# Panel Management:
## A “how-to” Discussion

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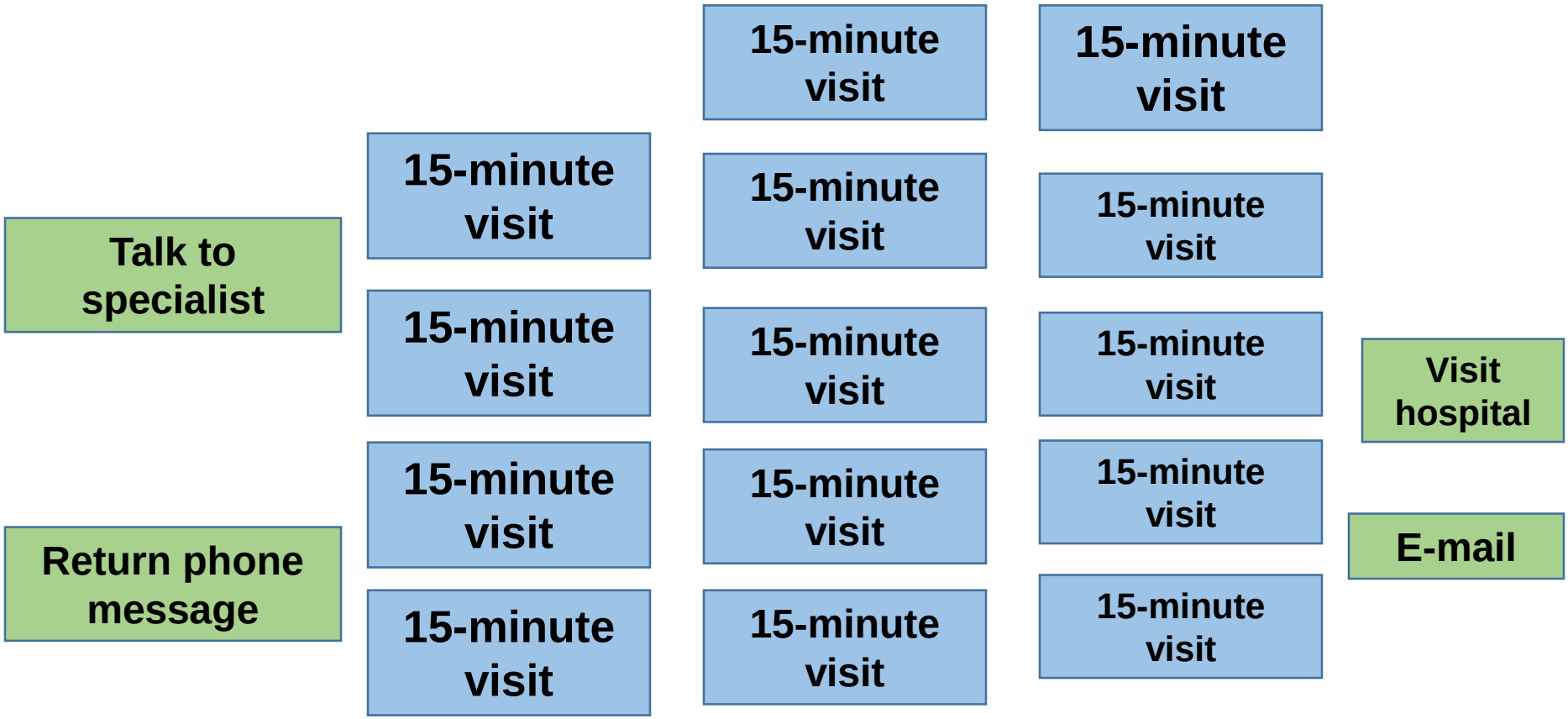
# Objectives

