Contact Information
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Physician Organization Name: **Bronson Network**
Practice Name:
Practice Address:
How many physicians in practice:
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): The Ambulatory Care Management team consists of 26 Ambulatory Care Managers (ACM) who are all registered nurses (RN).

Executive Summary (5-8 bullet points, must include summary of results)

- In January 2019, Ambulatory Care Managers (ACM) at Bronson began reporting through a centralized reporting structure to an ACM supervisor. They had previously reported to individual practice managers.
- As part of the change in reporting structure, the leadership team worked closely with practice leaders to revise and standardize the ACM orientation process.
- Every ACM at Bronson now receives an orientation skills checklist to complete during their orientation period. Likewise, they receive a customized orientation schedule to track progress.
- Bronson has also designated a number of current ACM as preceptors. Standardizing the preceptor process has assisted in ensuring a consistent orientation for all new hires. Preceptors go through a preceptor course, meet occasionally to discuss changes needed to the standardized pathway, and follow a preceptor checklist with all new hires.
- To ensure all current staff received appropriate training, the entire care management team went through a Chronic Care Management re-training in April of 2019 with MICMT.
- Process measures tracked by the leadership team have demonstrated that training and standard orientation has led to an increase in billing codes dropped, an increase number of patients in chronic care management, and an increase in ACM understanding of care management upon completion of orientation.

Category of Submission (see page 1): Care Management Workflow

Title of Submission: Standardized Orientation Pathway for Ambulatory Care Managers

When did the intervention start and end? (1-2 sentences)

Bronson implemented a new Ambulatory Care Manager (ACM) orientation process in January 2019. This process includes a standardized orientation checklist and schedule for the new hire, a new hire folder with resources, and a checklist for preceptors.

Goal of the Program/Intervention: (1-2 sentences)

The goal of the ACM orientation program is to ensure that all ACM receive a consistent and standard orientation process. The standard approach to orientation also ensures that our ACM is able to perform to best-practice standards in regards to caseload, self-management education, and the chronic care management process.

Who developed the program/intervention, and how? (2-4 sentences)

Bronson's Ambulatory Care Management Director, Manager, and Supervisors developed the ACM new hire orientation program in January of 2019. The leadership team worked with current staff to identify areas for improvement. They also reviewed resources from other sites including sample orientation materials from other chapters within their clinically integrated network and resources located on the MICMRC website. Leaders reviewed all sample materials along with best-practice standards and developed a customized orientation pathway for staff at Bronson.

Description of the Program/Intervention (2-3 paragraphs)

In order to standardize the ACM orientation process, the Bronson ACM leadership team developed a new hire orientation checklist, orientation schedule, orientation resource folder, and a preceptor orientation guide. The new

hire orientation checklist contains key skills that the ACM should be proficient in by completion of training (Please see a condensed version of the ACM orientation checklist in the Appendix). Skills are checked off as they are mastered by the preceptor. The finalized form is given to the supervisor upon program completion and kept on file.

Each new hire is also given an orientation schedule that outlines a timeline to complete key milestones along with a resource folder for reference. The resource folder contains helpful information including minimum work requirements, ACM/MSW contact list, Skilled Nursing Facility information, information on the various care team members, documentation information, a billing tip sheet, and various standard work documents.

How were patients identified for the program/intervention? (1-2 paragraphs)

All Bronson attributed patients benefit from this standardized orientation process as it ensures that our staff all receive the necessary training they need to support our patients. Likewise, we have seen that since implementation, care managers are more confident in their skills and are better able to build their caseload after orientation. Patients are identified for care management through a risk stratification process, disease registries, payor rosters, provider referral, and Social Determinants of Health (SDoH) screening.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)

