to increase productivity, allow for close monitoring of day-to-day operations and provide services to a broader segment of the society. Staff was also motivated with the possibility to use information systems for their day-to-day work.

We did invite private sector to join us. Important US based enterprises such as Welch Allyn, And Quest Diagnostics, have become our partners. Non-for profit private health institutions can successfully work in coordination with private and public sector and other institutions and such collaborative efforts strengthen health systems.

*Dr. Scott Allyn visits the Clinic*



*New beds for the elderly*

Our organizational standards also called for helping other institutions. With the support of UNEX, we donated several hospital beds for the local home for the elderly. We have been involved in activities with the local school system, including a local school for children with learning disabilities. Our involvement with local income generation private sector enterprises included exploring possible joint ventures with the local group of coffee exporters (UNEX).

***Exploring joint ventures with private sector***

## B. Patient’s options

We did use different media (radio, leaflets, brochures) to promote our services, but when exploring how patients had heard about services, direct patient to patient shared information was the most effective promotion tool. We quickly tested our premise: if presented with the option patients from very low-income sectors of developing countries are willing to pay for good quality health services.

***Clinic’s brochure (designed by our staff)***

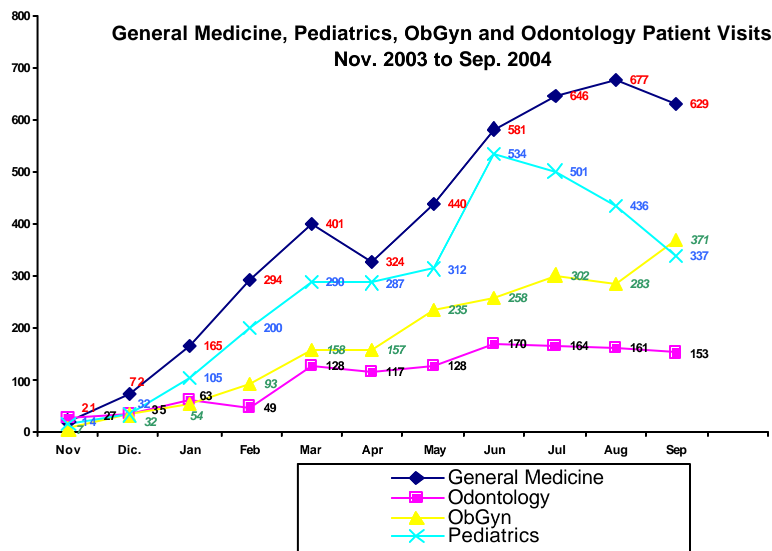
Patients value quality and compassionate care provided in a modern facility at affordable and subsidized prices. Our fee for services have been received.

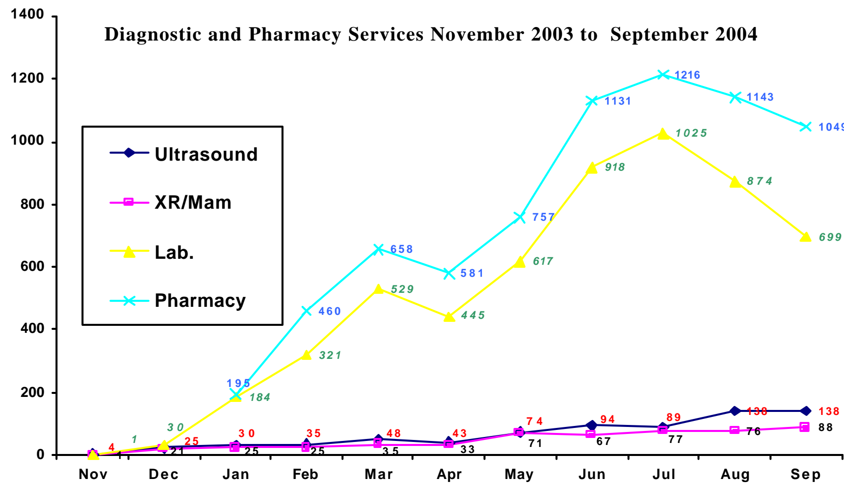
***Patients are the Clinic's raison d'être.***

Patients are the best promoters of the Clinic and a very important ingredient of our formula for obtaining sustainability[1]. Patient's involvement is two ways: they purchase our services (generate income) and as beneficiaries of subsidized services (potential donors see impact and feel attracted to the Clinic/provide additional income).

