Yuma District Hospital and Clinics

Yuma District Hospital and Clinics, both located in the same building, are in a rural area on the plains of Eastern Colorado.

We have six providers who see patients in the clinic and cover the hospital and emergency room. We see approximately 11,200 patients per year. We see all patients of all ages, provide OB and delivery services, and cover the long-term care facility and assisted-living facility in town.

SNMHI Team:

Dan LaPerriere, MD,
Teri Mekelburg, RN
Carmen Veliz, MA
Bev Funaro RN, Compliance Officer
Gina Eastin, Manager, Patient Business Office
John Gardner, CEO
Jason Hawley, IT services

PARTICIPATION

What motivated your practice site to participate in this initiative?

Serving a rural community, where access to larger facilities requires some time and travel, we intend to improve on the services that we provide and find new ways to assist our patients and collaborate with others in our community by participating and utilizing the tools and information provided by the SNMHI. We see that the Change Concepts set forth in this initiative will give us an outline and guidance for improving the performance of our practice.

Our mission as a clinic is to enhance the health of all whom we serve, knowing that patients want their healthcare provided by capable hands, and to provide care that exceeds industry quality standards. We want to instill trust, stewardship, integrity, and compassion. We believe that the SNMHI will guide us in achieving this mission and perhaps even set improved standards for the healthcare industry.

CHANGES

Change One: Community Linkages

- We saw a need to increase the utilization of available community resources, to better facilitate referrals, and to more quickly respond to social service needs of our patients.
- We hired a community health worker to facilitate patient referrals to different community resources and to do local outreach. With grant funding, she is also able to provide free glucose and lipid screening and offer weight management classes. We also work with our local county employed ombudsman in assisting patients with Medicare part D and referral to options for long-term care.
- Referral to community resources is easier in a small community due to close connections with community members and organizations. Although resources are limited, we have found ways to creatively meet our patients' needs.
- Some things we have done that make the referral process more streamlined include:
  1. Each provider is paneled with a nurse or MA who helps the patients with referrals to specialist, community resources or other social service needs. The team meets daily for a "huddle" to look over the schedule and follow-up on the previous day's patient needs, referrals, etc.
  2. We have contracted with an outside vendor to print daily reports on patients who are to be seen that day, highlighting what referrals or health maintenance exams are due.
  3. We work closely with area facilities that offer a higher level of care such as Banner Health Care and Poudre Valley Health Systems. This enables us to refer a patient for more advanced care with little difficulty or wait time

"We wanted to ensure that our patients received appropriate and timely appointments after an ER visit or hospital discharge.

Change Two: Integrated Behavioral Health

- We saw a need to provide easier access to mental and behavioral health care.
- We hired a clinical psychologist and licensed professional counselor to come out to our facility weekly. Appointments are made at our main admission area, which makes it easier for both patients to make appointments and providers to make behavioral health referrals. We also facilitated a meeting between the primary care providers from our clinic and the providers at a mental health facility in town to discuss what each had to offer and how to make the referral process easier.
- In making this change, we learned more about the available mental health resources already in place in the community. We also learned to better advocate for our patients and how seeking outside resources and working to bring them in to our clinic can help satisfy areas of need.
- Suggestions for others include:
  a. Meet with local behavioral health services and find out what programs they offer and how to best facilitate referrals into these programs.
  b. Offer "lunch and learn" sessions for the public. Our clinical psychologist does them, for example, he recently hosted a class on the holiday blues.

Change Three: Ensuring Timely Follow-up for Patients

- We formed a Coumadin clinic and CHF clinic that follows patients after discharge. Hospital nurses also call all ER patients and follow up the day after discharge, and it is now part of the hospital discharge protocol to make appointment for a follow-up in clinic as ordered before the patient is discharged.
- We learned that facilitating these changes was fairly simple for us as being a small hospital we have greater continuity with our providers. They provide the care in the hospital and in the clinic. If the need for an appointment happens after hours, the nurse just calls and leaves a message for receptionist in the clinic. Also, we have a wide variety of specialist who see patients here on a regular basis which enables patients to see them without having to drive long distances.
- Trying to ensure good communication with local ER/hospitals, so that follow-up can be made and records obtained, is crucial to good continuity of care. Being an all-in-one facility makes some of these things much easier!

