Lexington Regional Health Center Chronic Care Management

Lexington, Nebraska
25 bed Critical Access Hospital

"Our mission is to optimize the health of our patients and community through innovation and excellence in care, education and service"

Identifying Needs of the Community

Obesity

- Obesity costs the United States $147 billion per year
- Obesity effects 1 in 3 adults (33%) increasing risk of diabetes, heart disease, and some cancers
- Dawson County (population served) has an incidence of 34.4% obesity
- Obesity is a risk factor for Heart Disease/Stroke
- 1/3 of all deaths are heart disease and stroke related, costing healthcare $199 billion/year

Diabetes

- Healthcare costs Diabetes patient over $13,000/year (without diabetes, $2,500)
- A one point reduction in HbA1c leads to 40% reduction in micro vascular complications is reported (blindness, kidney disease, nerve damage)
- Over 30 million Americans have Diabetes, 84 million have Pre-diabetes
- Dawson County (population served) 10% of population has Diabetes

Implementation of Evidence Based Practices

- Beginning with all cause readmissions, some of the interventions included:
  1. Discharge phone calls
  2. Stratified risk assessment for readmissions
  3. Improved medication reconciliation
  4. Coordination with clinics after discharge
  5. Multi-disciplinary team
  6. Transition care visits at no cost

- With additional focus on chronic care management interventions added included:
  1. Completing rounds with provider and after rounds huddle with multi-disciplinary team
  2. Better coordination for after care and follow up visits including wellness screening
  3. Development of patient centered medical home
  4. Use of stratified big data to drive implementation of new processes

Case Example 1

- 39 year old female arrives at emergency room by squad, pt was found on floor unable to get up off floor after fall. Admitting diagnosis of rhabdomyolysis; skin abrasions; weakness; super morbid obesity; lice infestation. Pt had 5 day inpatient stay. Pt was readmitted to hospital in 13 days. Pt called unit and was not able to get off toilet. Pt had a 3 day observation stay followed by a 37 day swing-bed stay.
- During the swing-bed stay LRHC implemented their population health model, patient began seeing; mental health counselor, registered dietician, Ideal Protein diet protocol, skilled physical and occupational therapy.
- Patient was discharged on Ideal Protein diet protocol, continued with mental health counseling, and registered dietician and physical therapy.
- Pt has remained out of the emergency room, and hospital since implementation of the population health model. Pt is now able to get out of her home and participate in children's activities with a 102 pound weight loss.

Case Example 1-Results

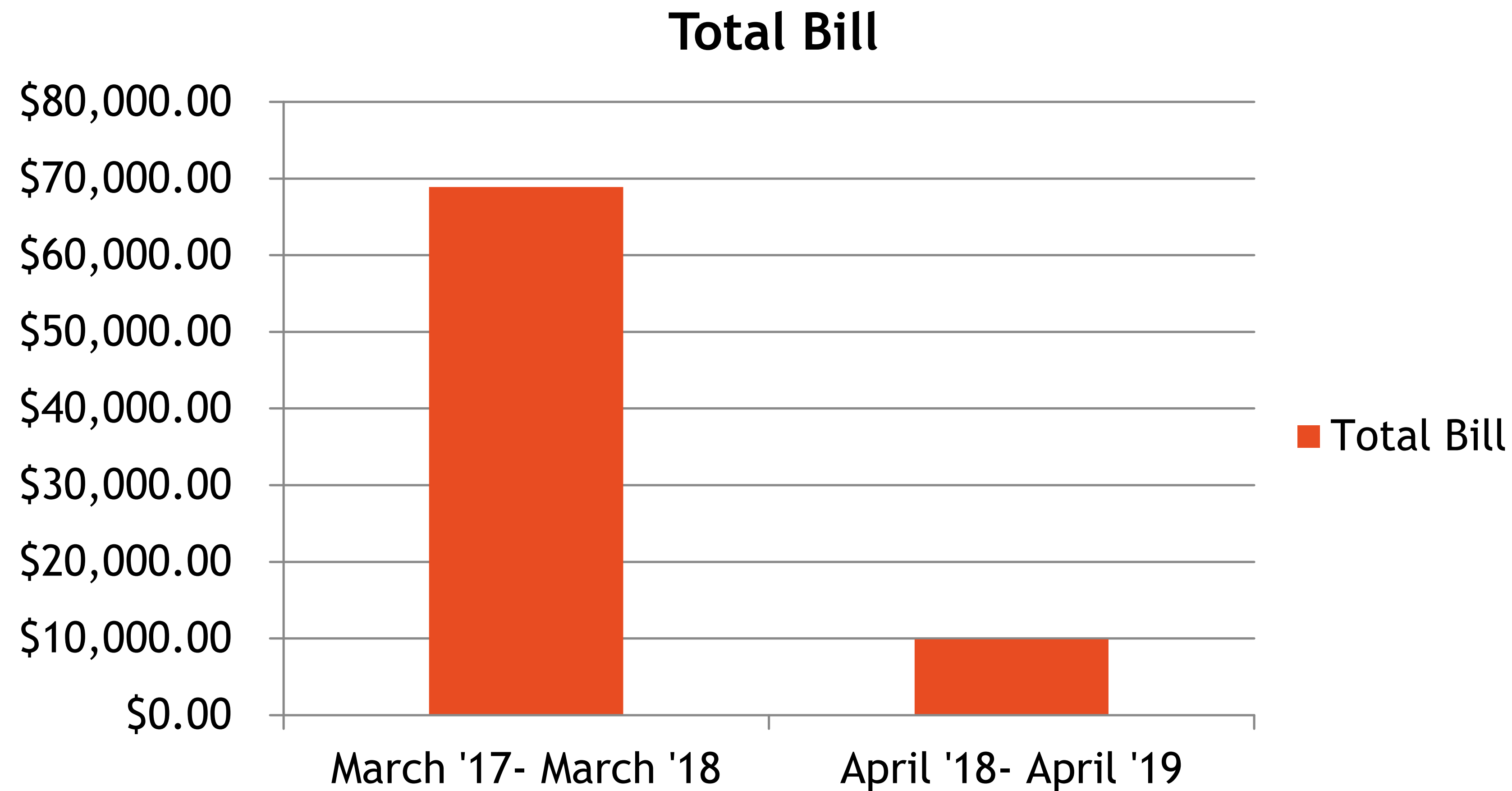
Before implementing Lexington Regional Health Center’s population health model:

