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

CCMC
COLEMAN COUNTY MEDICAL CENTER

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NRACC Exemplary Practice Profile: Coleman Medical Associates

Coleman Medical Associates provides care to an economically challenged patient population in and around Coleman, Texas.

We partnered with National Rural Accountable Care Consortium and the Transforming Clinical Practice Initiative to launch our Annual Wellness Visit program, boost our Merit-based Incentive Payment System score, increase our reimbursements and transition to a value-based care model.

NRACC helped us build a successful AWV program, get our Chronic Care Management program up and running and deliver better health care to the people of our community.

About the Practice

Coleman Medical Associates, located in Coleman, Texas, was established in 1995 to provide the people of Coleman and surrounding counties with a range of readily accessible, high quality primary care services focused on the health of the entire family.

To further this commitment, we became a certified Patient-Centered Medical Home and embraced a model of health care delivery that enables our staff to work with patients to assess their health status, address specific problems and concerns, and coordinate the specialty care provided by other health professionals. Our goal is to help our patients get healthy and stay healthy.

Coleman is the county seat of Coleman County, Texas, which has a population of 8,397. The ethnic composition is 76.5% white, 17.8% Hispanic and 3.2% black, according to the U.S. Census Bureau. Coleman County is challenged economically, with 25.2% of the population living below the poverty line. The median household income is $40,804, more than $18,000 less than the national median income of $59,039. Poverty is at the heart of many health conditions faced by Coleman County residents, such as high Hemoglobin A1c levels.

We partnered with NRACC and TCPI to get help with improving our processes and workflows around our AWVs. In particular, we wanted to effectively identify Medicare patients who are in need of AWVs, then reach out to those patients, get them to come into the office and consistently document what is done during their visits.

Our aim was to ensure every portion of a patient's AWV was properly completed, correctly tracked and documented. We report to MIPS for our traditional Medicare patients and we knew NRACC could help us improve our MIPS reporting via an AWV program. With NRACC's guidance, we knew we could achieve a higher MIPS score and be in a better position to increase our reimbursements and transition to a value-based care model.

The Transformation Process

Our goal was to ensure that at least 50% of our Medicare patient population makes AWVs. With help from NRACC, we were able to launch a successful AWV program and dramatically increase the number of AWVs we perform.

TCPI was instrumental in ensuring our program runs correctly. The first step in this process was to conduct an AWV Plan-Do-Study-Act, which entailed reviewing our processes to find opportunities for improvement. From there we created a plan to improve various workflows, such as patient outreach.

For instance, we created annual appointment reminder cards that go out in a mailing to patients and set up a program of follow-up calls to schedule appointments. As a result, a larger number of patients are now coming in for appointments when they're healthy, rather than waiting until they're sick.

NRACC also helped us get our CCM program up and running. First, we used our AWVs and other factors to identify candidates for CCM. After we'd done this, NRACC provided us with the information and support we needed to communicate with these patients and enroll them in the program.

When patients are in the program, they're more engaged with their doctor, which means they're more likely to visit their doctor than the emergency department when complications occur. What's more, the simple fact of being in the Chronic Care Management program encourages patients to stay on top of their symptoms. They're checked more often to measure variables like Hemoglobin A1c levels and to ensure they're taking their medications regularly. There is regular oversight of their condition, which helps keep these patients out of the emergency department.

Since the start of our CCM program, we've seen a dramatic reduction in the number of patients who don't properly control their A1c levels. The number of patients whose Hemoglobin A1c levels are higher than they should be has fallen from 100% to 70.1%. We reduced Hemoglobin A1c levels in a variety of ways, from putting patients on the right medication to offering them nutrition guidance to encouraging them to exercise more.