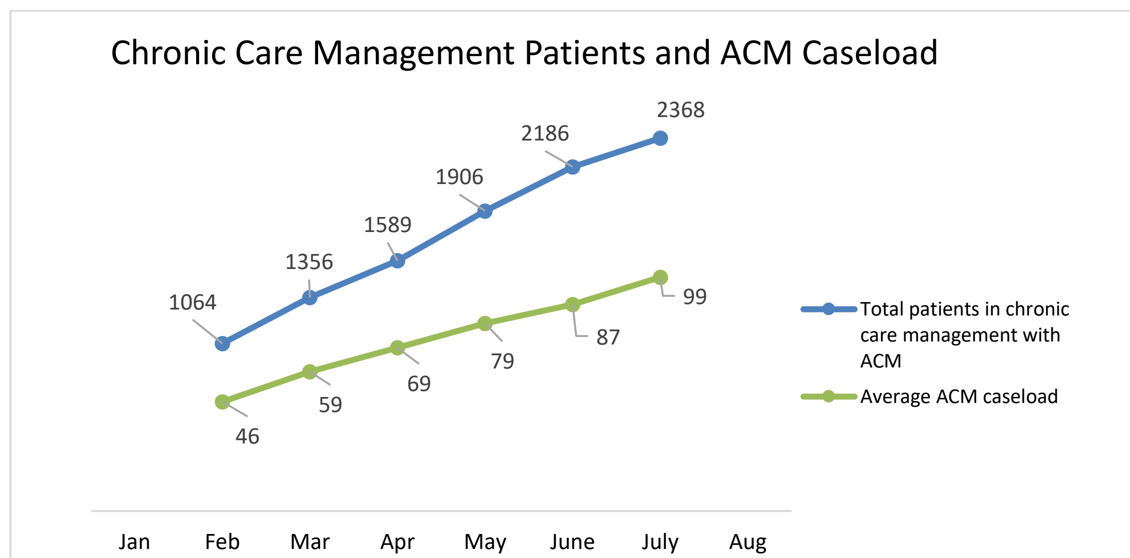
The success of re-training our current ACM team and of implementing a new training process for new hires has been measured using process-based metrics. Bronson began to track the following care management process measures for all primary care practices in 2019:

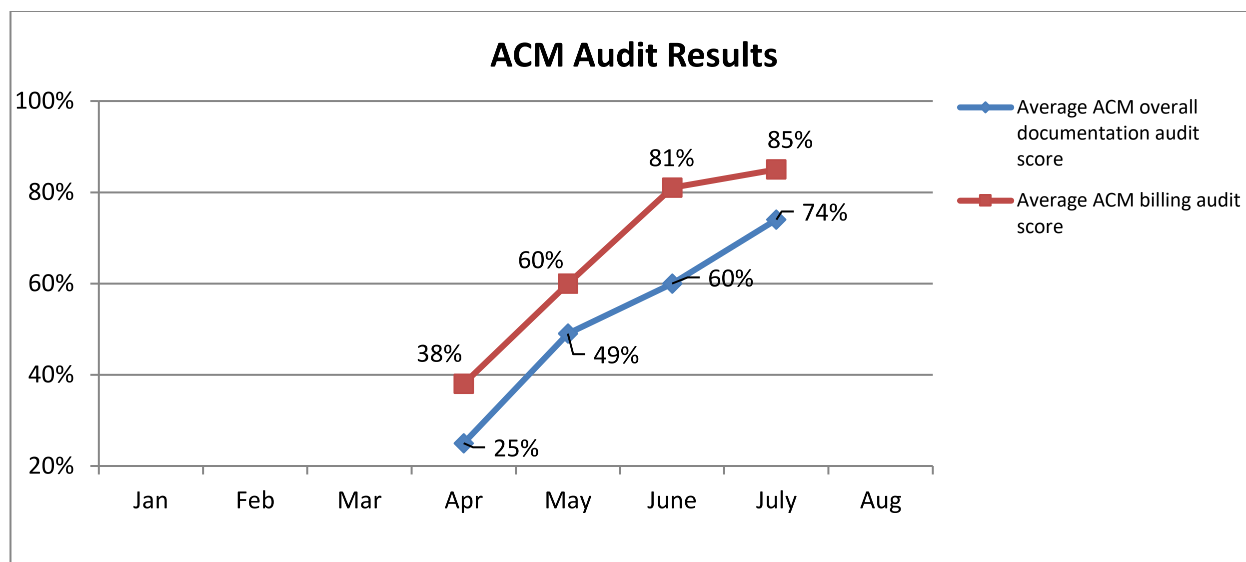
- number of patients enrolled in chronic care management
- percent of patients with hospital follow up within 2 business days of discharge
- percent of patients with ER follow up within 7 days of discharge
- percent of correct note templates utilized
- percent of correct codes dropped for service provided
- percent of patients in chronic care management with the care manager on the care team

