NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM
A 501(c)(3) ORGANIZATION

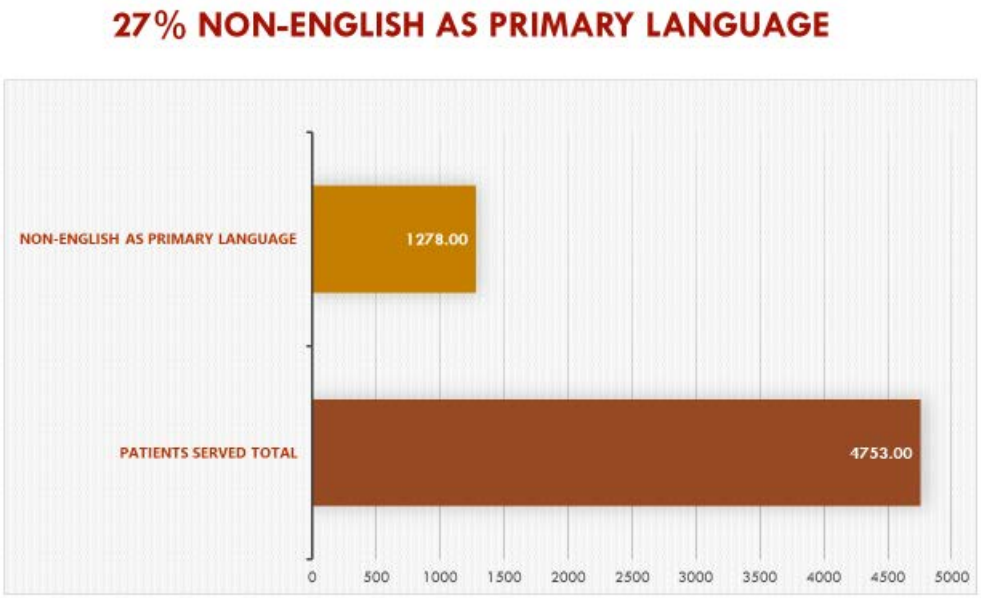
LEXINGTON REGIONAL HEALTH CENTER

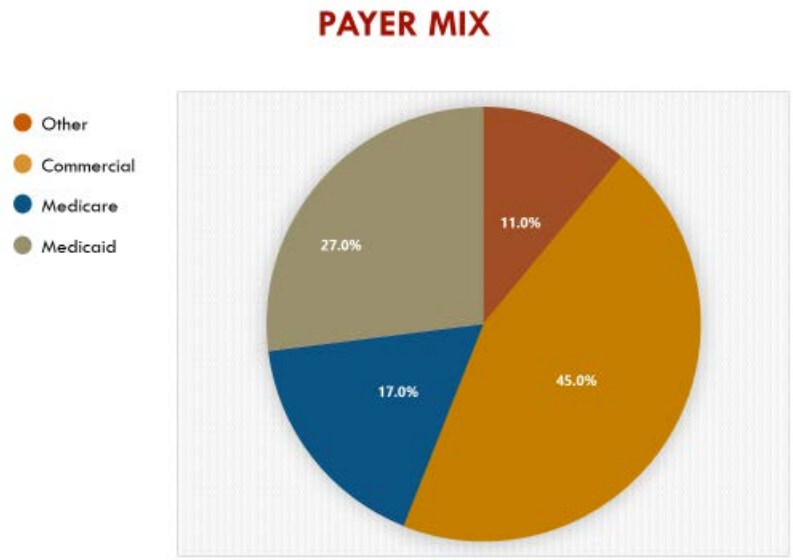
February 2019

NRACC Exemplary Practice Profile: Lexington Regional Hospital

About the Practice

Lexington Regional Health Center (LRHC) is a Critical Access Hospital in Lexington, Neb., serving the south-central Nebraska counties of Dawson, Phelps, and Gosper. The community has a large Hispanic and Somali population accounting for approximately 38% of residents according to the latest community health survey, and the majority of this population has no health insurance. More than 95% of the respondents for the Lexington Community Health Survey are refugees, immigrants, and/or minorities per the U.S. Census. Here at LRHC we have been focusing on breaking down cultural barriers and overcoming communication limitations related to language and health literacy. In 2018, 27% of our encounters were with patients whose primary language was not English.





