Case Study
Patient-Centered Medical Homes: Using Data to Improve Population Health

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Walker Clinic — April 2015

The Arkansas Health System Improvement Initiative is designed to create a sustainable patient-centered health system that embraces the triple aim of (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. While the initiative has broader goals of expanding coverage, enhancing health information technology, and developing a quality health care workforce, its major focus has been payment innovation and restructuring the system to incentivize quality outcomes. Patient-centered medical homes (PCMHs) are a primary strategy of this innovation. Design and implementation of the state's PCMH efforts have been led by Arkansas Medicaid with support from Arkansas Blue Cross and Blue Shield, QualChoice of Arkansas, Humana, Centene/Ambetter, Medicare, Walmart, the State and Public School Employees Benefits Plans, and others. This study is part of a series of case studies spotlighting practice transformation to the PCMH model, emphasizing how individual practices have approached innovation and implementation. For more information on the Arkansas Health System Improvement Initiative and access to additional case studies, visit www.achi.net or www.paymentinitiative.org.

"We've always tried to deliver patient-centered care, but what has really helped us is using our data to look at specific measures. Once we started using data, I was hooked." –Angie Walker, Office Manager

Practice Profile

Located in De Queen, Arkansas in Sevier County, Walker Clinic serves an active panel of approximately 3,500 patients. Dr. Randy Walker founded the multi-specialty clinic in 2003 along with his wife, Angie, who is the office manager. Dr. Walker is the sole physician at the practice and is assisted by a staff that includes an advanced nurse practitioner (ANP), six licensed practical nurses (LPNs), two X-ray technicians, a certified nursing assistant, and several administrative personnel. The team also includes a part-time behavioral health counselor and a part-time dietician.

Opportunities for Innovation

Walker Clinic is one of the original 69 practices in the state chosen to participate in the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care (CPC) initiative. The practice is also participating in the state's Medicaid-led PCMH program, as well the Arkansas Clinical Transformation (ACT) Collaborative, a program led by the Arkansas Department of Health that is designed to support practices in care transformation activities to improve chronic disease management among their patients. The goals of the ACT program are in alignment with PCMH principles including enhanced data management and practice management techniques.

Focusing on Preventive Care

In the ACT program, practices are trained in techniques to focus on specific chronic conditions. So far, the Walker Clinic team has focused on diabetes care, hypertension, and now preventive care. Part of the Walker Clinic's overall strategy to improve preventive care and transition to a PCMH has been to bring in a dietician and a behavioral health counselor. Angie Walker said, "We have a dietician come in two days a month. We've set up different processes within the office to use our measures, so our nurses understand that if a patient has an unacceptable Hemoglobin A1C level, then that patient has a high diabetes risk and needs to meet with our dietician. We also have a counselor come in one day a month because a lot of preventive care is associated with behavioral health issues" said Walker.

Patient-Centered Medical Homes

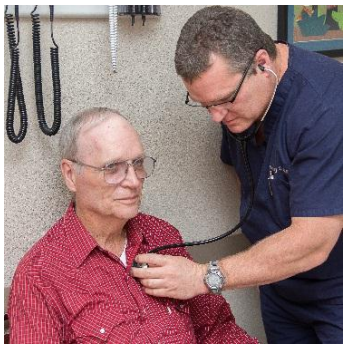
Through improved care coordination and communication, the goal of the Arkansas patient-centered medical home (PCMH) program is to help patients stay healthy, increase the quality of care received, and reduce costs. A PCMH accomplishes this by identifying and treating at-risk persons before they become sick. Success of the Arkansas PCMH program relies on statewide multi-payer participation, ongoing innovation, and achievement of a specific set of improvement milestones, such as 24/7 patient access to care via phone or e-mail, use of electronic health records, and development of customized care plans for each patient.

