YUMA DISTRICT HOSPITAL AND CLINICS

Bev Funaro, RN
Director of Quality and Regulatory Affairs
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

Year Administered

2011: 44%
2013: 82%
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

Blue Team
(Akron)

Green Team

Red Team

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

**Chosen Topics of Discussion:**
- Education
- Medications
- Nutrition
- Exercise
- Weight Management
- Cholesterol Management
- Tobacco Cessation

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

**Self-Monitoring Tools:**
- Blood Glucose Log
- BP Log
- Food and Exercise Journal
- Medication Log

**Goals Identified:**
- None
- Lack of Motivation
- Lack of Support
- Financial
- Medication Side Effects

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

**Referrals:**
- Colorado QuitLine
- CJ Barnes Diabetes Care Clinic
- Healthier Living Colorado
- Healthier 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:**
- 0-3 Not Important
- 4-6 Somewhat Important
- 7-10 Very Important

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

**Action Plan**

**Encounter Summary**

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**PN/HC Team Communication Template**

**Save and Close**

**Print PN/HC Team Communication**
EXAMPLE OF THE "PINK SHEET"

**PATIENT:**

**DATE OF BIRTH:**

**DATE:**

**PROVIDER:**

<table>
<thead>
<tr>
<th>Last routine visit: DM</th>
<th>HTN</th>
<th>Date Of Visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM ______</td>
<td>HTN ______</td>
<td>Date Of Visit: ________</td>
</tr>
</tbody>
</table>

**Vital Signs:**

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Height Ft</th>
<th>Height In</th>
<th>Weight Lb</th>
<th>BMI Calc</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>Year Administered</th>
<th>Percent Positive Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>43%</td>
</tr>
<tr>
<td>2013</td>
<td>73%</td>
</tr>
</tbody>
</table>
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

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!