Contact Information
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Physician Organization Name: Lakeland Care Network
Practice Name: N/A
Practice Address: N/A
How many physicians in practice: N/A
Description of care team Lakeland Care Network Care Managers: Registered nurses, Medical Social Workers, Clinical Pharmacist, CCC's (comprehensive care coordinator), Medical Assistants

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

- Standardization on Care Management Workflows and Processes
- Clear guidelines on identifying patients appropriate for Care Management
- Increased Care Management encounters and patient outreach
- Defined Longitudinal Care Management
- Increased Care Management team buy-in to the program
- Improved collaboration amongst team members

Category of Submission: Care Management Workflow

Title of Submission: Team-based Care Playbook Design & Implementation

When did the intervention start and end? The Ambulatory Team-based Care Playbook was thought up at the end of 2018 as a 2019 strategy to standardize Care Management processes. The project began in January of 2019 and the playbook was put into circulation at the end of July 2019.

Goal of the Program/Intervention: The goal of the playbook was to create a fluid document of the regular tasks that a Care Manager would performs on a daily basis. The playbook idea would ideally provide a reference to both newly trained care managers as well as veteran care managers.

Who developed the program/intervention, and how? The PO RN Care Manager along with the PO's High Risk Care Manager developed the playbook. The RN Care Manager comes with clinical experience within a practice that valued Care Management and the High Risk Care Manager came with experience within the community and a vast knowledge of resources. As we began drawing up the playbook and designing chapters, we began to realize that it needed to address the entire team as a whole; not solely RN Care Managers. We then changed the document name to "Team-based Care Playbook" and called out disciplines such as the physicians, medical assistants, social workers, pharmacists, as well as the comprehensive care coordinators that work alongside our care managers.

Description of the Program/Intervention: The Team-based Care Playbook serves as a guide to assist with carrying out the daily tasks and functions that a Care Manager is asked to do. It addresses members of the care team that they can call on for expertise or delegation. This playbook was developed with team involvement and in doing so, at each monthly care management meeting, we asked for feedback and current task hurdles to accomplishing tasks from the Care Management team themselves. We wanted to be aware of the current hurdles within the task so that we could make changes and address them. Once the changes were made and the document was ready, the group would vote on each chapter before it was placed into the playbook.

With the development of the playbook, we decided to have chapters based on tasks they are being measured on. These chapters include Patient Empanelment, Longitudinal Care Management, Advanced Care Planning, Team-based Care, Social Determinants of Health, Payer List/PDCM, as well as a miscellaneous section for Epic workflows and shortcuts to improve efficiency. Again, we included the whole team and encouraged feedback before the standard work documents were made final and placed into the playbook. Asking the team for feedback allowed for team buy-in and created a space that was welcoming and encouraged a team-based approach during the development of the playbook.

How were patients identified for the program/intervention? Patients were identified using a variety of the playbook chapters' standard work documents. For example, within the longitudinal care management chapter, as a group we identified those that were low risk, medium or rising risk, complex risk, and high risk. Once this chapter was approved by the group, each practice was encouraged to outreach to those high risk patients with a complexity score of 15 or more and offer care management.

Another example of how patients were identified was through the payer list chapter. As we obtain Targeted CM lists from payers we can then use them to identify patients that are at high risk for readmission or those that could benefit from longitudinal care management. The standard work document within this chapter outlines how to read and use the targeted lists to ensure you are reaching out to the most appropriate patients as well as reaching the 3-5% benchmark goals given by the various payers.

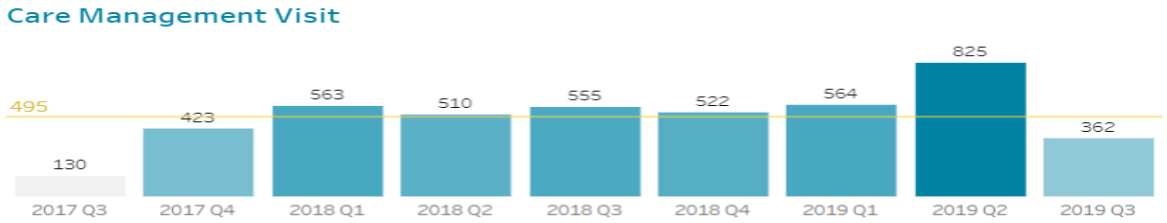
How was success measured? Please delineate whether metrics were process-based or outcome-based We measured success by tracking momentum on payer list and by using our developed Care Management Scorecard to track the increase in high risk patients enrolled into care management. With the playbook being implemented this year, this was also the first year we introduced the PDCM/PIP Targeted Care Management lists which came with its own confusions. Within our playbook we developed a chapter of standard work for understanding and working the payer list to find eligible patients for Care Management. We felt that the care managers needed something to reference as a workflow guide as they were getting these lists sent to them monthly from the PHO. Our care managers are now aware of how the VBR programs work and why we are pushing for the two touchpoints to reach 3% of their patient populations.