1. Define panel management in the context of shifting from individual to population-based care.

2. Describe the nuts and bolts of using patient registries to effectively manage the care needs of a panel of patients.

3. Identify key strategies that a team can implement when they return to work on Monday.

# How do we take care of our panel of patients?



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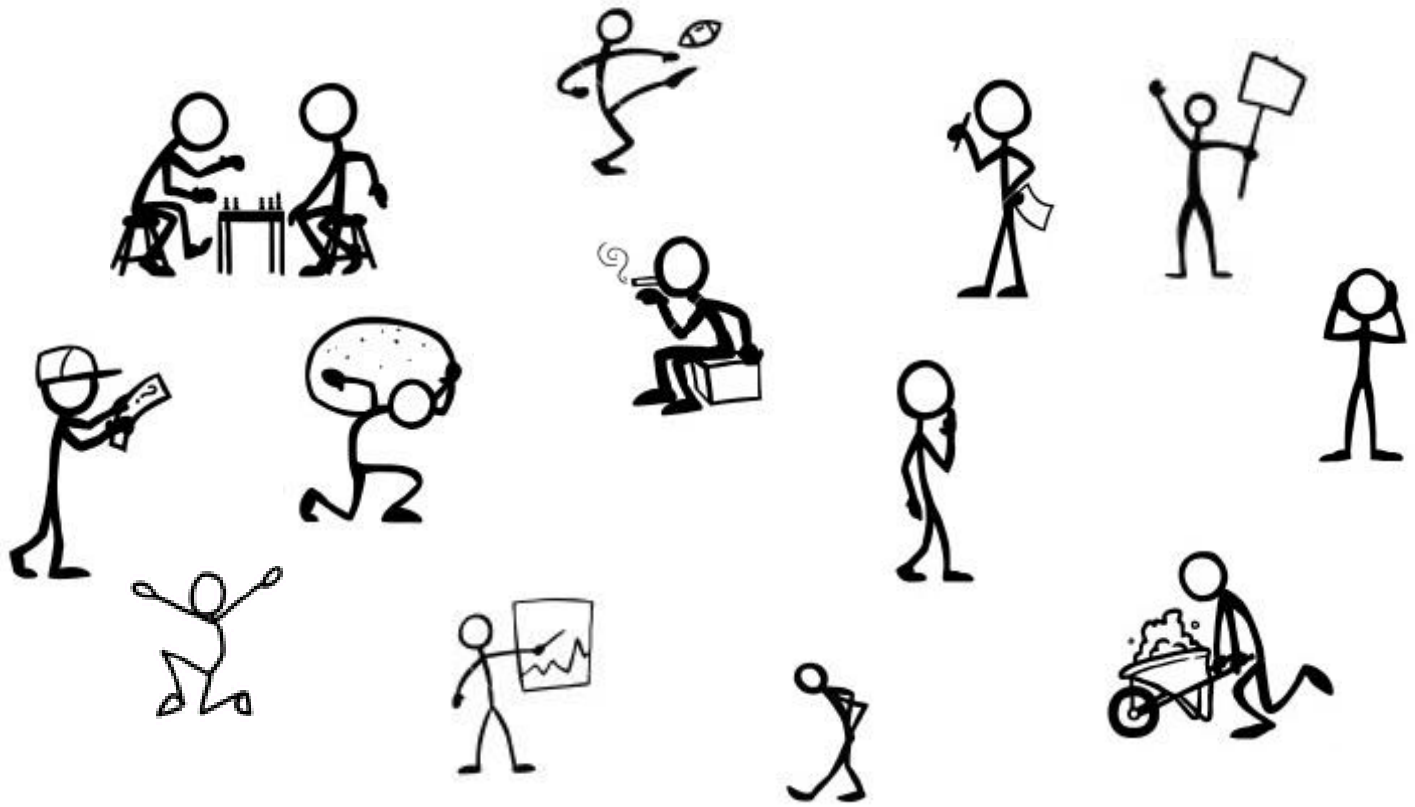
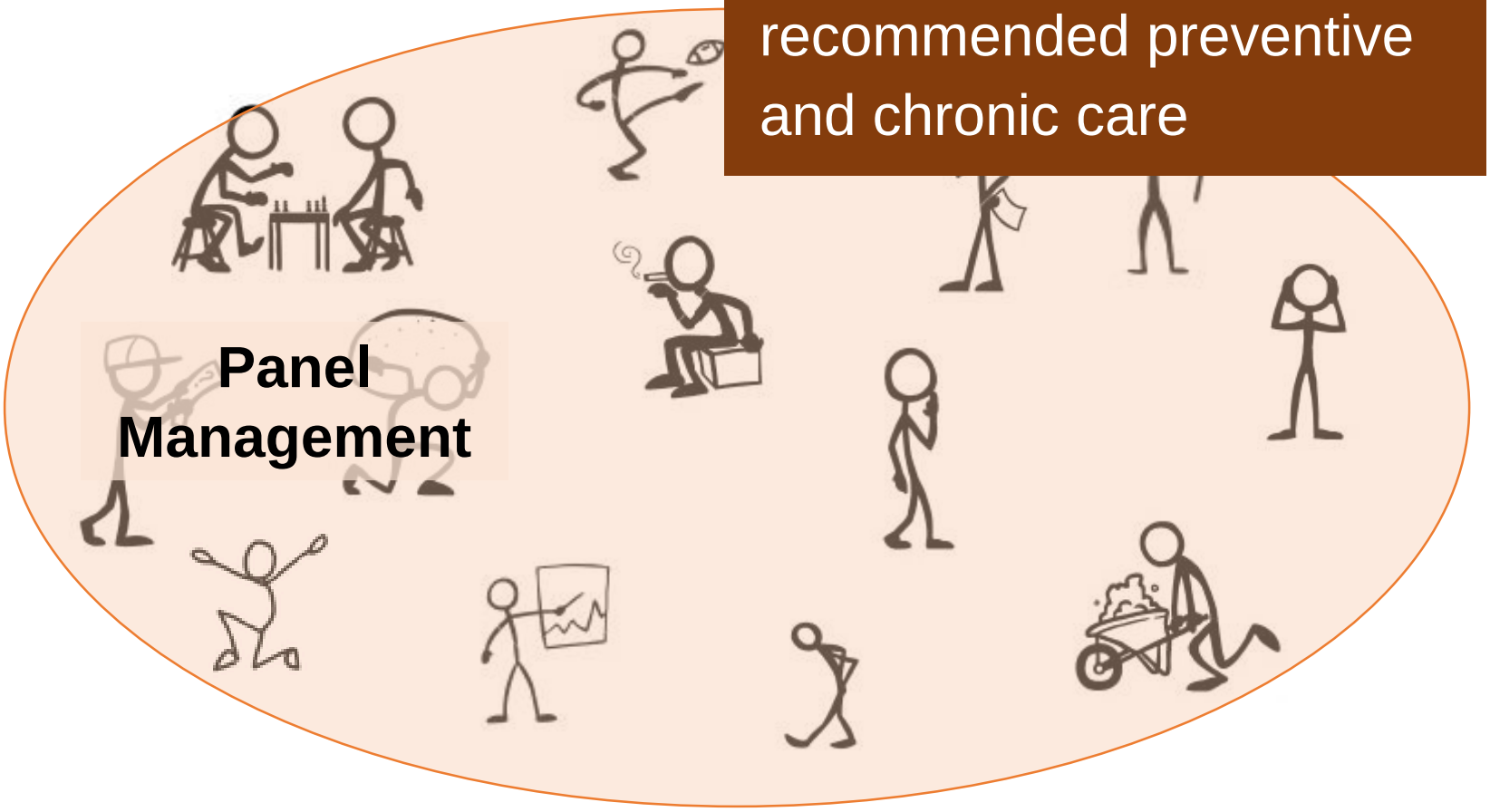