We have one primary care clinic, Family Medicine Specialists (FMS), which is a designated Rural Health Clinic with two physicians and four advance-practice providers. Overall our community population struggles to make traditional clinic hours appointments due to scheduling inflexibility associated with the types of employers where the population works. Our Urgent Care Clinic (UC) has four mid-level providers and provides primary care with extended evening and weekend hours. This is a huge benefit to our community for improving access to care. Our extended hours have helped us reduce hospitalizations, instead of patients going to the hospital they are seen in the clinic. Additionally, we have two satellite Rural Health Clinics with rotating staff from FMS and the UC. The satellite clinics are the only clinics in two smaller neighboring towns of Bertrand and Elwood, Neb.

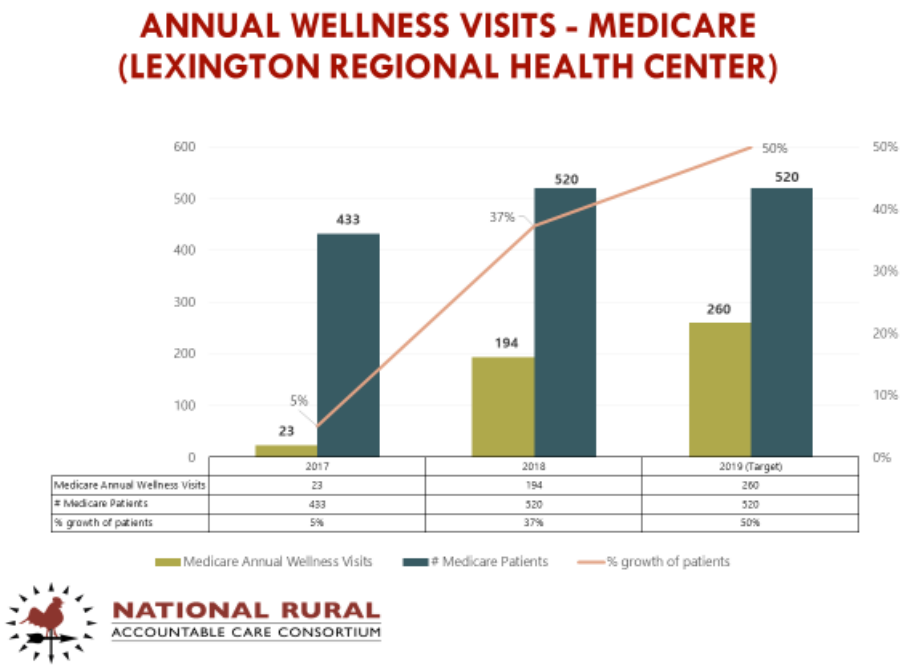
We initially joined the Transforming Clinical Practice initiative (TCPI) because we wanted to ensure we were moving from fee-for-service to value-based care. We also saw that TCPI would offer essential tools to allow us to provide outstanding care to our community. The top five diagnoses we see are routine child health exams, immunization encounters, essential primary hypertension, adult exams, and type 2 diabetes. Numbers are reflected in the following table.

The Transformation Process

Our first initiatives with TCPI were the Transitional Care Management (TCM) and Chronic Care Management (CCM) programs. Our TCM approach includes an initial home visit after hospital discharge followed by ongoing CCM for appropriate patients. We are especially focused on improving care for diabetes and congestive heart failure due to high rates of these conditions among our patients. One initiative that is having a significant positive impact is the utilization of a community health worker to assist in patient engagement. Specifically, our community health worker has made improvements in patient communication at home visits, office visits and through translation services offered. Our community health workers assist patients with their understanding of appropriate medication dosage and in compliance with medical regimes critical to maintain health or to heal. Home visits have identified unique cultural habits that impact diabetes management, such as using a tortilla as a spoon, and a lack of understanding that a tortilla (even when utilized primarily as a utensil) should be included in the patient's carbohydrate count.

Since enrolling in June 2016, our practice has been able to take advantage of National Rural Accountable Care Consortium's (NRACC) coaching and technical support to make progress in reducing hospital readmissions by implementing TCM and CCM programs. The information provided has helped us to achieve a NCQA Patient Centered Medical Home recognition through our CMS Certification Team. As one of the only Critical Access Hospitals in Nebraska to submit quality data for the Merit-based Incentive Payment System, we achieved a score of 95 with our Performance Year 2017 submission (55/60 for quality) and expect a 60/60 quality measure score for PY 2018.

Our NRACC Quality Improvement Advisor (QIA) has been useful to help us connect our CCM initiative with the initiation of Annual Wellness Visits (AWVs). Through TCPI we were able to see the need to increase our staffing to accommodate an increased rate of AWVs. We added part-time staff in late 2018 and were successful utilizing the Plan-Do-Study-Act (PDSA) change model to complete 37% AWVs for our Medicare population in 2018. Prior to this we were unable to provide the time needed to accomplish a significant number of AWVs. The graph below shows the progression for 2017 and 2018 with our target 2019 goal of 50%.