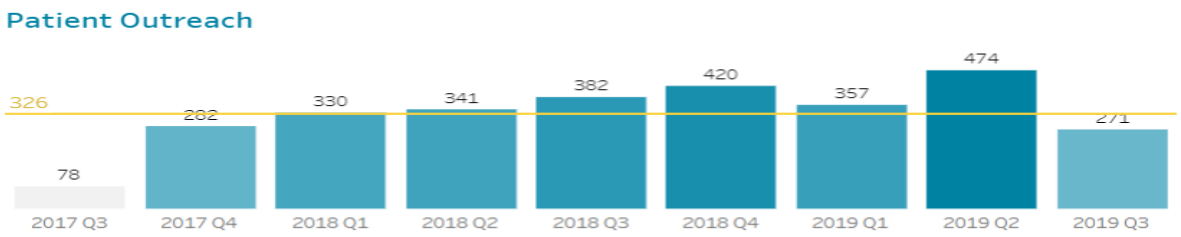
Another way we tracked results was within our Care Management Scorecard. The Care Management team at the PHO in collaboration with our Integrated Analytics department developed the scorecard as a Tableau dashboard. It displays information for the care managers to gauge their performance as well as information about how their practice is doing with the PDCM VBR measures of blood pressure control, A1c in control, ED/1000 and IP/1000. These were placed on their scorecard because we felt they were measures that care management could have an impact on. The specific result we were hoping for was an increase in the amount of high risk patients enrolled in care management. And it was a success! Within our PHO as a whole, we went from 4 out of 21 high risk patients involved in CM to 12 out of 22 within the first month! This number fluctuates as patients enter and leave care management.

With our success being primarily process-based, it was important to us to provide as much support to the care management team as possible throughout the change process. Lakeland Care developed what we call Touchpoints where the Care Management program coordinator goes out to see the Care Managers at their practices sites to spend time and give support in whatever areas are needed. The Touchpoints are performed at least quarterly and also consist of data review and updates on PDCM/PIP percentages and how far away they are at meeting their goals.

What were the program results? Include qualitative data/graphs With implementing our Care Management Scorecard and really focusing on providing longitudinal care management starting the first of the year, we have seen drastic increases, in not only panel size, but also the amount of encounters occurring with patients and number of telephonic outreach follow-ups. Below are examples showing the increase between Q1 2019 and Q2 2019 amount of face to face care management visits and telephonic patient outreach calls.

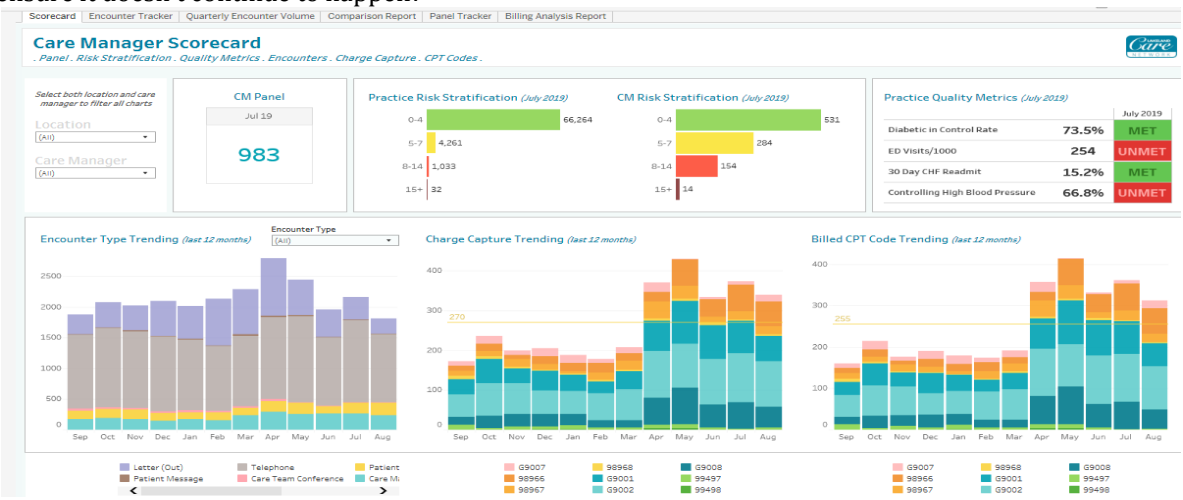
The CM Scorecard implementation gives the Care Managers a real-time look at how they are performing. The current information is blinded to their peers, but will be un-blinded beginning 2020 so they can compare their performance to other CM's based upon practice. Looking forward, we want to establish a standard expectation around amount of billable encounters performed in a day. This standard should increase the amount of CM encounters, both face to face and telephonically, resulting in more reimbursement and sustainability.





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

The tool we developed as a PHO was the Care Management Scorecard pictured below. This tool was developed to provide a single source to view the productivity of the Care Managers. It also captures every encounter opened by them, the codes that were dropped during the encounter, and the codes that were sent to the payer. We wanted to capture codes dropped versus codes sent to the payer to ensure we understand why the codes being held were being held and when they were being held or deleted, what needed to be done to ensure it doesn't continue to happen?



We also utilize the complexity score feature within Epic to identify patients for care management. This allows us to run a report to find the most complex patients within the offices to target. This list is also used to target those that would benefit from Advanced Care Planning. The Complexity Score also has a subjective component to it so that the Care Manager can give or take away 3 complexity points if they felt the score was not all-inclusive of the patient's condition.

What are you proudest of regarding this submission? Why does this work matter?

Establishing a standardized workflow for Care Management tasks and placing them within the Team-Based Care Playbook has allowed a level playing field for everyone to know what is expected. I am proud that the Care Management team, as a whole, decided upon what is expected and approved the workflows. It created accountability and buy-in knowing that their opinions were being considered in the process of standardization. We will continue this process as we expand into new chapters and tasks given the success we have had thus far.

How will your organization use the funds if your submission wins? While we have a variety of avenues we could spend the money on, the most important to us at this time would be to spend the funds on supplying iPads or tablets within the Primary Care practices. Providing iPads at check-in would allow more efficiency for the entire office. Information would automatically be inputted within our EHR, taking that task from the MA during the busy rooming process. Questionnaires such as demographics, social and surgical history, and social determinants of health could all be placed within the iPad's flowsheets to be done while waiting to room. Emmi education videos could also be watched while in the room waiting for the physician. Lastly, iPad's could be used to increase the rate of MyChart sign-up which, in turn, promotes patient access to their PCP and the health system leading to increased patient satisfaction.