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

Wagoner Community Hospital

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NRACC Exemplary Practice Profile: The Family Medicine Practice at Wagoner Community Hospital

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Wagoner Community Hospital's family medicine practice is leading the way in strengthening the quality of care we deliver in our rural community of about 8,300 people, 40 miles southeast of Tulsa, Oklahoma.

Our participation in the Transforming Clinical Practice Initiative has created more focus on prevention and better management of patients with diabetes and other chronic conditions. Our staff also is more vested in getting to know our patients and playing a bigger role in their health and wellness.

With the support of the National Rural Accountable Care Consortium, our family practice, led by Dr. David Good, has improved the care we provide to our diabetic patients. The percentage of patients with poor control of their blood sugar (Hemoglobin A1c >9%) has decreased from nearly 62% at the end of 2016, to 48% at the end of last year.

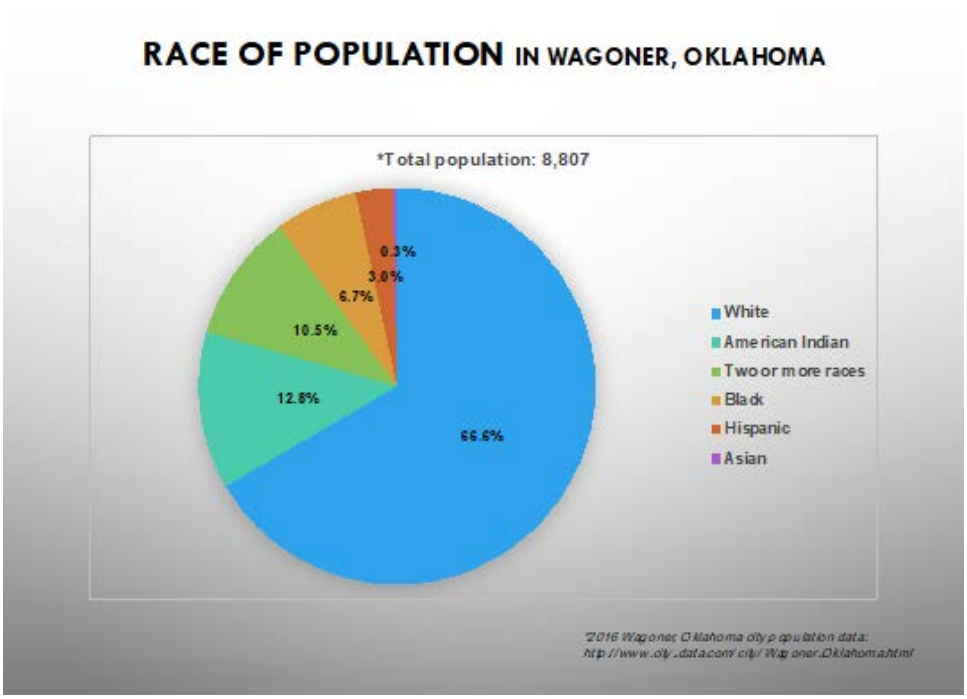
About the Practice

One of the foundations of Wagoner, Oklahoma is our 100-bed hospital. We are a publicly owned trust, and our mission is to provide "quality health care with courtesy and compassion." We provide a range of services, including 24-hour emergency care, intensive care, inpatient psychiatric services, radiology (X-ray, CT scan, MRI, ultrasound, digital mammography, bone density), surgical care and laboratory services. In addition, we partner with physicians who specialize in behavioral health, cardiovascular medicine, advanced wound care, pain management and sleep disorders.

The cornerstone of the hospital's growing Population Health Management program is Dr. Good and the Wagoner Community Family Medicine practice. Dr. Good received his Doctor of Osteopathic Medicine with honors in 1989. He specializes in family medicine and has more than 30 years of diverse experience in northeastern Oklahoma, including working with Wagoner Community Hospital, Saint Francis Hospital Muskogee and Northeastern Health System.

Dr. Good's practice employs a nurse, a nurse's assistant, a receptionist and a referral coordinator. We also employ a clinic coordinator who oversees four doctors' practices at the hospital. Together, they provide care to almost 2,300 patients. Nearly half of our patients (46%) are older than 45, and 20% of our patients receive Medicare benefits. About 12% of Wagoner's population is made up of American Indians. The American Indian population in the U.S. suffers disproportionately from heart disease, diabetes, mental health problems, and other chronic conditions. Poverty is at the root of many of these health disparities. Dr. Good's practice has many patients on Medicaid.

As our patients increasingly deal with chronic conditions, we place a high priority on obesity counseling, smoking cessation and diabetes management.



The Transformation Process

We joined the NRACC in 2016 because we needed support to transition to value-based reimbursement. We could not afford the coaching, technical assistance and quality-improvement seminars on our own. We were looking for resources that would enable us to develop a stronger focus on quality improvements that contribute to better health and care for our patient population.

We kicked off our work by gaining a better understanding of Annual Wellness Visits and learning how to implement those on a regular basis. We had been using a contractor to perform the visits but the program was unsuccessful.

