Safety Net Medical Home Initiative

Winding Waters Clinic
Enterprise Oregon

Our Mission is to Provide Excellent, Comprehensive Healthcare to the Residents and Visitors of Wallowa County.

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Safety Net Medical Home Initiative

- Wallowa County Profile
  - 7,250 people in 3,145 square miles (2.3 people per square mile)
- Health Care Services Profile
  - Local 22 bed hospital, mental health services, 3 primary care clinics
  - 66 miles from the next nearest hospital
  - 104 miles from the nearest cardiology office (no interventional cath lab)
- Winding Waters Clinic Profile
  - 2.39 Clinician FTEs (3 MDs and 2 NPs)
  - 14,162 visits in 2008
  - Main clinic in Enterprise, satellite clinic in Wallowa
- Patient Profile
  - 6,951 active patients
  - 33% of patients over 65
  - 97% Caucasian
  - 42% Medicare, 12% Medicaid, 10% Uninsured

Where are we in this journey?

- **Clinic Culture**
  - Defining what being a “Patient Centered Primary Care Home” means for Winding Waters Clinic
    - Patients are the #1 reason we are in business
    - Mission statements states “Provide excellent, comprehensive healthcare to the residents and visitors of Wallowa County”
  - Understanding and articulating how this is different from the current way we provide care
    - How can we be available to our patients when they need us without exhausting the resources we have
    - Building trust among staff to develop that network to meet our patients needs
    - Rebuilding a sense of a community purpose and care for our patients that we have struggled with in the recent past with all the internal changes we have been going through
  - Developing strategies for transformation in the middle of an already strapped practice
    - Asking staff for input on how to care for our patients
    - Being wiling to try something new and learn from the outcomes

Where are we in this journey?

- **Key Problem Areas from the PCMH Baseline Assessment Survey**
  - Access
    - Current Patients
      - Average wait-time for follow-up visit is 12 days
      - Average wait time for preventive health exam 36 days
    - New Patients (Currently have a wait-list to establish at WWC)
      - % population without doctor
        - » Working Uninsured
        - » People moving to Wallowa County
  - Follow-Through
    - Timely patient notification of results
    - Tracking of results and consults
    - Chronic care visits
  - Care Coordination
    - Use of Non-Physician Staff
- **Environmental Issues**
  - We need a new Medical Office Building!
    - Narrow hallways, limited wheel chair accessible bathrooms, not enough exam rooms, no space for group meetings/group visits, privacy concerns (visual and auditory)

How are we getting there?

- **Growing our non-physician care support team**
  - Hired Patient Care Coordinator
    - Database tracking of chronic diseases
    - Tracking of preventive health measures
    - Participating in Care Management Plus Program
    - Empanelment of our patients
    - Developing Care Teams w/providers
    - Networking with other practices for feedback and problem solving
  - Hired someone to track ordered tests and referrals
    - Timely letters out to patients w/results
  - Hired someone specifically for prescriptions management
    - Electronic Prescribing is in place, but does not work smoothly

- **Partnering**
  - Conversations with the hospital regarding a new Medical Office Building
    - Not a #1 priority for the hospital due to the current economic environment
  - ORPRN and other networking groups

- **Patient Satisfaction Surveys**
  - Regularly checking our progress with patients

How are we getting there?

- **Teams**
  - **How do you promote a team atmosphere?**
    - Section of updated job description “Clinic Culture”
    - Rose Awards – staff recognition from patients and other staff
    - Asking input
    - Visual Aide – “2010” timelines on whiteboard by water dispenser
    - Monthly newsletter – highlights staff, events, mission, goals
    - Verbalize mission statement in conversations or meetings
    - 1-1 conversations between owners and key staff members outside office (bkfst or lunch)
    - Remind staff what an important part of PCMH they really play
  - **Empanelment “teamlets” or “dyads”**
    - 1 provider starting at a time
    - open access – provider discussing with her patients and explaining the reason for it
    - MA has voice mail so patients can access her directly
    - MA works a partial day when the provider is not in the office to address questions
    - provider email and cell phone access given to patients
    - Remove barrier to provider and need will decrease
    - Pilot for 6 months before next provider transitions in

How are we getting there?

- **Future recruiting of Patient Educator**
  - Moving our focus to proactive care vs. reactive care
    - Patients can learn about and how to manage disease or condition
    - Families can network with other who share similar experiences
    - Another person patients can access for questions
    - Empower patients to be healthier
    - Adding to the building blocks of the PCMH

How are we getting there?

- **Challenges of implementation**
  - **“**Change” comes at a price
  - Overwhelming to an already busy practice
  - Seasoned staff skeptical of benefits of change
  - Threatened they will be replaced
  - “Not broken, why fix it?”
  - Lack of dedicated energy
  - Space
  - Meeting burnout
    - Trying to be very concise, outcome focused and mission driven
    - Trying to take small steps not tackling the whole world
    - Giving breaks – having a “meeting free” month

How will we know when we get there?

- **Patient Satisfaction**
  - Increased access to personal provider
  - Decreased inquiry calls from patients about test results and continued care
  - Survey how change has affected patient perception of care and visit experiences
- **Health Outcomes**
  - % Patients at goal for chronic conditions (by provider and by clinic)
  - % Patients up-to-date on preventive health measures
- **Staff Satisfaction**
  - Manageable work load for all
    - Updating/prioritizing job descriptions
    - Developing cross training schedule
  - Renewal of vision, creativity and innovation
    - Updating Policy and Procedure Manual
  - Staff see themselves as vital members of “The Team”
- **Successful Partnerships**
  - Establishment of rewarding relationships with other clinics
    - Providers and clinics that are really making a difference in patient care as they work towards becoming Patient Centered Primary Care Homes

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- **What does Winding Waters Clinic need to succeed?**
  - Manpower
    - Providers (MD, PA, NP)
      - Currently 2,908 patients per FTE
    - Nursing staff (Patient Educator)
  - Physical Space
  - Financial Resources
  - Technical assistance with
    - Interoperable EMR (selection, financing, implementation)
    - Better functioning of E Prescribing
  - Flexible and imaginative team working toward a common goal
- **How is Winding Waters Clinic succeeding?**
  - Provides sustainable jobs for the area
    - 2008 gross payroll of $925,000 directly back into our community
  - Providing good healthcare for our patients
  - Working to provide a primary care home for our patients
- **What can Winding Waters Clinic share with others?**
  - Our experiences so far in working through BIG changes