CRETE AREA MEDICAL CENTER

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Our Medical Home

Criteria 1: Leadership/Planning/Human Resources

Crete Area Medical Center (CAMC), located in Crete, Neb., offers a rural health access clinic and a critical access hospital in one location for residents of Crete and surrounding areas. A satellite clinic, the Wilber Medical Clinic, is operated by CAMC and staffed by designated CAMC providers to help create more accessible healthcare for the growing communities in Saline County. Today, CAMC employs five family practice physicians, and three midlevel practitioners in the clinic, as well as one physician and two midlevel practitioners in the emergency department. Additionally, we partner with many specialist physicians and surgeons who offer clinic and surgery in Crete, providing all patients with access to local, specialized healthcare.

We are committed to making a difference in our community and the lives of the individuals we serve through compassionate and exceptional care.

CEO Carol Friesen and her management team work with CAMC staff and board of directors to fulfill this mission and deliver quality healthcare to the residents of Crete and surrounding areas.

Through fulfillment of our mission we work toward our vision: to be a respected community leader and healthcare provider, where patients seek exceptional care, physicians prefer to practice, and team members desire to work.

Six key beliefs including integrity, respect, service, excellence, collaboration and leadership guide our staff in their pursuit to bring to fruition to our vision.

The CAMC Senior Leadership Team consisting of the CEO, CFO, CNO, Outpatient Clinical Officer, and the HR Director has developed a set of training tools and measurements to further cultivate our organizational culture based on our mission, values and beliefs.

Facility and department balanced scorecards are one of those tools. Used to measure success and maintain focus as we work to carry out our mission, CAMC uses these scorecards which focus on: people, quality, service, and growth.

Additionally, the management team has quarterly leadership meetings to emphasize and train on skill sets to engage and lead team members. These meetings are also used to support team members and discuss our mission, vision, values, and performance expectations. In addition to quarterly meetings with leadership, team members have three meetings a year to emphasize and train on areas to promote quality improvement, innovation and service skill sets.

Management meets monthly to review the strategic plan, the facility scorecard, and other leadership topics. Information from these meetings is then communicated to the rest of the team members through department meetings with their respective managers. Additionally, the CEO writes a weekly newsletter to the staff that incorporates topics to promote all the above.

Innovation is an underlying principle in everything we do. To support this principle, all CAMC team members have committed to submitting at least one idea per month to improve upon or strengthen our existing practices and procedures.

Additionally, we have developed a program we call the "Professional Development Institute" where a group of high performers are selected and teamed up with members of senior leadership. With that comes a commitment to learning through reading four pre-assigned books that they then discuss with their mentors.

All new team members hired into the organization are then paired with a past member of the Professional Development Institute for mentoring and training on the mission, vision, values and performance expectations at CAMC.

Because all team members are educated in the mission, vision and values of CAMC, they are also included in the annual strategic planning process. It starts with management giving input and ideas, then physicians and the board of directors, then team members, and finally senior leadership.

This approach creates a strategic plan that is a true working tool throughout the year which helps set the tone and goals for the facility and department balanced scorecards.

Goal-setting, both individually and departmentally, is instrumental in our success. Each team members has two individual goals for the year for which they work with their manager to set action plans. Each department has goals with measurable outcomes that are usually set, when possible, by national comparison and include action plans that are reviewed monthly with their senior leader. All department goals support the facility goals which are also measurable and generally based on national standards and comparisons.

A foundation of accountability is set through our values and mission but also re-enforced through our performance evaluations. For team members, 50-percent of their evaluation is

based on how they personally performed, 25-percent on how their department performed (departmental scorecard) and 25-percent on how the organization performed (facility scorecard). For managers, 20-percent of their review is based on personal performance, 40-percent on their departmental scorecard, and 40-percent on the facility scorecard.

When we experience success we celebrate, sometimes we simply celebrate teamwork, for fellowship and fun. Conversely, if we have goals that are not being met or something in the strategic plan that isn't coming together we discuss it, involve others when needed and then reset the course. Regardless of the issue, everyone is accountable to one another.

Our approach has created a culture where all team members value education and innovation; team members are not only personally invested in the organization but also hold a responsibility to further the goals and mission of CAMC.

Criteria 2: Patient and/or Community Focus

Chronic disease is inundating the nation's healthcare scene. Seven out of 10 deaths among Americans each year are from chronic disease. In 2005, 133 million Americans, nearly one out of every two adults, had at least one chronic illness and about one-fourth of people with chronic disease are limited in their daily activities due to their illness. Just as alarming is the effect these diseases have on healthcare costs. According to the CDC's At a Glance 2009, more than 75-percent of health care costs are due to chronic illness.[1]

These statistics come to life at CAMC. As of 2010, 627 of our patients were diagnosed with Diabetes, 1,100 with Hypertension, and 520 with Hyperlipidemia.

[1] National Center for Chronic Disease Prevention and Health Promotion (2009), The Power to Prevent, The Call to Control: At a Glance 2009, *CDC Website*, Retrieved July 20, 2011 from http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf.

The CAMC Medical Home

The concept of a Medical Home is to partner with patients to effectively manage chronic diseases. This concept is also a key strategy in the nation's healthcare reform efforts that encourages medical facilities to invest in patients' long-term health.

Obtaining Medical Home recognition by the Nation Committee for Quality Association (NCQA) was a part the strategic plan to help CAMC fulfill our mission and vision. The changes associated with becoming a Medical Home manifested into a renewed commitment to clinical excellence – a commitment that results in real outcomes and creates a healthier community.

