Klamath Health Partnership

Klamath Health Partnership (KHP), a private, not-for-profit corporation, operating as Klamath Open Door Family Practice Clinic, was started in 1997 by three healthcare professionals with longstanding commitments to providing access to preventive and primary care to the underserved in Klamath County, Oregon. We are currently Klamath County's only FQHC. We offer access to culturally appropriate, high quality, and affordable primary and preventive healthcare.

Our team includes six family practice physicians, one internist, three PAs, one advanced practice psychiatric nurse practitioner, one nurse practitioner, three RNs, four dentists and two dental hygienists, along with many capable staff.

SNMHI Team:

Dr. Esteban Miller, Medical Director
Gretchen Young, Administrative Coordinator
Angela Leach, Information Services
Adolfo Camacho, EMR Site Specialist
Ryan Dutton, Clinical Services Coordinator
Revolving members from other departments

Medical Patient Demographics:
Total number of patients: 8,196
Gender: Male 40%, Female 60%
Race: Non-Hispanic 80%, Hispanic 15%
Below 200% FPL: 83%

PARTICIPATION

What motivated your practice site to participate in this initiative?

Our motivation to join the SNMHI was due to the fact that we were already practicing many of the key change concepts. The physical layout of the building we moved into in 2005 was designed with co-located care teams in mind. We have four different teams in the medical department ,each with two providers and three medical assistants. We also provide in-house lab and x-ray services. With the help of the SNMHI, we are currently mapping the work that is done by all staff and re-evaluating responsibilities in hopes of redesigning and expanding support rolls to better serve the patient.

In addition to changes such as using an RN case manager and an increased access system, we are currently in the process of reviewing the provider team/patient assignments and have begun to weigh panels for age and gender. We are using panel sizes to guide patient re-assignment and understand supply and demand to determine our capacity for new patients when a provider leaves.

Ultimately, we felt that this initiative would be extremely beneficial by providing the experience, guidance, training, and resourses necessary to reach our highest potential. In hindsight, we also realize that this collaborative is guiding us on the cutting edge of health care and leading us to make preemptive changes towards the pay-for-performance model.

"Patients have been positively impacted by being more informed via more vitals, medication lists being updated, and after-visit summaries. They have come to expect the same things at every visit regardless of who they see, by every person on the medical team."—Certified Medical Assistant

CHANGES

Change One: Uniformity to the Rooming Process

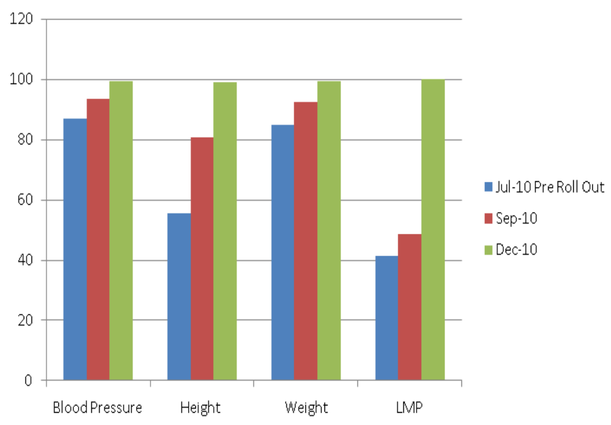
What was the specific problem or issue being addressed?
- Nurse/Medical Assistants job duties varied from POD to POD
- When RN or MA would cover in other PODs, the flow was impacted due to confusion surrounding variances in procedures and expectations from provider
- Providers could not expect the same quality of work from every RN or MA

What did you hope to achieve by making the change?
- Standardized RN/MA roles and responsibilities
- Lay a foundation for Medical Home changes

What was the plan for making the change?
- Gain 'top-down' support
- Establish core work group and weekly meetings
- Identify the areas in need of standardization: rooming of patients, Medicare ABNs, medication refills
- Using best-practice standards, identify all necessary information that needs to be obtained during each task
- Develop a way of measuring performance
- Gain near-unanimous approval from all providers
- Group training for RNs and MAs
- Develop and run monthly reports and share with RN/MAs at monthly meeting and annual reviews

What did you learn from the process of making the change?
- Executive management must be involved and must provide a united front
- Getting a near unanimous consensus on the rooming standards by the providers is a must
- Follow through, follow through, and follow though

What would you recommend to other sites trying to make a similar change?
- Find the key points and advantages to the changes you are trying to make. Then sell, sell, sell. You need to have support staff and provider buy-in.
- It helps to have a provider on the core team to speak to their peers and gain support.



Change Two: Prepping the Patient for Visit

What was the specific problem or issue being addressed?
- Missed opportunities in the standard of care for chronic conditions

What did you hope to achieve by making the change?
- Improve clinical metrics for A1c, immunizations, foot exams
- Lay a foundation for medical home changes

What was the plan for making the change?
- Identify the areas in need of standardization
- DM visits – Self-management goals, foot exam, A1c, flu and pneumovax, retinal exam referrals, dental referrals, and education handouts at every visit
- Well Child Checks - Immunizations
- OB visits
- Using best-practice standards, identify all necessary information that needs to be obtained during said tasks and at what intervals

What did you learn from the process of making the change?
- By adhering to best-practice standards, we were able to reach a general consensus of requirements for the different types of chronic illness
- Patients knew what to expect during their visits no matter which provider team they saw

What would you recommend to other sites trying to make a similar change?
- Sell the changes in order to have support staff and provider buy-in

PATIENT IMPACT

"Before the standardization, it was easier for chronic pain patients to get their refills without being seen as often as necessary. With the standardization project, everyone is on the same page with refills so our patients are being called and brought in for their regular pain management appointments and getting the care they need." —Medical Assistant

PROVIDER OR STAFF IMPACT

"Diabetic standardization has improved. A1cs are done more frequently; and when I come in the room, patients have their shoes off for monofilament exams." —MD

"Patients are getting refills on time and with less of a delay than before. Multiple patients commenting that they have spent less time waiting and felt like they are getting more coordinated care. I am taking less time to do paper and EMR refills and spending more time with my patients." —Physicians' Assistant

Safety Net Medical Home Initiative

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