"Continuity of care was always good but by becoming part of the medical home project people are more aware of and take the extra time to make sure referrals are done and follow-ups are not lost. Communication between hospital, clinic, and community resources has improved."—Medical Assistant

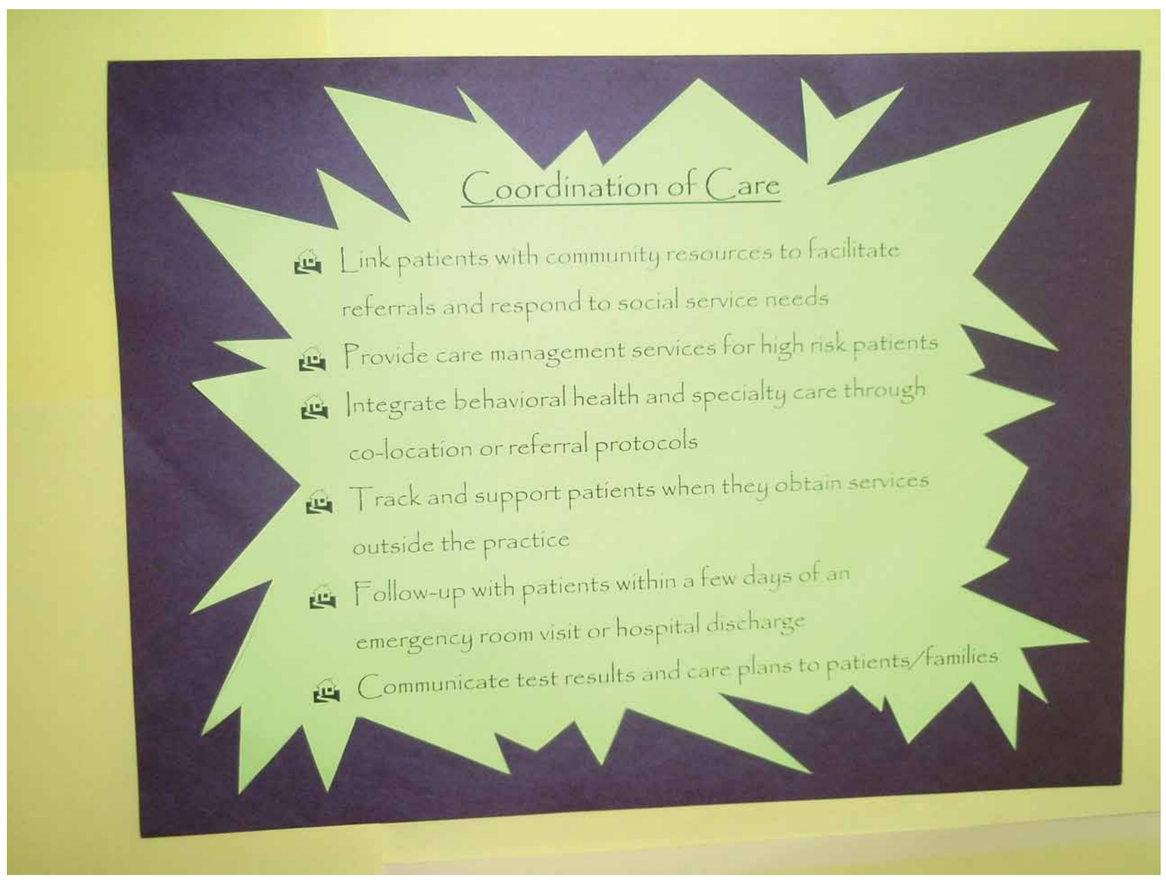
PATIENT IMPACT

"I have the pleasure of seeing patients referred to me by our medical staff for free screenings through the Colorado Heart Healthy Solutions program. Through these free screenings, we are able to identify risk factors for the patients to work on, give them additional referrals in our community for help with lifestyle change, and also stay in close contact with these patients to encourage compliance with lifestyle change and physician follow-up. This program is effective in helping manage risks associated with hypertension, cardiovascular disease, and diabetes."—Community Worker

PROVIDER OR STAFF IMPACT

"The change to a PCMH has been slow, but has had many benefits. For one, it has brought individuals from various clinic aspects together to discuss issues and find solutions to improving access, referrals, etc. This has given us all insight into the jobs others play in the clinic and the different challenges that we each face. And two, we've made changes to improve access to one's own PCP. The way our scheduling system had functioned was that the on-call provider saw nearly all of the acute care visits. This meant that if your patients had any acute problem, you rarely were able to see them. We made the change to allow more daily open access spots in everyone's schedule. I remember that soon after this occurred, I actually saw one of my patients and family for an acute illness. They were so pleased they were able to see me, 'We're never able to get into you when we really need it.' It was fulfilling to get to see this family, who I know well, and it made the healing process better for all involved."— Medical Director

"The transformation process has been very educational and challenging. While we are doing many new processes, many were already in place but were conducted in an informal manner. I think that taking the casual element out of service delivery represented a cultural shift that challenged staff. However, we are beginning to see the rewards. Our clinic has been able to efficiently accommodate more patients and get them in the schedule with reduced waiting times without having to increase the number of providers. In fact, we have one less provider now than we had a year ago. The greatest personal benefit of the transformation is that I am no longer receiving complaints from community members about not being able to get in to see their preferred provider without a two to three week wait."



Safety Net Medical Home Initiative

QUALIS HEALTH™ · THE COMMONWEALTH FUND · MacColl Institute at Group Health Cooperative