SEVIER COUNTY PROFILE

Overall County Health Ranking: 19 (of 75)
Uninsured: 31% (AR: 20%)
Primary Care Physicians: 1,729:1 (AR: 1,586:1)
Diabetic Screening: 77% (AR: 82%)
Mammography Screening: 53% (AR: 58%)
Social & Economic Factor Ranking: 53 (of 75)
Poor or Fair Health: 27% (AR: 19%)
Mental Health Providers: 4,294:1 (AR: 696:1)
Low Birth Weight: 7.3% (AR: 9.0%)
Unemployed: 7.8% (AR: 7.3%)
*http://www.countyhealthrankings.org/app/#!/arkansas/2014/rankings/sevier/county/outcomes/overall/snapshot

Using Data to Support Team-based Care Planning

Walker Clinic's success can be attributed in part to the tailored use of an electronic health record (EHR) system and data available to track key processes and health indicators. The team has increasingly used their EHR system and patient data to guide their care coordination activities. "We use this information to risk-stratify our patients, and depending on where they fall—that determines our course of action. We develop patient care plans for our high-risk patients, and those patients receive action plans," said Angie. "Our care coordinator looks at the patients that are coming in the next day and identifies who is high-risk and what services need to be caught up for them." The staff begins each day with a team huddle where the care coordinator communicates patient needs to lead nurses. Angie said that the entire staff is included. "We make sure that our whole team is involved in these huddles because the front-desk staff may be aware of environmental situations such as the death of a family member."



Staff members participate in weekly meetings to review progress toward milestone-specific quality measures, which include those designated within the PCMH program to control and prevent chronic conditions. Many of these measures are tracked within the clinic's EHR system. Angie said, "We have a blackboard we update that lists all our measures. We're specifically looking at blood pressure control, hemoglobin A1C, and rates of foot and eye exams, and starting to see those measures come to where they need to be." The use of data to meet specific targets is now part of the team's overall mission. "Our staff understands our ultimate goal is to improve the health of our patients and that these are the actual metrics we're using to do that" said Angie.

Patient Engagement and Education

Improved patient engagement is another benefit of the team-based care that Walker Clinic provides. The nurses and other staff have been empowered to take on a larger role in patient education. Angie explained that if one of their patients were to visit the emergency room for a non-emergent issue, an LPN would follow up with the patient and explain what a better course of action would be for the next time the issue arises. "Once the staff began educating patients, they liked it and embraced it as part of their job," said Angie. Dr. Walker said, "I get the conversation with patients started and then the nurses take over, and that's been successful. They are good at breaking down information and helping patients set goals." Additionally, the clinic's EHR system has proved an important asset for facilitating patient education. The clinic's EHR system is integrated with a patient education tool, which allows the clinic to generate condition-specific resources such as printed instructions, videos, and care plans, which assist in shared decision-making with patients.

> *"The key is educating the patient and trusting the patient so they feel they have control to manage their health and letting them play a role in their health care."*
> --Dr. Randy Walker

Continuing Improvement

Walker Clinic has grown significantly while implementing new systems and care coordination activities in transitioning to a PCMH. Dr. Walker said, "We've changed our open access times and learned a new EHR and billing system. We make sure we take care of our staff because this constant change can create added stress." Though challenged by a period of change fatigue, the staff has adapted and gained efficiencies in the PCMH model, allowing them to better serve an increasing volume of patients. "Right now we carve out time each day for myself and our ANP for same-day access, and staff have the ability to overbook for high-priority patients," said Dr. Walker. "We're also preparing to expand to another location, probably led by a nurse practitioner, where we may offer expanded hours." Like many PCMH practices in the state, Walker Clinic is demonstrating the benefits of using data and team-based care to improve the overall health of their patients.

This report was composed using information obtained during an in-person interview and discussion with Dr. Randy Walker and Angie Walker of Walker Clinic. The Arkansas Center for Health Improvement was granted written permission to use this information. Additional information included was gathered from the Arkansas Department of Human Services Division of Medical Services, the Arkansas Center for Health Improvement, and County Health Rankings from the Population Health Institute at the University of Wisconsin.