Primary Care Practice Facilitation Curriculum

Module 31: Facilitating Panel Management

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

IMPROVING PRIMARY CARE

Primary Care Practice Facilitation Curriculum

Module 31. Facilitating Panel Management

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. HHSA2902009000191-Task Order No.6

Prepared by:
Mathematica Policy Research
Princeton, NJ
Project Director: Deborah Peikes
Deputy Project Director: Dana Petersen
Principal Investigators: Deborah Peikes, Erin Fries Taylor, and Jesse Crosson

Primary Author
Lyndee Knox, Ph.D., LA Net Community Health Resource Network

Contributing Author
Cindy Brach, M.P.P., Agency for Healthcare Research & Quality

AHRQ Publication No. 15-0060-EF
September 2015

This document is in the public domain and may be used and reprinted without permission except those copyrighted materials that are clearly noted in the document. Further reproduction of those copyrighted materials is prohibited without the specific permission of copyright holders.

The findings and conclusions in this document are those of the authors, who are responsible for its contents; the findings and conclusions do not necessarily represent the views of AHRQ. Therefore, no statement in this report should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

Suggested Citation

Knox L, Brach C. Primary Care Practice Facilitation Curriculum (Module 31). AHRQ Publication No. 15-0060-EF, Rockville, MD: Agency for Healthcare Research and Quality; September 2015.

Contents

Suggested Citation ii
Contents iii
Module 31. Facilitating Panel Management 1
Instructor's Guide 1
Time 1
Objectives 1
Exercises and Activities To Complete Before and During the Session 1
Module 31. 3
What Is Panel Management? 3
Why Is Panel Management Important? 3
Does Panel Size Matter? 4
How Large Should a Panel Be? 4
What Variables Affect Panel Size? 4
How Do You Assign Patients to Panels? 5
What Policies and Procedures Are Needed? 5
How Does a Practice Monitor Empanelment? 6

Module 31. Facilitating Panel Management

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Specialized skill in facilitating panel management
- Basic skills in change management

Time

- Pre-session preparation for learners: 75 minutes
- Session: 80 minutes

Objectives

After completing this module, learners will be able to:

1. Identify steps involved in training a practice on key concepts of panel management.
2. Use panel management training by Bodenheimer and Ghorob to train key practice staff on panel management.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-2 and watch video. (75 minutes)

1. The content of this module.
2. Empanelment Part 1: Establishing Patient-provider Relationships. Implementation Guide. Seattle, WA: Safety Net Medical Home Initiative; May 2013. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf
3. Video on outcomes of panel management. Available at: http://www.youtube.com/watch?v=qKiD-4deFPQ.

Note to instructor: Explain that the video shows an example of proactive care at Kaiser Permanente and demonstrates the difference good information systems, empowered staff, and proactive care can make.

During the session. Presentation (65 minutes)

1. Present key concepts from this module.
2. Bodenheimer T, Ghoreb A. Panel management. University of California San Francisco, Department of Family and Community Medicine; 2012. See Appendix B.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. Why does panel management matter?
2. What elements are necessary to effect panel management at a practice?
3. What role can a practice facilitator play in helping practices implement panel management?

Module 31.

A panel is a list of patients assigned to each care team in the practice. The care team (e.g., a physician, a medical assistant, and a health educator) is responsible for preventive care, disease management, and acute care for all the patients on its panel. This means that a patient will have the opportunity to receive care from the same clinician and his or her care team.

What Is Panel Management?

Panel management, also known in primary care as population management, is a proactive approach to health care. "Population" means the panel of patients associated with a clinician or care team. Population-based care means that the care team is concerned with the health of the *entire* population of its patients, not just those who come in for visits. For example, a care team with a panel of 1,500 patients would be concerned about the health care needs of the entire 1,500. The team would work on anticipating and planning for this care proactively (in advance) rather than reactively (when the patient shows up for a visit and requests care).

Why Is Panel Management Important?

Some practices do not use panels and operate more as acute care centers—services rendered to patients needing urgent medical attention (e.g., infection, injuries, or flu).

The Care Model and patient-centered medical home (PCMH) concepts require a different approach to care. Instead of thinking about patients episodically (a string of loosely connected appointments), practices must find ways to proactively reach out and develop continued relationships with their patients to provide continuity of care. Continuity of care is designed to provide higher quality of care to patients by providing consistent care over time through a primary care clinician.

