Petersburg Medical Center

Joy Janssen Clinic Report May 15, 2024

Workforce Wellness

Over the past six months, the Joy Janssen Clinic has experienced stable staffing with minimal turnover. We have initiated cross-training for some medical assistants in the clinic reception area, which has proven particularly beneficial during staffing shortages. Currently, two of our staff members are participating in the Alaska Primary Care Association's Clinic Medical Assistant Apprenticeship program, which will enable them to become Certified Medical Assistants. Additionally, some staff members have advanced their careers by obtaining LPN licenses in Alaska, while others are taking courses in preparation for enrolling in an RN program in the future. New team members include Rose Mommsen, LPN who transitioned to the clinic in November 2023.

Community Engagement

The clinic has engaged with the community through outreach events and has also collaborated with others as outlined below:

1. On March 28, 2024, the Clinic Manager engaged in a live radio session on KFSK, where updates were provided regarding the upcoming Specialties including Dermatology with Cameron French, PA-C scheduled for May 20-24, 2024, Optometry with Dr. Kapp in May 14-24, 2024, and ENT with Dr. Raster May 15 & 16, 2024.
2. Hypertension Quality Program Report: Community Awareness, Education, Diagnosis, and Treatment

Overview: Our Hypertension Quality Program focuses on enhancing community awareness, education, diagnosis, and treatment to combat the widespread issue of hypertension. This report outlines our initiatives and the critical reasons behind our efforts.

Community Initiatives:

1. Health Fair:
    - Provided free blood pressure screenings to the community during the blood draws and during the Health Fair event on 03/23/24. Approximately 85 people screened.
    - Offered educational materials on hypertension, its risks, and prevention strategies.
    - Engaged with residents to discuss the importance of regular blood pressure monitoring.
2. Community Clinics:
    - Completed community blood pressure screenings during Heart Health Month Feb 2024 at the grocery store and local coffee shop.
        1. 17 people screened, 12 referred for follow-up.
    - Referred patients who were elevated back to the clinic for follow-up, provided education at time of blood pressure screening, additionally had RN case manager call patients for follow-up if indicated.
3. Home Monitoring Programs: HealthSnap
    - Clinic is able to distribute home blood pressure monitors to high-risk individuals who are referred by a provider. We utilized a program called Health Snap.
    - RN staff are able to view patients' blood pressure values in real time in a portal and follow up with patients via phone call.
    - RN Case Manager or RN Home Health nurses follow up regularly and check in with participants to review their readings, inform their primary care provider and provide guidance if appropriate.

The Why:

- Prevalence and Undiagnosed Cases:
  - Nearly half of Americans suffer from hypertension, with many unaware of their condition.
  - Regular monitoring and early diagnosis are crucial as hypertension often presents no symptoms until significant damage has occurred.
- Health Risks:
  - Untreated hypertension can lead to severe health complications, including heart attack, stroke, aneurysm, kidney failure, and loss of vision.
  - Education and preventive measures are vital in mitigating these risks.

Prevention and Treatment:

- Key Strategies:
  - Regularly check your blood pressure to catch potential issues early.
  - Adopt a healthy lifestyle, including a balanced diet, regular exercise, and stress management.
  - Follow medical advice and take prescribed medications as directed.

Conclusion:
Our Hypertension Quality Program is dedicated to reducing the prevalence and impact of hypertension in our community through proactive measures. By raising awareness, facilitating education, providing accessible diagnosis and treatment options, and encouraging regular monitoring, we aim to improve overall health and prevent the serious consequences of untreated hypertension.

Patient Centered Care

The clinic's primary commitment revolves around the consistent delivery of patient-centered care. We actively engage in collaborative efforts with various departments to ensure that patients enjoy a positive experience throughout their medical treatment at our facility. Several examples of initiatives that embody this patient-centered approach include:

1. **Meeting patient's individual needs and improving access to care**: The clinic works to provide the proper availability on a daily basis to meet the need for "acute care" or same day appointments. The clinic leaves several visits open per day to allow for this type of scheduling.
2. **Chronic Care Management:** We have an RN Case Manager to assist patients in navigating the healthcare system and establishing strong connections with their healthcare team. They provide invaluable support in complex medical situations and conduct monthly follow-ups, ensuring that patients receive continuous care and attention.
3. **Transitional Care Management**: The Clinic and Nursing staff jointly participate in Transitional Care Management, providing essential support for patients transitioning from inpatient to outpatient care. This includes following up with patients via phone within 48 hours of discharge and ensuring they are scheduled for a follow-up appointment at the clinic within 7-14 days, or sooner if possible.
4. **Remote Home Monitoring:** Health Snap is now available to patients, allowing them to enroll in home monitoring programs that include devices such as blood pressure machines, scales, blood glucose monitors, and pulse oximeters. Patients using these monitoring devices can conveniently log their health information into a portal, which our healthcare providers at PMC can access and monitor.