Additionally, our supervisor performs chart audits each month for all ACMs. She provides them with individualized feedback on their results and tracks progress throughout the year. Our leadership has found that since our full team re-training and implementation of a new orientation process scores across all primary care offices are steadily increasing.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

We began to track process data monthly (for most measures) in February 2019. Re-training of our ACM team occurred in April of 2019 with documentation and billing audits also beginning that month. The new orientation process was implemented in January of 2019 and to date, the new ACMs that have been hired this year have completed orientation using the new tools. Please note the steady increase in all scores in the graphs below.





Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

Yes, please see full descriptions above and attached competency example. New tools include an orientation checklist for both the ACM and preceptor, orientation schedule, and an orientation resource folder. The tools are integrated into the new orientation process.

In addition, we have updated our shared computer drive to a standardized format that provides resources including patient education materials, billing tip sheets, monthly reports, and standard work. This change serves as a convenient and accessible tool for our team, especially new hires as they become acclimated to their new role. Our ACM supervisor role has also been updated to incorporate scheduled rounding with each ACM at their respective practice in order to answer questions and provide support and guidance as needed. Finally, the team developed a one-page document to demonstrate their role and when to refer to the ACM, this is shared with other care team members such as providers, MSWs, and other office staff.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

Bronson is most proud of the commitment to quality and service that this submission demonstrates. Bronson has had care managers in the PCP practices since 2012. The program has continued to grow and adapt to patient and practice needs over time. The rapid growth of the program caused challenges with standardization and training across practices.

Our leadership team is proud of this new standardized process and of the commitment Bronson has made to ensure that all ACM are trained to the best practice standards that we strive to meet while providing exceptional care to our patients. Having a standardized orientation pathway provides structure to retain team members and promotes developing talent. We are proud that with the training our ACMs receive, they are able to provide an advanced approach to the health and wellbeing of the patients in our communities.

How will your organization use the funds if your submission wins? (1 paragraph)

Funds will be used to support and sustain care management efforts across the Bronson system. They will be utilized to assist in further training and development of our team, tools, and resources. Additionally, funds will provide the necessary support to maintain our orientation process and materials, and the development of outcome reporting to demonstrate the impact that our orientation and training have on patient outcomes. Funds will support ROI for our care managers, provide further venues for training opportunities, and continue process improvement efforts. This support will ultimately assist Bronson ACM in providing care management to more patients within our community.

APPENDIX

BRONSON AMBULATORY CARE MANAGEMENT ORIENTATION SKILLS CHECKLIST
Ambulatory Care Manager (ACM)

Directions: The technical procedures requiring validation of competency during orientation are listed below. Each must be validated by a designated staff member prior to independent performance.
* = Affirmant competency

