YUMA DISTRICT HOSPITAL AND CLINICS

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Yuma Clinic Background

- Participate in the Hospital and Medical Office surveys
- Administered survey in 2011 and 2013
- Survey mode: Paper
- Survey announcements and reminders provided through email
- Approximately 20 staff
- Part of the Yuma District Hospital
- Yuma Clinic is a federally qualified Rural Health Center

Patient Care Tracking/Follow up

Percent Positive Response

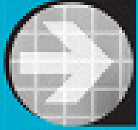
100%
80%
60%
40%
20%
0%

44%
82%

2011
2013

Year Administered

Patient Care Tracking/Follow up



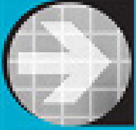
Key factors with the implementation of PCMH:

1. Development of healthcare teams opposed to a single provider

2. Development of a Patient Navigator position

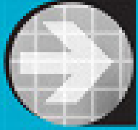
3. Development of Patient Navigation tools

Patient Care Teams



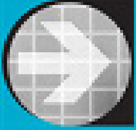
http://www.yumahospital.org/

Healthcare Team Concept



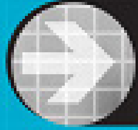
- Developed to ensure continuity and quality of care for all patients
- Teams consist of Physicians, Nurses, Patient Navigators, and Schedulers
  - Red Team (Yuma Clinic) – Full time doctors
  - Green Team (Yuma Clinic) – Part time doctors
  - Blue Team (Akron Clinic)
- Day begins in the clinic with morning huddles
  - Daily schedule reviewed
  - Patient needs addressed, i.e. lab orders, diagnostic procedures, etc.

Patient Navigator



- Conducts pre-visit preparations of patients with chronic conditions
- Involved in morning huddles with physicians, nurses and schedulers
- Works closely with the physician and patient to develop an individual care plan
- Tracks patients –
  - Reviews and updates treatment goals at each relevant visit
  - Assesses and addresses barriers when goals not met
  - Informs patients of tests needed prior to appointment
  - Follows up with patients who have not kept important appointments

EXAMPLE OF THE PATIENT NAVIGATOR EHR TEMPLATE



PATIENT NAVIGATOR

Type of Encounter: ○ In Person ○ Telephone ○ Pre-Visit Prep | Pre-Visit Preparation | ☑ Completed

Chronic Problem: ☐ CHF ☐ COPD ☑ Diabetes ☑ Hypertension ☐ Obesity ☑ Tobacco Use
☐ Other: Explain

Chosen Topic/s of Discussion ☐ Education ☐ Medications ☐ Nutrition ☐ Exercise ☐ Weight Management
☐ Cholesterol Management ☐ Tobacco Cessation ☐ Other: Explain

Current Level of Self Management: ○ Not Started Yet ○ Educating ○ Starting to Practice ○ Fully Self Managing

Self-Monitoring Tool/s: ☐ Blood Glucose Log ☐ BP Log ☐ Food and Exercise Journal ☐ Medication Log
☐ Other: Explain

Barriers Identified: ☐ None ☐ Lack of Motivation ☐ Lack of Support ☐ Financial ☐ Medication Side Effects
☐ Other: Explain

Readiness for Change:
0-3 Not Ready | 4-6 Unsure | 7-10 Ready

Education:
☐ Handouts
☐ Video/s
☐ Website Link
☐ Webinar
☐ Other-Explain:

Referrals
☐ Colorado QuitLine
☐ CJ Barnes Diabetes Care Clinic
☐ Healthier Living Colorado
☐ Healtheir Living Colorado-Diabetes
☐ Clinic Nurse or CHF Clinic
☐ Fitness Center/Personal Trainer
☐ Health Department
☐ Human Services
☐ Patient Financial Representative
☐ Rural Communities Resource Center
☐ Other

Importance of Action Plan to Patient | **Action Plan in Place** ○ Yes ○ No ○ Patient Given Copy of Action Plan
0-3 Not Important | 4-6 Somewhat Important | 7-10 Very Important | Follow up by: / /

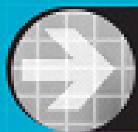
Confidence Level to Complete Plan
0-3 Not at all Confident | 4-6 Somewhat Confident | 7-10 Very Confident

ACTION PLAN

Encounter Summary

PN/HC Team Communication Template | **Save and Close** | **Print PN / HC Team Communication**

EXAMPLE OF THE "PINK SHEET"



PATIENT:
DATE OF BIRTH:
DATE:
PROVIDER:

Last routine visit: DM ______ **HTN:** ______ **Date Of Visit:** ______________

VitalSignsDate | Blood Pressure | Height Ft | Height In | Weight Lb | BMI Calc

Last Lab report showing only abnormal results and tests requested:

Today's Vitals: BP ______/______ Weight ___________ Connect with PN _____

Provider's Section:

Patient seen today for **DM** ______ **HTN** ______ **Other** ________________

Foot exam completed today **Yes** ______ **NO** ______

Patient is meeting treatment goals and was instructed to maintain the current self-care plan. ______

Next DM Visit: __________ **3 mo.** ___ **6 mo.** ___ **1 year** ___

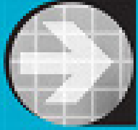
Next HTN Visit: __________ **3 mo.** ___ **6 mo.** ___ **1 year** ___

DM/HTN Labs: __________ **3 mo.** ___ **6 mo.** ___ **1 year** ___

HgBA1C ___ **Fasting Lipid Panel** ___ **BMP** ___ **CMP** ___ **Malb/Creat** ___

Other ____________________________________

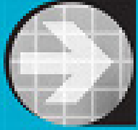
Organizational Learning



PCMH Meetings

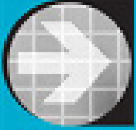
- Review/Discussion of Processes
  - What worked? What didn't? Why?
  - EHR data abstraction shows successes and areas in need of improvement
  - Process Mapping
  - Solutions discussed
- New process suggestions taken back to clinic for implementation
- Follow up at next meeting to see if new process is working – will use abstracted data for validation purposes

Work Pressure and Pace

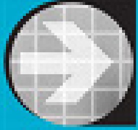


Year Administered	Percent Positive Response
2011	44%
2013	73%

Work Pressure and Pace

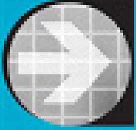


- Teams
  - Improved working relationships between schedulers, clinic staff and providers
  - Staff working at the top of their licenses
  - Morning huddle
- Patient Navigator
  - Focuses on tracking patient information allowing our nurses to focus on the clinical aspects of care
- Team Concept – So Important!
  - No one person is responsible for the care of the patient, the TEAM is now responsible for the patient.



In Closing

- By implementing the whole Patient Centered Medical Home concept, we have seen:
  - Improvement in our Safety Culture Survey Results
  - Improved Continuity and Quality of Care
  - Improved Communication
  - Increased Patient Satisfaction
  - Increased Employee Satisfaction
- Care coordination requires additional resources such as health information technology and appropriately trained staff.
- Obtaining PCMH recognition would not have been possible without the support of the Administrative Staff and our Board of Directors.



Thank you for allowing us to share our story!