Exhausted by our multiple attempts to implement a consistent and effective workflow for AWVs, we decided to use NRACC's Plan-Do-Study-Act tool. The area of greatest need was the lack of provider time to complete a dual AWV and Evaluation and Management Visit. We applied the NRACC return-on-investment calculator and determined that we should hire a medical assistant who could assist Dr. Good in seeing patients during these visits

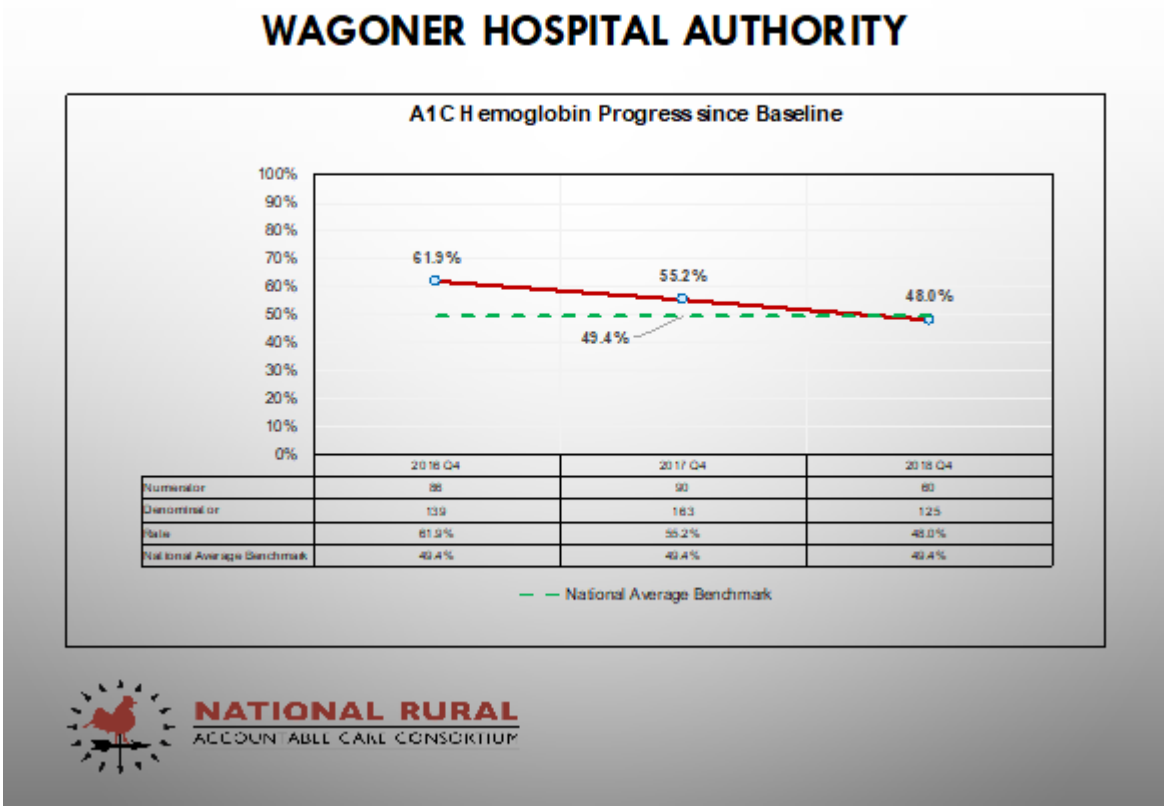
Monthly coaching calls with our NRACC quality improvement advisor showed us how to better track these visits in our electronic-health-record system. In 2018, 20% of our Medicare patients received an AWV. We did no AWVs in-house the year before.

Because of the AWVs and a better understanding of our electronic health records, which we started using in August 2017, we have seen improvement in the care of our diabetes patients. We ensure their Hemoglobin A1c is checked every three months. Our EHR system automatically sends reminder emails and texts to patients about their next blood test. If someone fails to come in for a blood test, the nurse follows up. Diabetic patients on medication can't get refills without seeing a doctor. The goal of better management is to prevent our diabetic patients from developing other chronic conditions that lead to hospitalizations. Better management of diabetes has led to cost savings of about $66,000.

Increased AWVs also have led to incremental improvements in rates of colorectal cancer

screenings and pneumonia vaccinations.

Our next step in improving our AWV model includes identifying more successful outreach procedures specific to the primary patient population. As many of our patients approach Medicare age, it will be important to provide them with information regarding the benefits of an AWV. Additionally, we plan to recognize supplementary billing codes within an AWV related to smoking cessation and intervention, as well as obesity counseling. Additional health education will not only provide more revenue; it will also promote wellness by providing the patient with a more comprehensive preventive care plan moving forward.



Next Steps

Our work with NRACC is not done. Prior to beginning our change work with NRACC, we used a third-party company to perform chronic care management services for our patient population. After several years, we realized that communication between the vendor and our provider was lacking. Our goal for 2019 is to bring CCM services in-house and hire a care coordinator to spearhead the program. Future meetings with our quality improvement adviser will center around the documentation of patients who may be eligible for CCM, employing our electronic health record and historical data, and developing workflows for the documentation of minutes and care plan information.

We are also proud to start a new treatment program to address drug and alcohol addiction. The New Vision drug and alcohol withdrawal service accepts adults who are dependent on opioids, alcohol and certain other drugs. The treatment involves a medically supervised hospital stay for inpatient stabilization that typically lasts three days. The inpatient stay introduces a screening process, assessment, admission, medical stabilization and appropriate discharge planning, which may include behavioral health integration in the future.