2019 Priority Health Topics and Resources

Priority health topic	Implementation strategies	Gillette resources	Partnerships	Metrics
Care Management (CM)	Outpatient care managers (OP CM) will meet with patients/families to create patient centered goals that aligns with their medical plans of care. Patients enrolled in CM will have pertinent care plans (with associated respiratory or seizure action plans) proactively shared with primary care providers/healthcare home and homecare agencies. Create and implement a one-call access line for patients/families enrolled in OP CM. For patients enrolled in OP CM, the care managers will proactively address transition planning from adolescence to adulthood with the patient and family. For patients enrolled in OP CM, the care managers will work to identify potential parent support networks and connect patient and families to them. For patient enrolled in OP CM, the care managers and social work team will screen for social determinants of health and refer them to the appropriate resources.	• Care Managers • Child and Family Services • Complex Care Pediatric Program • Care Management Phone Line • Family Advisory Council	• NowPow • Family Voices • Primary Care Clinics • Home Health Agencies • MN Department of Health • Local social services and community based organizations	> 90% of patients enrolled in care management will have an individualized care plan with patient centered goals. > 90% of patients enrolled in care management will have an individualized care plan and associated action plans proactively sent to their primary care provider/ health care home. Monitor number of calls to CM line annually (utilization metric). A minimum of 50% of OP CM patients (18y/o or >) will have a goal related to transition to adulthood in their care plan (aim: all patients will transition to adult services by the age of 26.) Monitor (monthly) number of referrals to parent support networks. > 90% of patients enrolled in OPCM will complete social determinants of health screen.

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Patient Education	Increase patient and family education offerings and access on GilletteChildrens.org and the patient portal. Enhance patient education modalities at inpatient and outpatient visit discharge. Leverage mobile applications for pre-op and post-op education.	Patient Education Committee Providers/nursing participation in content creation • Gillette task force for review of new education/ television platforms • Information Systems • Family Advisory Council	• NowPow • Family Voices • Primary Care Clinics • Home Health Agencies • MN Department of Health • Local social services and community based organizations	Access to education is available on the patient portal. Education content on external website is searchable. Dot phrases for education content built for commonly utilized education materials. Organizational wide and mobile education and television platforms evaluated and implemented.
Community Resources	Social determinants of health (SDoH) screening program roll out with NowPow tool. Create list of community resources for patients and families available on external GilletteChildrens.org and patient portal. Examples: • Recreational resources for children with adaptive needs. • Resources to help with understanding financial programs available to families with children with complex conditions.	• Child and Family Services • Care Managers, IP and OP • Child and Family Services	Gillette to formalize community partnerships based on SDoH screening data identifying most prevalent support needs. Examples include: Family Voices and other local social services and community based organizations.	90% of outpatients will be screened for SDoH. 90% of screened patients with a qualifying need will be provided a community referral. Community resource section created on external website.

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Patient Access	Implement a patient engagement platform to facilitate improved communication between patient access staff and patient families allowing for multiple methods for outreach and response. Implement self-scheduling functionality for targeted appointments to allow for easier direct scheduling and create capacity for the remaining in-person and on-phone scheduling. Implement wait-list functionality to allow families to take advantage of late cancellations. Revise workflow to track outpatient order volume and the percentage of orders that convert to active appointments, including the timeframe of an outpatient order and the time from request to first contact to scheduling action and final appointment date.	• Patient Access Specialist • Prior Authorization Staff • Telehealth • Providers	• Software vendor	Automated outreach and reminders implemented by July, 2020. Implement 4 self-scheduling appointment types in 2020. Publish conversion to business dashboard containing statistics related to times between appointment request, first contact, scheduling action, and appointment date to establish baseline metrics by July, 2020.
Access and Financial Advocacy	The financial advocate position will be created in Charge Integrity and will work closely with that team as an escalation resource, providing a holistic focus on the patient financial profile. Financial Advocates will be a dedicated resource for our patients, families, physicians, and staff to assist in answering financial coverage questions and concerns both pre and post service. Create alignment for the patient/family financial profile, including payer source alignment lines of business. Increase awareness and participation in the Gillette Assistance Program (GAP). Proactively increase patient/family awareness around outpatient facility fee for visits.	• Patient Access Specialist • Prior Authorization Staff • Telehealth • Financial Advocate • Family Advisory Council	• MN Department of Health • Local social services and community based organizations • Payors	Two Financial Advocate positions created and filled by September, 2019. Increase Shooting Stars Fund candidates matched by 100% over 2018. Increase GAP approvals by 100% over 2018.