## C. Service delivery.

The facility was built and equipped with USAID funding (Award No. 519-A-00-01-00213-00). We were ready to begin delivering health care services the 17th of November 2003. From the initial 69 patients seen in those first 15 days in November, our volumes have increased substantially. Our Pediatrician, General Practitioners, Gynecologist and Dentist received 10440 patient visits by September the 30th 2004. More than 6800 diagnostic procedures had been offered (imaging and clinical laboratory) and over 7000 prescriptions had been filled. Our Clinic has been called by Salvadorians "a very welcomed alternative model of service delivery in the region".






## III. Section describing program success stories

### A. Ribbon Cutting Ceremony.

The 30th of October 2003 in Santiago de María, Departamento of Usulutan, in eastern El Salvador, special guests made their entrance and took their places at the principal table. The ceremony received local radio and TV coverage and national written press coverage. November the 17th , once the Salvadorian Council of Public Health approved all operating permits, we opened our doors to the public. The ribbon cutting ceremony was presided by the Minister of Health, and counted with distinguished personalities: Mr. Roberto González, Santiago de María's Major; Mr. Mark Silverman, USAID Director; Mr. Philip French, Chargé D'affaires US Embassy; Dr. Pedro Houdelot, President Order of Malta and Mr Curt Welling, our Presidente and CEO. Around 100 guests including ex-President of El Salvador, Mr. Alfredo Cristiani and his wife, joined members of AmeriCares Board of Director and AmeriCares HQ staff for the ceremony.

### B. Community Involvement.

Through different activities and programs, including promotion of early prenatal care, promotion of early childhood immunization, creation of a diabetes support group, talks on prevention of family violence, training of local teachers on adolescent behavioral and health issues; weekly educational radio talks, and oral hygiene education for local school children, we not involved local community, but became part of the community.

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[1] We have already talked about another key ingredient: our staff.

We established a Volunteer program that is ongoing. From an initial timidity (some very humble citizens were even reluctant to enter our premises), and undertaking conscientious educational efforts, our wonderful staff of 30 people, has been able to reach out to the neighboring communities and towns: currently, women, men and children are enjoying every minute of their visit to "their Clinic", and taking care of the facilities as something they cherish.

## C. Information Technology

AmeriCares global general guiding vision - of particular relevance to AmeriCares Family Health Clinic – uses as corner stone private sector managerial techniques, including utilization of current information technology tools to increase productivity.[2] A need analysis of information technology[3] to increase the likelihood of recuperating direct costs through income generating strategies (selling our services to different payers) resulted in AmeriCares Information Technology Department joining forces with local Salvadorian computer experts to collaborate in the development, adaptation and implementation of a software tool to

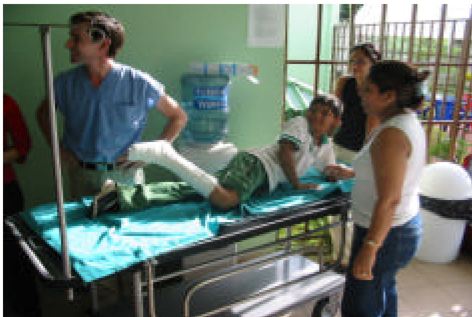
[2] AmeriCares seized the Mother and Child Community Health Services Project as an opportunity to develop within the modernization of El Salvador's Health System a model health care organization providing integrated primary care to vulnerable families is a leader in El Salvador and has international projection

[3] Included discussing existing US hospitals information systems (Yale New Haven Hospital) and field visits to local Salvadorian public and private clinics by AmeriCares El Salvador and CT.

control and administrate AmeriCares first international family health clinic in Santiago de María. Pivotal to our decision making process, in addition to AmeriCares vision of running private sector enterprises, and the Project Director's experience with IT applied to Hospital Management, were our field visits and discussions with Salvadorian Clinicians and administrators. *The analysis concluded that efficiency and precision would be enhanced through a paperless clinic approach, via computer based patient records (CPR) also called EMR - Electronic Medical Records*. Currently, our Information System is up and running in an updated platform and has allowed and us to reach our objectives efficiently and with accuracy.

## D. Training

AmeriCares Clinic in El Salvador established its name as a center where continual education takes place for both our own staff and other Salvadorian health professionals. The very successful clinical training program begun in July and extended to the end of September. Both the Minister of Health and USAID congratulated AmeriCares for this effort, where volunteer MDs and RNs traveled from the States to provide training at our Clinic. The following topics were covered: basic ultrasound; small wounds care; basic splinting; newborn care; diabetes; metabolic syndrome; benign conditions of the breast; PAP and cervical cancer; women's health issues; quality of care issues.