Increased attention on our AWV rate led us to understand the need to establish a Behavioral Health Initiative by employing a certified psychiatric nurse practitioner and two social workers to address patients' behavioral health needs.

Our mental health staff provide health services from diagnosis to treatment. These professionals are available to patients through our outpatient clinics, as well as in both emergency room and inpatient settings. The psychiatric nurse practitioner provides medication management for our patients with mental health conditions. Common practice areas include depression, anxiety, schizophrenia, post-traumatic stress disorder, mood/bipolar disorders, attention deficit hyperactivity disorder and oppositional defiant disorder, as well as life changes, and pre/post adoption counseling.

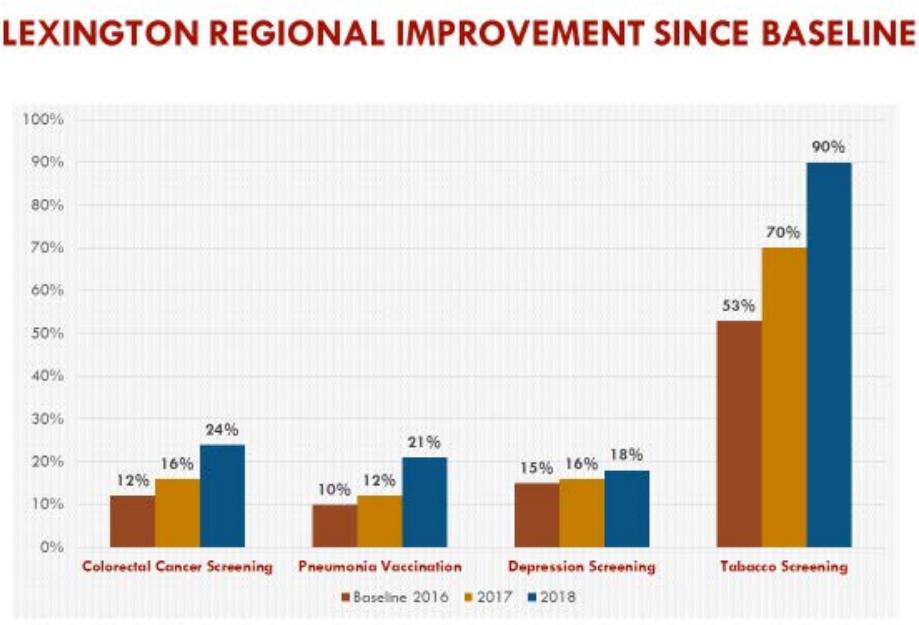
Providing Patient-Centered Care

We regularly consult our Patient Advisory Council, which is culturally diverse and highly representative of our community, on topics such as critical review of patient education materials and strategies for effective cross-cultural communication. Our Health Literacy Team assures patient input is cross-cultural to optimize patient understanding of their condition as well as improve patient engagement in self-care.

We have established a Suboxone clinic to serve patients coming from as far as three hours away to access this service. Our program addressing all aspects of opioid safety has led to a successful and rapidly growing clinic. Use of patient pain-management contracts, grant funding sources to overcome cost barriers, and experienced clinicians have led to success. In the fall of 2018 we were given an opportunity to share the history and creation of our Suboxone clinic with other NRACC practices, providing an opportunity to spread this successful intervention to other rural communities. Our Chief Nursing Officer Nicole Thorell stated, "the resources and support we have received through NRACC have been extremely valuable in assisting us to continue to grow and provide high quality care to the patients we serve."

Improving Quality and Lowering Costs

The establishment of our TCM and CCM programs have reduced our 2018 readmission rate to 3.9%, as compared to a 2017 rate of 5.3%. The reduction in readmissions adds to patients' quality of life and contributes to cost savings. With our new AWV workflow, we were able to increase our pneumococcal vaccination from 10% to 21% over course of 2018. We understand that improving pneumococcal vaccine rates will prevent patients from catching pneumonia and being hospitalized.



Here at Lexington Regional, we have always struggled with proper care for patients with mental/behavioral health needs; our closest psychiatrist is located more than an hour away. NRACC suggested that we hire a social worker to assist in treatment for our patients with these needs. We hired two social workers and a licensed mental health nurse practitioner, helping us treat more patients in-house. Within a few short months of hiring our behavioral team, we improved our depression screening rate by 4% and contributed $448,000 in cost savings. We will significantly improve this measure with our newly implemented team and workflow.