CONTACT INFORMATION

Submitter Name: Christina Hildreth
Submitter Title: Executive Director
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Physician Organization Name: Metro Health Integrated Network
Practice Name: Metro Health employed primary care offices (Alger Heights, Allendale, Caledonia, Cascade, Cedar Springs, Community Clinic, Comstock Park, Grand Rapids Northeast, Hudsonville, Jenison, Lowell, Rockford, Southwest-East, Southwest-IM, Southwest-Peds, Southwest-West, Wayland)
Practice Address: various. CIN address: 5900 Byron Center Ave SW, Wyoming, MI 49519
How many physicians in practice: 72
Description of care team: 72 physicians, 55 advanced practice providers, 18 RN care managers, 17 MSW care managers, 7 PharmD care managers, 18 clinical RNs, 14 certified diabetes educators, 149 MAs

EXECUTIVE SUMMARY

Opportunity: To improve care management workflows and have a better picture of our patient population's overall health.

Mission: Metro Health committed itself to create a standard care management workflow and clinical documentation process to identify continuity of care plans for our patient's overall health.

Your Solution: Our integrated solution contains a holistic picture of our patient's social, behavioral, and physical health and is accessible to all members of the care team at all levels of care.

Market Focus: Patients attributed to a Metro Health primary care physician.

Expected Returns: Expanding and strengthening patient care collaboration between Metro Health providers, increased visibility of our patient's healthcare needs, streamlined documentation for care managers, increased care management encounters, and reduction in number of readmissions and emergency room visits.

Category of Submission: Care Management Workflow

Title of Submission: Implementing a redesigned standardized care management workflow

When did the intervention start: In August 2018, Metro Health Integrated Network (the Clinically Integrated Network (CIN) for Metro Health, University of Michigan Health) created a team to develop a standard care management workflow. The new workflow (Appendix) was rolled out to Metro Health primary care practices on April 8, 2019.

Goal of the Program/Intervention: Implementation of a standard care management workflow and documentation template to be accessed by all members of the care team.

Who developed the program/intervention, and how: After approval from senior leadership, the template and workflow was developed by Metro Health's clinical informatics staff with input from care managers, care providers, CIN clinical quality manager, and Epic representatives.

Description of the Program/Intervention: The first part of the program was researching the care management capabilities and functionalities within Epic. This included trainings, educational events, and collaborating with other organizations using these functionalities.

The second part of the program was to take the information gathered and create the workflow within our system. Clinical informatics worked closely with care managers (RN, MSW, PharmD), providers, and the CIN clinical quality manager to develop this program to fit Metro Health. The outcomes of this group's work included; standardized note templates, adoption of additional tools/resources such as standardized Patient Health Questionnaire 9 (PHQ-9), Generalized Anxiety Disorder 7 (GAD-7) screening, Edinburgh Postnatal Depression screening, a depression/anxiety screening trend report to track patient scores over time, integrating external claims data into the plan of care using our data warehouse, and having the care manager workspace open directly to the longitudinal plan of care.

The final part of the program was implementation and providing education and training to the practices. The training objectives were; understanding the importance of a standardized process, defining the steps of the workflow, emphasizing the additional tools and data integrated in the care plan template, and learning how to document and use the new template.