Bronson Ambulatory Care Management	**Method of Validation***	**Date**	**Validator Initials**
Documentation/Care Management Process- to be covered with Preceptor			
A day in the life of a care manager, time management, advocate for pt*			
Navigate shared drive: H drive overview- tools and documents			
Outlook- ACM e-mail group			
Review how to handle emergent/ urgent issues			
Patient safety report			
EPIC set-up/How to…*			
Add reports to my reports			
Add to smart phrases & how to create/use smart phrases			
Referrals and referral work queue			
Printing medication list & list of patient's goals			
Sending a patient letter			
Create patient lists			
Documenting call as episodic, chronic, and/or TCM*			
Medication reconciliation*			
Transitional Care Management (TCM) Calls*			
How to run TCM reports*			
Identifying high-risk patients discharged (ROUR, high-risk dx)*			
ROUR- review tip sheets & how ROUR is used*			
Making & documenting a TCM call*			
Care Coordination*			
What is care coordination?*			
Documentation for care coordination*			
Assesses and identifies resources appropriate to patient needs*			
Facilitates referrals as appropriate*			
Skilled nursing facility (SNF)*			
Home health*			
Hospice*			
AIM services & criteria*			
CHF clinic*			
COPD clinic*			
Diabetes education*			
Other community agencies*			
SNF care coordination notes*			
Chronic Care Management			
Identify patients for chronic care management & how patients are referred to care management			
Introduction of care management services			
ACM adds & removes self to Care Team			
Patient outreach- initial comprehensive assessment*			
Review assessment & screening tools*			
Initial and ongoing assessment is age-appropriate and complete*			
Assess & address barriers in care for patients in CCM*			
Longitudinal plan of care (LPOC)*			
Assess and address Social Determinants of Health (SDoH)- review standard work*			
Plan of care individualized, age appropriate, & evidence based*			
Care plan promotes progression towards outcomes & self-care*			
Care plan is updated according to patient needs*			
Goal setting*			
Entering goals with self-management*			
Interventions are appropriate and timely based on patient needs			
Implementation and evaluation of interventions are documented*			
Patient progression toward problem resolution, self-care, and discharge are documented *			
Process & steps to close a case*			

Managing a caseload			
Identify timeframe for patient follow-up & utilize tools to track*			
Advance care planning*			
Review care team members (Provider, MSW, Pharmacist, etc.) & ways to communicate with each*			
Psychosocial & behavioral health management identification*			
Patient Education & Disease Management*			
Assess patient/family teaching needs at each visit			
Develops a comprehensive teaching plan that is individualized and age appropriate			
Documents education & patient and family teaching response*			
Review educational materials available for patients- including disease specific materials- zones, etc.*			
Disease management- overview- how to partner with patients in management of chronic conditions*			
Scheduling & Visit Types			
How to access provider schedules			
Scheduling an office visit			
Scheduling follow up calls			
Scheduling appointments			
Face to Face (F2F) visit- explain, attend one			
Complete a F2F patient visit			
Complete charting a visit*			
Registries			
Registry overview- how to run, how to set up for practice, adding columns			
Exporting registries, sorting, etc.			
General risk registry- review checklist & standard work (H:)*			
Understand how to modify General Risk Score- standard work*			
Disease registries: brief overview* Diabetes, COPD, CHF, HTN, Asthma, ADHD			
Pediatric Disease Process (if applicable)* Asthma, BPD, Vent dependent, G tube dependent, Cerebral Palsy, Cystic Fibrosis, Diabetes type 1, Prematurity, Congenital heart defects			
Care Management Billing*			
Review billing cheat sheet & when to use each code*			
Review documentation requirements for each code*			
Meeting with ACM Supervisor			
Review job description			
Review Orientation pathway & calendar- schedule follow-up meetings on progress			
Set up weekly/monthly touch bases, 90-day evaluation, & annual evaluation			
Scheduling process			
PTO request process, high needs PTO times, & PTO buddy system			
Sign up for MICMT class			
Sign up for Mi-CCSI class			
Expectation for ongoing education and tracking (via micmrc.org, etc.)			
Staff meetings			
Expectations for using desktop Outlook and checking email & calendar use			
H drive overview- how to access			
Review MWR- CBL requirements			
Epic classes attended (add date):			
CAD Schegistrar 100			
CAD Referral Coordinator 300			
MSW/RD EPIC class			
Epic EUPA			
Payor program initiatives (SIM, CPC+, PH, BCBS, PCMH)- review patient lists & targets*			
Check in on registry set up week 6			
Registry review week 8			
Meeting with Practice Manager			
Meet & greet/ tour of the practice/ office hours/ introduction to staff & providers			
Office and desk space- supply location, printing & faxing, set up voice mail			
Office key/alarm code			
Huddle board location			
Provider meetings & staff meetings			
Interpreter services			
BMS overview & process Improvement Initiatives in practices			
Printing & faxing from the practice			