UCSF Department of Family & Community Medicine

Center for Excellence in Primary Care

# Panel Management

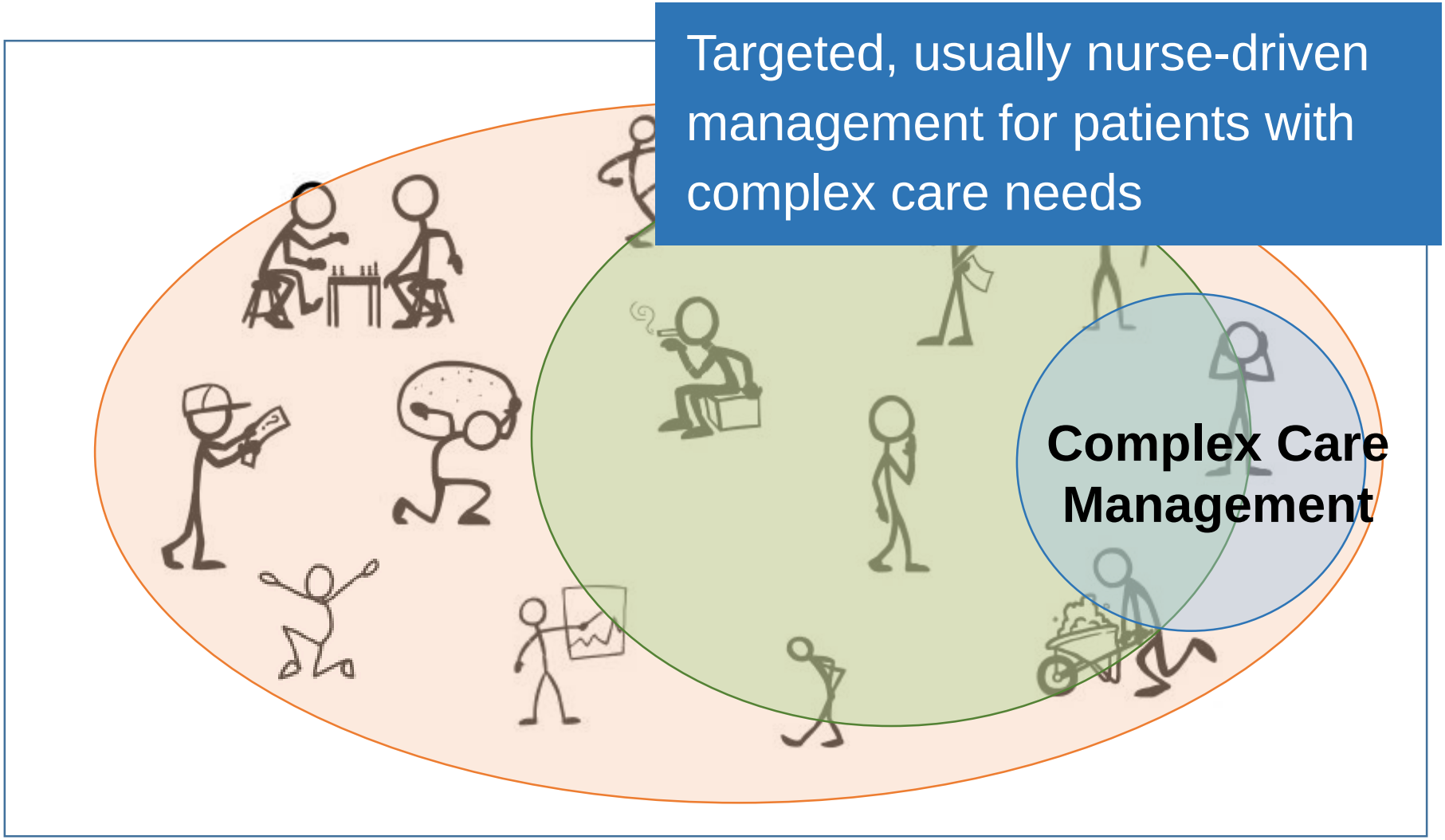
Ensuring that ALL of the patients in our panel get recommended preventive and chronic care



