Silver Linings Award Winners

PRACTICE	THEME	INNOVATION
Ascension Providence Medical Center South Lyon	Coumadin Management/PT INR Testing	An NP, MD and RN team devised a plan for proactive outreach and management of Coumadin patients during the COVID-19 pandemic. The scope consisted of all patients regularly seen in the in-person Coumadin clinic, as well as patients new to Coumadin during the pandemic. Patients were contacted via phone for medication management shared-decision making. If the patient was controlled with most INRs within range, they were advised of signs and symptoms to watch for. All patients were also evaluated for home INR monitoring coverage, and if eligible received devices and were educated on their use. Patients were also evaluated for possible switches to Direct Acting Oral Anticoagulants (DOACs). Patients preferring remote management were scheduled for an in-person INR within 12 weeks (vs. typical 2 to 4 weeks on traditional management) unless symptoms occurred. Both remote and in-person Coumadin patients already had direct phone numbers of the nurse and NP who manage this population. Patients on Coumadin who were not in normal range were brought into the office with INRs performed in parking lots, at our lab, at home visits, or by visiting nurse if preferred, based on patient preference. For patients who preferred in-person visits, the practice met them at the door and escorted them out a side door to minimize patient risk. Each person had a personalized care plan for Coumadin management during this time, vetted by patient, NP and RN and MD. Six patients switched to home monitoring (of the typically 50-55 patients seen each month for management). No one was hospitalized for abnormal bleeds due to INR out of range. No ER visits for falls during pandemic, (INRs remained in range when checked at those times). No evidence that any patients INR went out of control, all have since had INRs done and have remained in range. Those switched to home machines are pleased and have remained on in home monitoring. There was no change in pre vs post INR control (which was the goal). In terms of lessons learned, the INR machine did not work as well as desired in the parking lot, despite trouble-shooting.

Silver Linings Award Winners

PRACTICE	THEME	INNOVATION
David M. Byrens, M.D., P.C.	Continuity of Preventive Care Provision	To make sure that preventative visits were not unduly delayed, the practice added drive by, curb side and remote options. For example, for a well-child check, visits were conducted virtually followed by in-person immunizations, reducing patient exposure. The same technique was used for patients who required PT/INRs to monitor Coumadin levels. They were able to call patients ahead to offer them options that worked and were safest for them. The front desk made advance reminder calls and the nursing staff facilitated care with the providers conducting the visits. The PA worked to document the protocols and ensure that all the staff was on board with the rapidly changing external environment.

PRACTICE	THEME	INNOVATION
DayOne Family Health Care P.C.	Proactive Care Management Outreach for High Risk Patients	The practice identified their high-risk populations (immune compromised on medication therapies, high risk interventional radiology patients, immune suppressed patients, etc.) and had a Care Manager and clinical staff reach out to them. Their EMR vendor also worked to develop an application enhancement to enable panel-wide “Wait-in-Car” notifications before entering the medical building. They also organized office suites into "sick” and “well” sides to minimize exposure for patients. Going back to basics helped to drive the results, by using their population data to drive outreach to patients.

Silver Linings Award Winners

PRACTICE	THEME	INNOVATION
Hastings Internal and Family Medicine	Patent Support for Telehealth Technology	To make the telehealth process smoother for patients and providers, a staff person contacted the patient before the telehealth appointment, troubleshooting any barriers and collecting data, lab reminders etc. before the scheduled telehealth visit. After the visit, a staff member followed up with the patient clarifying any questions and making sure the patient could receive any plan of care documentation either through the portal or mailed to the patient. This intervention was implemented panel-wide initially to scaffold the telehealth experience for the least tech-savvy patients. Over time less support was needed and the process was modified to adapt to the needs of the patients and providers. This was a collaborative effort led by a physician with input and adaptation from all providers and staff. The practice learned to anticipate problems, listen to patients and staff about what frustrates them and to not be afraid to dedicate resources up-front to support change.

PRACTICE	THEME	INNOVATION
PRISM Medical Group	Care Management Scheduling	The practice created a phone call schedule for each Care Manager in their Allscripts EMR for Care Management outreach. Patients were scheduled at check-out for a care management phone call or a face-to-face visit with an RN, SW, Dietitian or Pharm D. They were provided an appointment reminder card for the phone call. This care management call scheduling system allows patients to choose their availability for the phone call. They can also request face-to-face visits if they prefer. Recently discharged patients are also added to the schedule to assist in post hospitalization follow-up care.