- March 2017 – March 2018 Pt had 2 Inpatient hospitalizations, 1 Observation hospitalization, and 1 Swing Bed hospitalization
  - **Total bill March 2017- March 2018: $68,899.73**
  - **Non LRHC facility costs: 4 clinical visits**

After Implementation of Lexington Regional Health Center’s population health model

- April 2018 – April 2019
  - **Total bill: $9,897.00**
    - Clinical Social Work
    - Physical Therapy
    - Medical Nutrition Therapy
    - Ideal Protein Protocol
  - **Non LRHC facility costs: 7 clinical visits**
    - Follow Up with Provider

Cost of Patient Prior to Program vs. After Implementation



Case Example 2

- 85 year old man, history of chronic obstructive pulmonary disease, myocardial infarction, peripheral vascular disease, congestive heart failure, mitral valve regurgitation, hypertension, aortic valve stenosis, obstructive sleep apnea syndrome.
- Patient was looking at having to move from independent living due decreasing health status related to chronic conditions.
- Patient was struggling to complete daily tasks. Since implementation of program patient is now exercising 5 times a week, able to cook meals for himself and company, and complete activities of daily living without exhaustion.
- He was able to remain living independently.

Case Example 2-Results

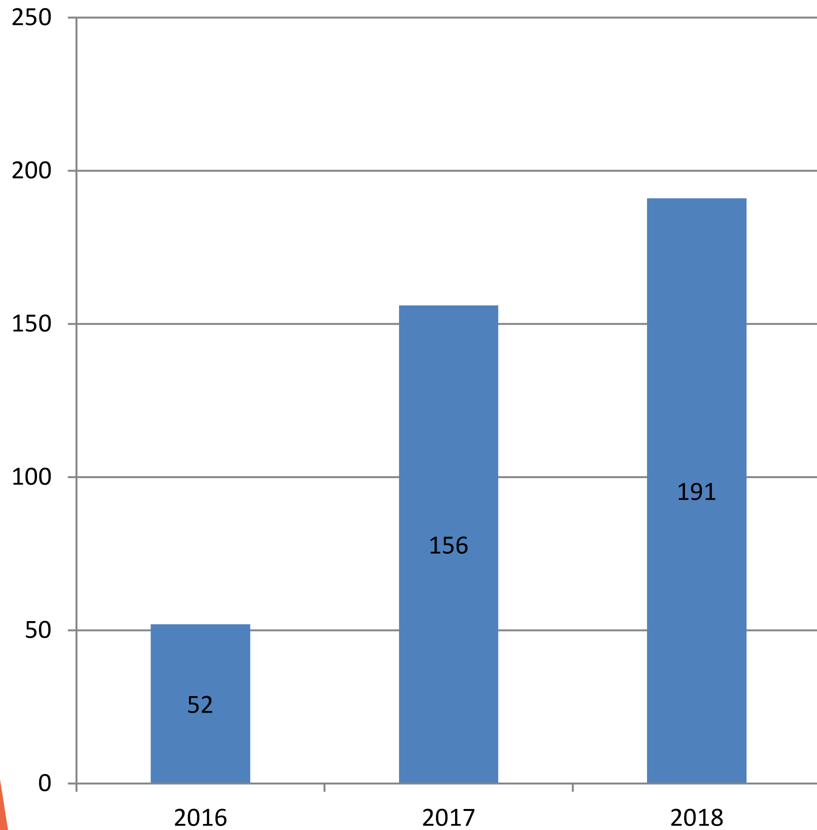
Before

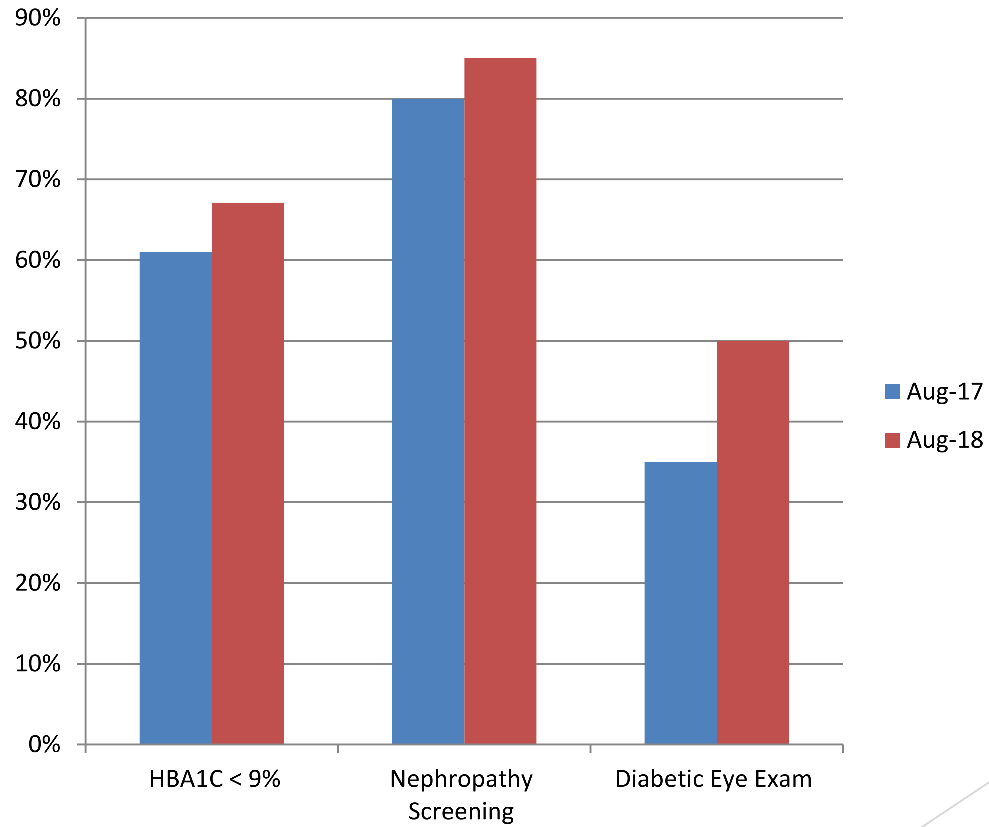
- April 2017- April 2018:
  - 3 ER visit
  - 3 Inpatient Hospitalizations
  - 2 Swing bed hospitalizations:
    - **LRHC Cost: $81,694.76**
    - **Non LRHC facility costs: Inpatient Stay**

AFTER

- May 2018 – Current
  - Follow Up with Provider
  - Transitional Care Management
  - Cardiac Rehab
  - Chronic Care Management with Exercise Program
    - **Cost: $6,786.46**

LRHC Diabetic Results to Date





Community Garden and Outreach

2018 Community Garden Produce Results

- Cucumbers 408.4 lbs.
- Zucchini 88.8 lbs.
- Tomatoes 1239.5 lbs.
- Peppers 282.5 lbs.
- Squash 251.5 lbs.
- Carrots 65.8 lbs.

Chronic Care Management takes a Team!