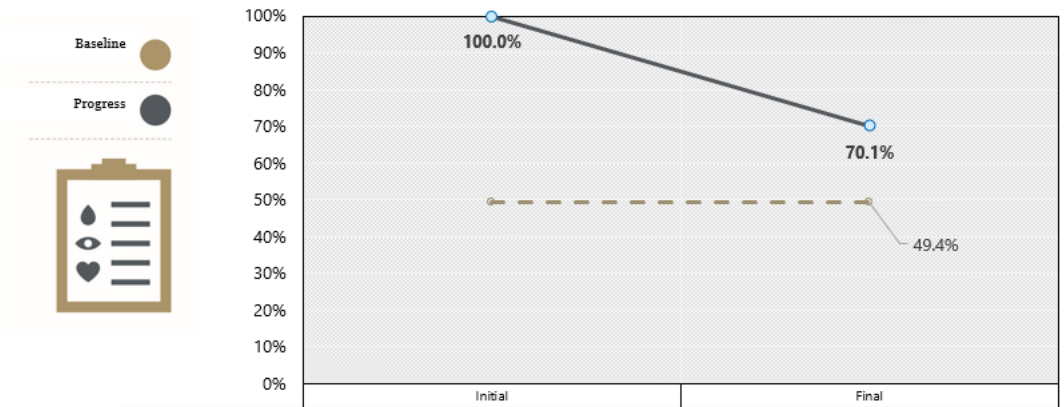
The introduction of our CCM program also helped us improve our colorectal cancer screening from 14.1% to 26.6% of our Medicare patient population. TCPI helped us better identify and communicate with patients who need this type of screening, then coordinate and record any follow-up procedures that may be required.

We also saw improvement in influenza immunizations from 19.3% to 27.6% of our Medicare patient population and in pneumonia vaccinations from 19.1% to 47.9%. These improvements are very impactful because both influenza and pneumonia are among the top causes of preventable death among seniors.

Overall, we saw cost savings of nearly $570,000 thanks to our ability to correctly document the risk levels of our patients and better manage their conditions. For example, the decrease in our patients' Hemoglobin A1c levels has translated to fewer hospitalizations over the course of the year and thus cost savings.

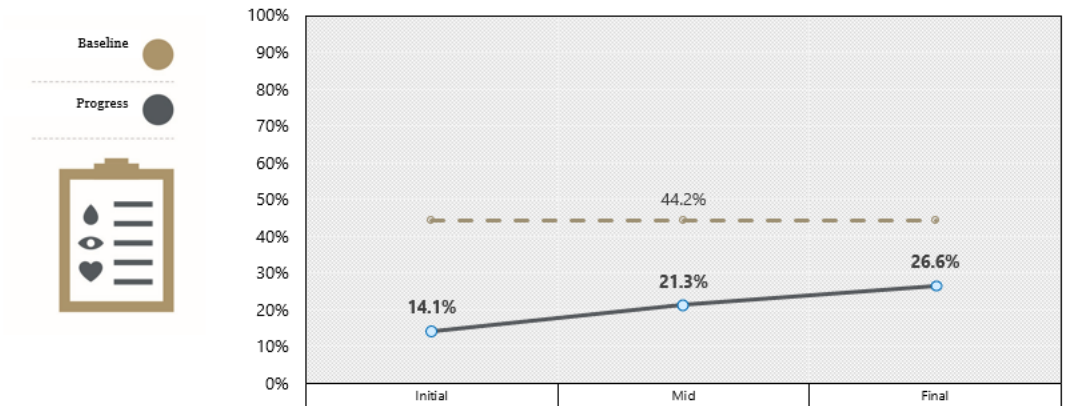
COLEMAN MEDICAL ASSOCIATES

Progress in Hemoglobin AIc Poor Control Since Baseline



	Initial	Final
Numerator	283	162
Denominator	283	231
Rate	100.0%	70.1%
National Average Benchmark	49.4%	49.4%

Progress in Colorectal Cancer Screening Since Baseline



	Initial	Mid	Final
Numerator	173.0252	151	190
Denominator	1228	710	715
Rate	14.1%	21.3%	26.6%
National Average Benchmark	44.2%	44.2%	44.2%

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Providing Patient-Centered Care

Patient satisfaction is a priority for our practice. To improve it, we deployed the patient satisfaction tablet, with assistance from TCPI. This is a 10-question survey we now give our patients after their AWVs. We record the data patients provide and make improvements to our practice based on this patient feedback.

We also now leverage TCPI's Care Planning Modules, which we use to build a patient's care plan and help us decide how to treat the patient going forward. The module provides the rules, structure and content needed to drive care management and care coordination solutions. The care plans are patient-centric and up to date. Each condition has a care plan, which is determined by evidence-based guidelines and analytics. This helps ensure the very best treatment plans for all our patients.

Sustainable Care for Years to Come

TCPI has helped us improve our existing processes and create new ones around Chronic Care Management. We've transformed our processes and our practice overall. From here, we'll continue our journey toward lower costs, improved patient satisfaction and better, more sustainable care for the residents of our community.