# Health Coaching

Helping patients with chronic conditions to improve their self-management

# Complex Care Management



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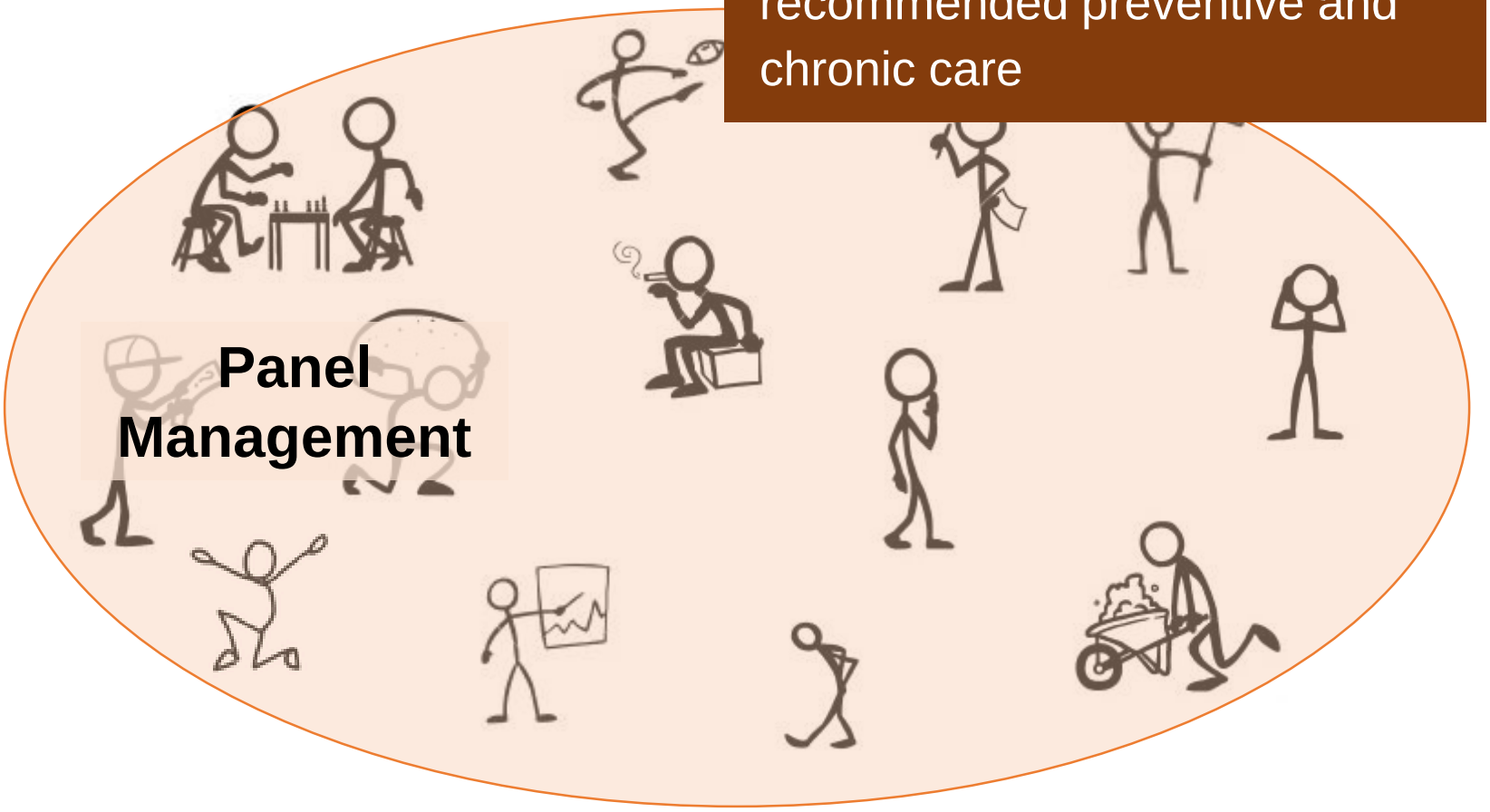

# Definitions

Panel Management: Processes that close identified care gaps to ensure all patients in our panel get recommended preventive screenings and chronic disease care.

## IN-REACH vs. OUTREACH

In-reach: Processes to close care gaps when patients come to the practice for any reason.

Outreach: Processes to close care gaps when patients are not in the office, such as telephone calls, e-mails, and regular mail.

# Panel Management IN-REACH

"Best Practice Alert"