***Training (International volunteer Physicians and Nurses)***

## E. Sustainability

Our sustainability strategy created a fees-for –services culture in a gratuity driven environment; created cost awareness/cost control culture among staff; promoted solidarity and quality of care (internal and external); searched for additional income sources (in the USA and El Salvador). We also developed a Patients' payment plan and a socio-economic patient classification for discount purposes. Both strategies were very successful. The patient's payment plan to give patients' the option to pay in several installments the total amount of the charges and the patient's behavior showed that the payment plan was a viable payment alternative. Our strategy allowed us to recuperate above 23% of operating costs in less than 11 months of operation

***Table 1. Monthly Revenue and % of operating costs covered June-Sep 2004.***

| Month | Projected revenue | Actual revenue | % |
|---|---|---|---|
| Jun-04 | $8,066.60 | $7,600.76 | 20.78% |
| Jul-04 | $9,093.88 | $8,377.88 | 22.90% |
| Aug-04 | $10,430.39 | $8,780.88 | 24.00% |
| Sep-04 | $11,457.77 | $8,551.00 | 23.38% |

# IV. Activities completed summary.

The following tables summarize activities completed prior to initiating consutruction and health delivery activities developed.

| Timeline Sept 01- Oct 02 | Sep-01 | Oct-01 | Nov-01 | Dec 01 | Jan-02 | Feb-02 | Mar-02 | Apr-02 | May-02 | Jun-02 | Jul-02 | Aug-02 | Sep-02 | Oct-02 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Week | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| Presentation to USAID the original project Drawings | | | | | | | | | | | | | | |
| USAID evaluated the construction drawings | | | | | | | | | | | | | | |
| USAID returns drawings with observation and modications | | | | | | | | | | | | | | |
| Hiring of a Civil Engineer as a Consultant | | | | | | | | | | | | | | |
| Electrical Energy feasibility for the project | | | | | | | | | | | | | | |
| Potable water junction | | | | | | | | | | | | | | |
| Ministry of Environment construction permission | | | | | | | | | | | | | | |
| Construction Line permission at Ministry of Lodgings & Urban development | | | | | | | | | | | | | | |
| Revision and complementation of Technical Specifications | | | | | | | | | | | | | | |
| Revision and adjustment of construction budget | | | | | | | | | | | | | | |
| Construction design and specification final approbation by USAID | | | | | | | | | | | | | | |
| Construction design and specification final approbation by Ministry of Health | | | | | | | | | | | | | | |
| Construction companies qualifications document approbation by AmeriCares | | | | | | | | | | | | | | |
| Invitation to Construction Companies to participate on the qualification process | | | | | | | | | | | | | | |
| Qualification process of Construction Companies | | | | | | | | | | | | | | |
| Bidder basis Document approbation by AmeriCares | | | | | | | | | | | | | | |
| Construction design and specification final approbation by Ministry of Lodgings & Urban development | | | | | | | | | | | | | | |
| USAID approbation to Hospitable residues procedures | | | | | | | | | | | | | | |
| Mayor of Santiago de Maria approves Construction design. | | | | | | | | | | | | | | |
| AmeriCares approves Bidding process | | | | | | | | | | | | | | |
| Invitation to participate in bidding process a Construction companies qualify | | | | | | | | | | | | | | |
| Formal communication to USAID and Auditors Firm of the initiation of the process | | | | | | | | | | | | | | |
| Construction Bidding process period | | | | | | | | | | | | | | |
| Opening and evaluation of construction services offers | | | | | | | | | | | | | | |
| USAID NO Objection for construction contracting | | | | | | | | | | | | | | |
| Construction contract subscription | | | | | | | | | | | | | | |
| Construction process initiation | | | | | | | | | | | | | | |
| Building first stone ceremony | | | | | | | | | | | | | | |

**Table 2. Weekly activities developed between 4th week of September 2001 and laying of first stone**

| Activities completed September 2001 - September 2004 | 2001 | | | 2002 | | | | | | | | | | | | 2003 | | | | | | | | | | | | 2004 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| **Construction of Mother and Chid Clinic** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous Consulting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Construction Process | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Procurement of Equipment and Supplies** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| "Mayor Medical Equipment and Devices | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procurement and shipped to el Salvador | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delivery and Installation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Report and Certification signed all Equipment are full Working | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Medical Equipment and supplies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procurement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delivery and Installation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| "Physical Plant" and Office Equipment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procurement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delivery and Installation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| "Supplies" | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procurement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delivery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Inplementation of system and Instutional Capacity** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contrating the Project Coordinator | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contrating personal for key position at the Clinic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contrating all Progam personnel | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Personnel Training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Base-line Study of the Target population | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conducting the public awareness campaign | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relation ships with other area healcareproviders | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Final Implementational of institutional capacities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinic openning services to public | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinic Full operation and follow progress | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Table 3. Summary of cosntruction, initial procurement and capacity building to have an operating clinic.**