Access to Care Reports:

1. We are tracking the following measures for access to care.
   i. Clinic Volumes
   ii. Referrals
   iii. First next available acute care appointment with PCP
   iv. First next available appointment
   v. Third next available appointment

vi. Same-day acute care visits scheduled daily

2. **Clinic Volumes**:

Month	Total Clinic Visits	Total Encounters
January 2024	775	807
February 2024	683	710

3. **Referrals:** These outbound referrals include internal and external referrals. Internal referrals are for: audiology, nutrition, rehab/therapies, home health, wound care, and behavior health. External Referrals are to any other specialist outside of Petersburg.
    i. **2023 Quarter 1 Data**: 1/1/23 thru 4/30/23
        1. 857 referrals
    ii. **2024 Quarter 1 Data:** 1/1/24 thru 4/30/24
        1. 781 referrals
    iii. The decrease in referrals is consistent with the absence of one provider this year, indicating a potential impact on overall referral numbers. Dr. Hyer wrote 204 referrals in that timeframe.

4. Next Available Reports:

The data on next available versus third next available is a standard metric in primary care settings to assess provider availability. Our data over the past 6 months indicates improvement in the average availability of appointments from October 2023 to April 2024.

October 2023 Data:

Report Date:	**10/24/2023**		
Resource	Next acute with PCP	Next available open	Next third avail open
#1 Provider	10/26/23= 2 days	11/14/23= 21 days	11/15/23= 22 days
#2 Provider	10/26/23 = 2 days	11/3/23 = 10 days	11/15/23 = 22 days
#3 Provider	10/28/23 = 4 days	11/17/23 = 24 days	11/22/23 = 29 days
#4 Provider	10/24/23 = 0 days	10/26/23 = 2 days	10/26/23 = 2 days
#5 Provider	10/24/23 = 0 days	10/24/23 = 0 days	10/30/23 = 6 days
Average days to wait	1.5	11	16

April 2024 Data:

Report Date:	**04/10/2024**		
Resource	Next acute with PCP	Next available open	Next third avail open
#1 Provider	4/15/24: 5 days	5/1/24: 21 days	5/2/24: 22 days
#2 Provider	4/10/24: 0 days	4/16/24: 6 days	4/18/24: 8 days
#3 Provider	4/16/24: 6 days	4/23/24: 13 days	4/23/24: 13 days
#4 Provider	4/11/24: 1 day	4/11/24: 1 day	4/11/24: 1 day
#5 Provider	4/12/24: 2 days	4/12/24: 2 days	4/15/24: 4 days
Average days to wait:	2.8	8.6	9.6

5. Number of Same Day Acute Care Appointments Scheduled:

Week Ending: 3/02/2024	
Date	# Of Same Day Acute Care Appts
Monday 02/26/2024	18
Tuesday 02/27/2024	6
Wednesday 02/28/2024	14
Thursday 02/29/2024	12
Friday 03/01/2024	7
Saturday 03/02/2024	8
AVERAGE:	10.8

Week Ending: 3/23/2024	
Date	# Of Same Day Acute Care Appts
Monday 03/18/2024	11
Tuesday 03/19/2024	12
Wednesday 03/20/2024	8
Thursday 03/21/2024	11
Friday 03/22/2024	11
Saturday 03/23/2024	4
AVERAGE:	9.5

Facility

The Joy Janssen Clinic team, comprising of the Clinic Manager, Assistant Manager, Medical Director, Medical Assistants, and Reception Supervisor, are actively participating in the planning of our new facility. We regularly attend meetings to offer input regarding the design and operational flow of the clinic.

Financial Wellness

The clinic Actively pursuing strategies to boost patient volume and optimize provider schedules to enhance revenue by the following techniques:

- Implementing innovative scheduling techniques.
- Proactive patient bookings on on-call days.
- Outreach efforts for timely delivery of overdue preventive care.

Management and registration staff diligently addressing work queues.

- Reviewing accounts to identify and rectify issues or errors in the registration process.
- Preventing delayed reimbursements or claim denials.

The clinic has made a concerted efforts to secure increased reimbursements for care management services by:

- Focusing on Chronic Care Management and Transitional Care Management programs initiated in October 2023.
- Implementing remote home monitoring through the HealthSnap program.

Submitted by: Kelly K. Zweifel, Clinic Director