Your patient is due for:
MAMMOGRAM
FLU SHOT
A1c TESTING

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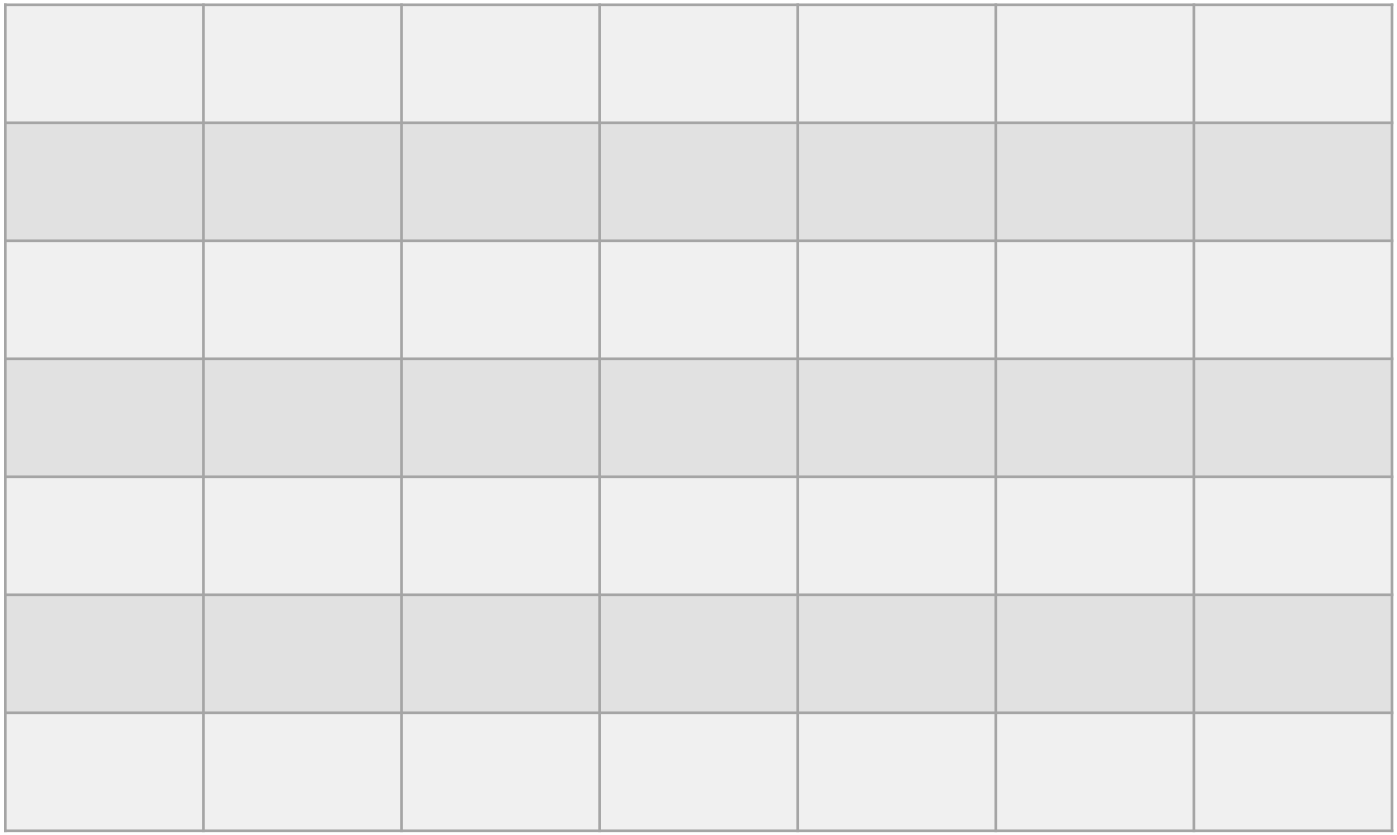
# Panel Management OUTREACH

## Step 1: Building the Registry



# What's in a registry?

| Patient's Name | ? | ? | ? | ? | ? | ? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# Sample Chronic Disease Registry

| Name | BP DATE | BP/s | BP/d | A1c DATE | A1c | DIABETIC | SMOKER |
|---|---|---|---|---|---|---|---|
| Patient A | 12/5/2015 | 127 | 70 | | | NO | NO |
| Patient B | 2/2/2016 | 110 | 55 | 2/2/2016 | 11.3 | YES | YES |
| Patient C | 3/12/2016 | 158 | 87 | 3/12/2016 | 6.7 | YES | NO |
| Patient D | 5/1/2016 | 148 | 95 | 5/1/2016 | 8.9 | YES | YES |
| Patient E | 1/18/2016 | 129 | 72 | 1/18/2016 | 9.6 | YES | YES |
| Patient F | 4/5/2015 | 125 | 88 | | | NO | |
| Patient G | 1/20/2016 | 149 | 85 | | | NO | NO |
| Patient H | 2/27/2016 | 147 | 90 | 2/27/2016 | 12.1 | YES | NO |
| Patient I | | | | | | NO | NO |
| Patient J | 2/22/2016 | 117 | 81 | 2/22/2016 | 5.9 | YES | YES |
| Patient K | 7/24/2010 | 152 | 85 | | | NO | |

# Panel Management OUTREACH

## Step 2: Translating the guidelines

| Chronic Care Routine Measures | | |
|---|---|---|
| Routine Measure | Frequency | Goal |
| **HbA1c** | Every 3 months if not at goal | HbA1c < 7% |
| | Every 6 months if at goal | Frail patients: HbA1c < 8% |
| **Blood Pressure** | Every 3 months if not at goal | Systolic < 130<br>Diastolic < 80<br>(BP <130/80) |
| | Every 6 months if at goal | |
| **Smoking** | Every year | "No" |