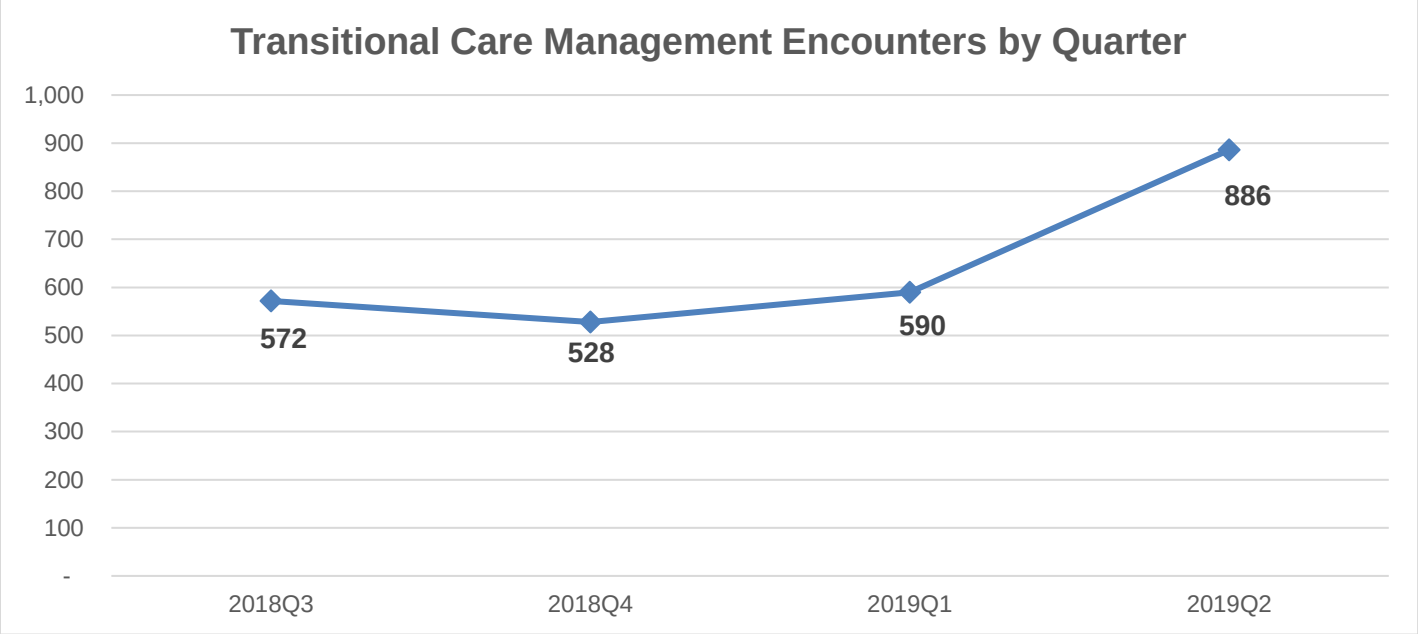
How were patients identified for the program/intervention: Metro Health identified patients for care management a few different ways: 1) payer generated care management lists 2) referrals from providers and 3) Admission, Discharge, Transfer (ADT) notifications for both admissions and emergency room visits.

How was success measured: The measurement of success for the care management workflow is process-based. The initial success was to have a standardized workflow for care managers to access and document relevant patient health information. Practices and care managers were able to share their feedback on the new workflow, which included how it impacted their practice operations, the benefits to performing their duties more efficiently, and the expected benefit to the patients and their overall health.

Ongoing success will be measured through reports monitoring care management encounters, patients engaged in care management, and emergency room visits and inpatient readmissions.

What were the program results: The feedback from practices on the program and the technical support during implementation was positive. Based on their feedback, documentation is easier and more streamlined, collaboration is better between providers in offices, and providers are able to meet more healthcare needs of their patients.

After the intervention was put into place, we had an increase of 296 transitional care management encounters in Quarter 2 of 2019 compared to Quarter 1 (a 50% increase).