## V. Summary of lessons learned with recommendations

1. Pre-requisites prior to star building a Clinic in the developing world with USAID funding are multiple. The utilization of Federal Funding is attached to many processes as dictated by federal law and USAID and the grantee are accountable for fulfilling all law requirements. It took one year to complete pre approval process and start construction. Recommendation: In order to comply with all legal and technical requirements, enough time should be planned for the pre-approval stage of a project like ours.

2. When selecting a potential partner organization (NGO) due diligence should include making sure NGO understands the operating costs up-front. Recommendation: discuss real project dimensions and financial implications with potential partner.

3. Explaining some USAID functionaries' basics aspects of running a clinic can be time consuming. In our particular project, during several months we did not receive an answer to our request of an agreement modification from a non-medical CTO The unresponsiveness of that person affected the project's progress, but this was transitory thanks to intervention of USAID's Directors, USAID's Contract's Officers and thanks to USAID's decision to assigning a Physician as CTO once the modification of the agreement was signed. Recommendation: It is a good practice prior to signing an Agreement, which includes building a clinic to have a Medical Doctor or a person familiar with Health Systems as CTO.

4. Although one entity oversees accreditation standards (*Consejo Superior de Salud, CSS*) and is responsible for granting operating permits, CSS groups four additional surveillance entities (*Juntas de Vigilancia*) and each one of them has a set of regulations. In addition, in order to offer imaging diagnostics, you need a permit from another regulatory unit, the *Unidad Reguladora de Imágenes y Radiaciones Ionizantes (UNRA).* The process became very complicated: in order to get the approvals we had to have hired Area Directors (Regentes). USAID would not approve hiring personnel prior to receiving the date when we would start seeing patients and we could not begin operations without the permits. Recommendation: Share with USAID the special regulations of each surveillance entity early on the process.

5. Qualified human resources. Finding specialized technical human resources in a small town is a problem often seen in the developing world. Specialists tend to concentrate in medium size and large cities. The chief difficulties were related to willingness of specialized professionals to accept leadership roles in two technical areas of special interest for us as "productive cost centers": Radiology and Clinical Laboratory. We also had initial difficulties finding additional Senior Staff willing to leave their already established careers to settle (at least

during the week) in a small town. Our open and respectful managerial style was and constant support from Connecticut was key for the recruitment and staff satisfaction. Recommendations: Include in your budget higher salaries and provide additional incentives if you wish to keep a motivated staff that is willing to sacrifice family time and comfort to work in the field.

6. The information system paperless clinic approach provides quick returns eliminating the possibility of lost charts, illegible handwritten notes and high costs related to storage, maintenance and Medical Records accessibility and increase patient volumes. Similarly, the software allows managers to understand and contain costs. Upon registration, patient demographic and payer information gathered by a clerk, was be directly entered into the system, without delay. Through computer communications, we replaced Primary and Secondary Paper Chart Functions. We utilized workflow systems information technology to increase staff's efficiency. We reduced potential costs by streamlining clinic's work processes (medical and administrative) and replacing the flow of paper. We ensured that all clinical charting by all providers is done electronically and can be accessed by AmeriCares CT as needed. We ensured that all patient data are stored electronically (and not routinely printed except for prescriptions and bills). Recommendation: Incorporate IT solutions to your operations, it saves time and money and it helps diminish the gap between developed and developing world.

At the date of this submission, final audit reports have not yet been filed by the auditors. Mid-project audit reports, both in-country and the A-133 did not present any material observations of note.

**In conclusion:** even in very economically deprived third world settings, it is feasible to provide high quality medical attention in an efficient and human manner in an ambulatory clinic setting. Services, delivered in a comfortable clinical environment, where patients are respected by service providers from the moment they make their appointments or enter the Clinic's doors, can generate important revenues, thus contributing to the sustainability equation. Information systems in a paperless environment render the operation of a Clinic efficient and contribute to patient satisfaction and financial and product contributions from donors.