# Panel Management OUTREACH

## Step 3: Create Standing Orders

- **If A1c> 7, order repeat A1c test if last test over 3 months ago.**
- **If A1c> 9, mail patient invitation to diabetes group class.**
- **If A1c> 9, send note to Care Coordinator.**
- **If last Blood Pressure greater than 140/90, call patient and schedule them with RN for blood pressure check.**

# Sample Preventive Care Registry

## Step 1: Building the Registry

| Name | Age | Sex | Date of Pneumovax | Date of FOBT | Date of Colonoscopy | Date of Mammogram |
|---|---|---|---|---|---|---|
| Patient A | 76 | F | 12/22/2007 | 4/11/2016 | 10/24/2005 | 12/15/2013 |
| Patient B | 55 | M | | 4/21/2016 | | |
| Patient C | 66 | M | | | | |
| Patient D | 52 | F | | 7/14/2015 | | 5/30/2014 |
| Patient E | 53 | F | | 12/6/2014 | | 1/8/2014 |
| Patient F | 58 | F | | | | |
| Patient G | 55 | M | | | 4/23/2010 | |
| Patient H | 42 | F | | | | |
| Patient I | 68 | M | 2/3/2015 | 2/5/2016 | | |
| Patient J | 62 | M | | | 3/27/2005 | |
| Patient K | 75 | F | | | 12/17/2002 | 7/22/2011 |

# Step 2: Translating the guidelines

| Preventive Care Routine Measures | | |
|---|---|---|
| Routine Measure | Who should get it? | Frequency |
| **Pneumococcal vaccine** | Adults > 65 years old | Once* |
| **Colorectal Cancer Screening** | Adults 50-75 years old | FOBT/FIT once a year<br>or<br>Colonoscopy every 10 years |
| **Mammograms** | Women 50-75 years old | Every 2 years |

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# Panel Management OUTREACH

**Step 1: Building the Registry**

**Step 2: Translate the Guidelines**

**Step 3: Create Standing Orders**

***Step 4: Go!***

# Keys to Panel Management Success:

1. Total staff buy-in/panel ownership
2. Teamlets (match each Medical Assistant to a panel)
3. Fine-tune your in-reach process
4. Identify time in the template when MA is free.
5. Designate time for panel management
6. Designate time for process improvement

# 1. Total staff buy-in/panel ownership

- Ask your teams why they went into health care.
- **Give everyone the opportunity to contribute directly to making our patients healthier.**
- Panel management makes people healthy.
- **Make sure that every person in the clinic recognizes and appreciates these roles.**

***This is a critical step to success (try not to skip this one).***

# 2. Teamlets (match each MA to a panel)

- ***Caution***: this can be very difficult because of vacation days, sick days, personality issues.

**What it allows:**

a) **Total panel ownership:** MA will have a defined panel. MA will know the patients better. MA will be able to celebrate improved outcomes of the panel.

b) **Team-based care:** Small, consistent teams generate ideas for improved care. PDSAs.

# 3. Fine-tune your in-reach process

- **Panel Management = outreach + in-reach**

- ***In-reach***: making sure every patient is up-to-date on routine preventive and chronic care measures every time they step into your practice.

- Difficult to take the leap to outreach if you haven't built the foundation for in-reach.
- **Involve the people who are doing the work to help create standard work-flows.**

# 4. Identify time when MA is free

- ***Impossible?*** Even if this is during the provider meeting. Or on Thursday afternoons from 1-5pm. Or when providers are returning phone messages.
- **“Protected time” can be intimidating but it is possible. Start small.**
- Create a team that includes MA’s to figure out when the schedule allows the MA’s to contribute directly to patient care.

# 5. Designate time for Panel Management

## MA Suzanne sample schedule

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| Dr. Elsa AM clinic | Dr. Elsa AM clinic | Dr. Bob AM clinic | Dr. Bob panel mgmt | Dr. Bob AM clinic |
| Dr. Elsa panel mgmt | Dr. Elsa PM clinic | Dr. Bob PM clinic | Back-up MA | Dr. Elsa clinic |

# 6. Designate time for process improvement

- ***How are we doing?***
- Meet monthly with panel management team to review progress.
  - What have been the barriers?
  - Have we chosen the right interventions/standing orders?
  - Do we have all the right team members involved?

# Panel Management can be Beautiful

- Find your stars
- Start small
- Involve the whole team when possible
- Use available best practices (each other, literature search, Mi-CCSI

***Questions?***