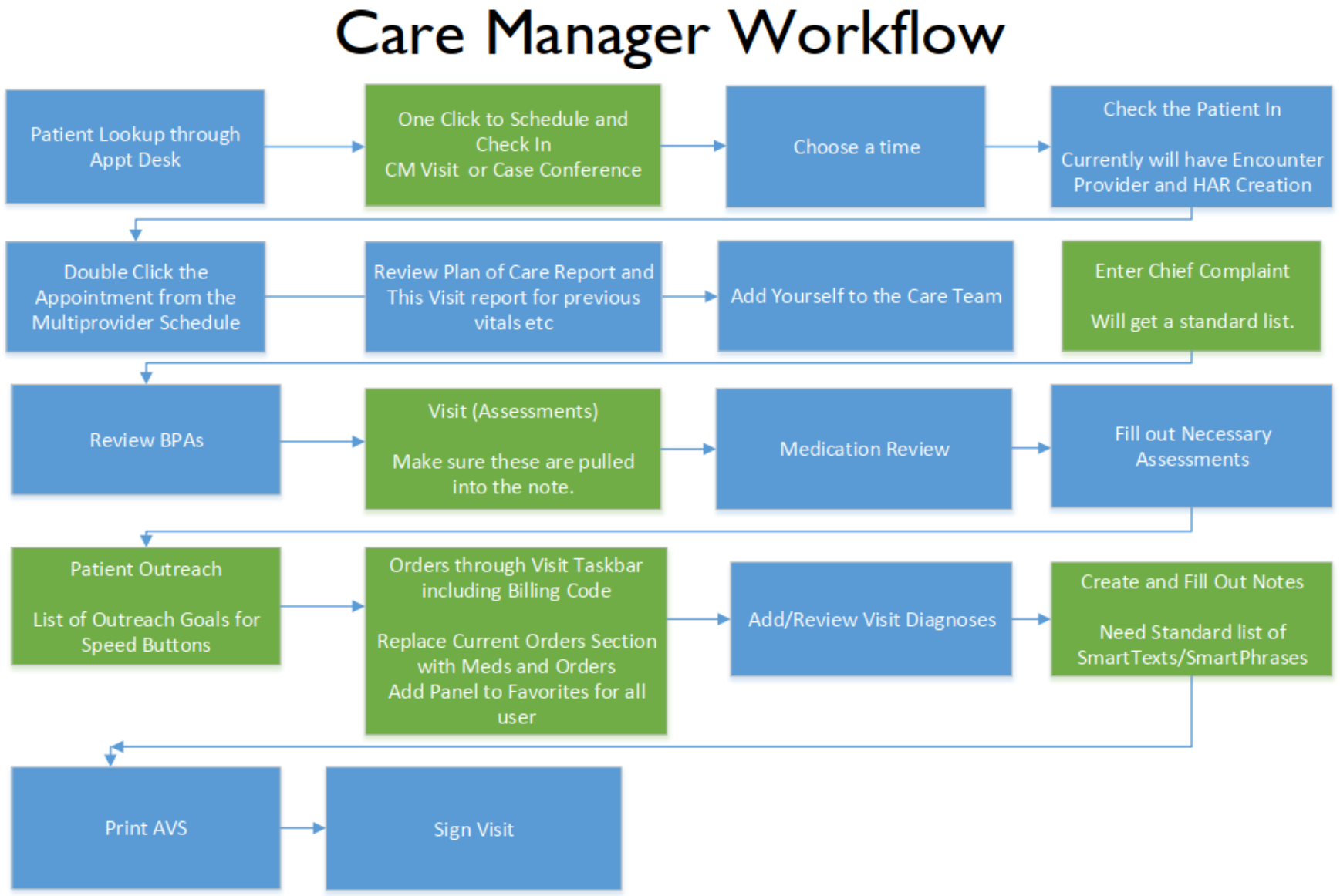
Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention: As mentioned previously, the new tools were the note templates, longitudinal plan of care, standardized PHQ-9, GAD-7 screening, and Edinburgh Postnatal Depression screening. The new processes were the care management workflows. The new resources developed were related to community resource documents and the integration of external claims data into our data warehouse.

What are you proudest of regarding this submission: Metro Health is proudest of the fact that care managers have a standard workflow and template to document, are able to incorporate more information relating to our patient's overall health, and make it accessible to all members of the care team.

How will your organization use the funds if your submission wins: If this submission wins, Metro Health will use the funds in the following ways:

- Expand and improve the risk stratification capabilities to accurately assess the risk of our patient population
- Integrate more comprehensive community resource information in Epic for easier access by providers
- Expand the community resource follow-up capabilities in Epic

APPENDIX


Care Manager Workflow
Patient Lookup through Appt Desk
One Click to Schedule and Check In
CM Visit or Case Conference
Choose a time
Check the Patient In
Currently will have Encounter Provider and HAR Creation
Double Click the Appointment from the Multiprovider Schedule
Review Plan of Care Report and This Visit report for previous vitals etc
Add Yourself to the Care Team
Enter Chief Complaint
Will get a standard list.
Review BPAs
Visit (Assessments)
Make sure these are pulled into the note.
Medication Review
Fill out Necessary Assessments
Patient Outreach
List of Outreach Goals for Speed Buttons
Orders through Visit Taskbar including Billing Code
Replace Current Orders Section with Meds and Orders
Add Panel to Favorites for all user
Add/Review Visit Diagnoses
Create and Fill Out Notes
Need Standard list of SmartTexts/SmartPhrases
Print AVS
Sign Visit

Transitional Care Management Workflow