We know that preventative care can help people live healthier longer and have a better quality of life, and that preventing just one hospital stay can pay for a patient's preventative care for years.

We also know that patients do better when they have timely access to a primary care provider with whom they have an established relationship. Additionally, patients benefit when they have the majority of the health care needs met in one locally accessible clinic where their care is coordinated and monitored in a proactive manner. This includes the utilization of disease registries, medication reconciliation and coordination with family and caregivers.

Through implementation of these concepts, our patients have the tools they need to improve their health. They are true partners in the healthcare and can take ownership of

their health and focus on preventative care. This helps patients stay ahead of chronic illnesses and encourages healthy habits, wellness checks, and screenings for all ages.

Criteria 3: Process Management/Organizational Performance Results

Year one

Prior to seeking Medical Home recognition, our goal was to increase compliance with patients coming in for their chronic disease management. The philosophy here was if we can get the patient to be compliant with coming in for their disease management then their outcomes/health will be improved. So with research and our patient population in mind, we selected Diabetes, Hypertension and Hyperlipidemia as the chronic diseases to address.

Our journey started out with a 43-percent compliance rate of those specific patients coming in for their care on a routine basis, which we defined as at least once per year. By the end of year one, we were up to 53.9-percent. The increase was attributed to follow-up calls and letters stressing the importance of chronic disease management to those patients who were overdue to be seen.

Year Two

In July 2010, while we were examining how to expand on our first year's success, we learned CAMC's physicians clinic in Crete became the first rural health clinic in Nebraska to earn Medical Home recognition by NCQA and was one of only three in the state (the other two in the metro Omaha area).

While this news was cause for celebration organization-wide, we refused to rest on the 10-percent increase. We challenged ourselves and took a new approach, setting the bar a little

higher with the compliance goal of 69-percent as well as stipulating that diabetics be seen at least once every six months, in addition to hypertensive and hyperlipidemia patients being seen yearly.

On our journey toward this new goal we implemented a refill protocol designed to have support staff help our providers manage their day-to-day case load. An additional benefit that came with that refill protocol was increased compliance with disease management. Now patients are not able to get their medications refilled (exception: one courtesy refill to allow time for them to make an appointment) without having seen their primary care provider for their chronic disease management. This tactic helped us to not only meet, but exceed our year-end goal of 69-percent compliance with a remarkable 84-percent compliance rate.

To get a better idea of the lives impacted by our efforts we looked to the Saline County Behavior Risk Factor Surveillance Survey (BRFSS) report which revealed that among Saline County adults, 7.8-percent reported ever being told they had diabetes. 37.3-percent reported heights and weights that placed them in the "overweight but not obese" category, and Obesity prevalence rates for the county were 28.9 percent.

In terms of hypertension and hyperlipidemia rates, the BRFSS reported 4.5-percent of Saline County adults said they had ever been told by a health professional that they have coronary heart disease and 26-percent of Saline County residents reported having high

blood pressure. More than one-third of Saline County residents (37.3-percent) reported having high blood cholesterol. [2]

Year Three

We are now seeking to measure and improve upon the care management of our patients diagnosed with one or more of these three diseases and help drive outcomes. We are tracking how many of our diabetics have their HGBA1c below seven, how many hypertensive patients have their blood pressure below 140/90, and how many patients with coronary artery disease or atherosclerotic disease have their LDL below 100.

We set goals based on national averages, and comparisons with peers. With these new goals we are able to run reports to see which patients are not meeting those goals, then with that information we are able to further drill down to see what we need to do to specifically help each of those patients meet those goals.

Our baseline measurements: (Appendix A)

	CAMC Q1 (2011)	National Average[3]
Diabetes Patients with HgbA1c <7%	50%	39.8%
CVD/Atherosclerosis patients with LDL <100mg/dl	72%	*(no data)*
Hypertensive patients with BP <140/90	64%	29%

By proactively helping our patient's better manage their disease process, we can help them reduce their health care costs and improve the quality of their lives.

According to the American Heart Association, healthcare costs for diabetics are 2.3 times more than the average person without diabetes: $11,744 on average for the one year per

[2] Public Health Solutions (PHS) District Health Department (2007), *Saline County Behavior Risk Factor Surveillance Survey*

[3] National Health and Nutrition Examination Survey

patient with diabetes, of which $6,649 is directly related to the diagnosis. In terms of Cardiovascular disease, $475.3 billion in 2009 was spent on CVD and stroke, or approximately $5,864 per person.[4]

Reducing healthcare costs and improving our patients' quality of life are at the heart of our strategic plan and measured on our facility balanced scorecard. It is something we are consistently revisiting in order to maintain and improve the quality service we provide our community.

What a Medical Home means for Our Patients:

- Ongoing relations with a continuous and comprehensive care
- A physician-led team of professionals
- A personalized plan for managing your health
- A focus on the patient's coordination of care
- Enhanced access to care

What a Medical Home means for our community:

- Committed to patients for life
- An emphasis on quality and attainment of optimal outcomes
- Focused on population health including chronic disease management, prevention, ill care, and end of life care
- Fiscal implications of controlled/therapeutic care versus uncontrolled diseases

The difference to belonging to Medical Home is we:

- Focus on prevention and chronic illness
- Use a team approach
- Promote Therapeutic and Control Disease through standardized protocols
- We measure outcomes by disease and experience
- We are accountable to provider for results
- Reduce inpatient, ER encounters, and testing through coordination
- Improved population health

[4] American Heart Association (2009)