> Empanelment must be an early change on the journey to becoming a PCMH because other key features such as continuous, team-based healing relationships; enhanced access; population-based care; and care coordination depend on the existence of such linkages..
>
> —Wagner, 2012

Assigning patients to particular clinicians or care teams helps change this approach. It designates teams responsible for caring for specific patients and supports continuous relationships between patients and their care teams. It also makes it possible for care teams to "manage" care not just for individual patients as they appear, but to plan care for all of the patients assigned to their panel.

Care teams oversee and track proactively the care needs of the patients on their panel and ensure that patients receive the services they need to optimize their health and well-being. Creating panels also makes it possible to monitor the performance of care teams with their assigned patients and monitor how effectively they are providing needed services to each patient in their panel.

Does Panel Size Matter?

The first question most practices will ask is, "Is patient panel size important?" The best answer is, yes, size matters. Imagine a clinician who is seeing too few patients. That may be great for him or her because the workload is lighter but not so great for other clinicians in the practice who are working into the evenings to keep up. You can imagine that it wouldn't take long for resentment to build among clinicians.

On the flip side, a clinician with a patient panel size that is too large is not effective. Patients may find it hard to get in to see their clinician, workloads may be deflected to others in the practice, and frustration will increase. The goal is to find balance in the practice between supply (time offered by the clinician) and demand (the need for the patient to be seen).

How Large Should a Panel Be?

The average panel size for a care team is 1,500 or 2,000 patients. Panel size is calculated by taking the clinician's "supply" of visit slots and dividing it by the average number of visits by a typical patient during a year. The result is the total number of unduplicated patients a clinician can care for in a year. For example:

- A clinician who works 230 workdays in a year and sees 24 patients a day has a "supply" of 5,520 slots a year (230 workdays × 24 patients/day).
- Patients average 3.19 visits to the clinician a year.
- This clinician could care for a panel of 1,730 average patients in a year (5,520 ÷ 3.19).

As noted in Module 29, however, a clinician working alone would not be able to care adequately for a panel that size. It is only through the delegation of care tasks among team members that a care team can provide high-quality care to this many patients. A resource for calculating panel size is the Family Practice Management Toolbox: Patient Panel Size Worksheet, available at: http://www.aafp.org/fpm/2007/0400/fpm20070400p44-rt1.xls

What Variables Affect Panel Size?

Empaneling the patients in a practice is not as simple as taking the total number of patients divided by the total number of care teams. In reality, dividing patients among care teams in a practice can entail using some complicated formulas that rely on additional information. You need to consider factors such as how many hours clinicians devote to patient care (vs. administrative duties or other responsibilities) and the types of patients they typically care for. For example, more complex patients require more frequent and longer visits. Similarly, obstetric patients have a period of high-intensity care. A clinician who sees many of these patients would be able to care for fewer patients.

The size and skill level of the care team will also affect panel size. A clinician who has teammates who can take over complex or specialized care tasks (e.g., dietitian, pharmacist,

phlebotomist, health educator) can see more patients in a day than a clinician who has a single medical assistant on the care team.

Finally, panel size will need to be adjusted to accommodate part-time clinicians and the unique practice requirements for residents if they are present in a practice.

How Do You Assign Patients to Panels?

There are several ways to assign patients to panels. Here are some steps for one of these methods:

1. Begin by reviewing patient visit records to determine if there are patients who have been seen by only one clinician. If so, assign those patients to those clinicians.
2. If a patient has been seen by more than one clinician, determine if there is a clinician whom the patient has seen more than the others. If so, assign the patient to the most frequently seen clinician.
3. If no particular clinician stands out for a patient, determine which clinician saw the patient for his or her last physical. Assign the patient to that clinician.
4. If there is no recent physical for a patient, assign the clinician the person saw last.
5. Incorporate the voice of the patient in this process as well. This can be done by training front office staff or the clinic's call center to ask patients which clinician they see regularly and assign them as they register.

At the end of this process adjustments will have to be made to ensure that panel sizes are manageable. For example, a clinician who is new to the practice will have fewer patients assigned to his or her panel through this process than a clinician with a long tenure. You may need to help the practice align panel size with each clinician's capacity, all the while keeping in mind patients' preferences.

What Policies and Procedures Are Needed?

Processes need to be established in the practice to ensure the sustainability of managing patient panels over time. For example, training materials and job descriptions need to be established with panel management processes embedded within them. The Safety Net Medical Home Initiative also has a set of procedures that can guide your clinic in implementing guidelines to better suit the needs of the clinic. Available at: http://www.champsonline.org/ToolsProducts/CrossDiscResources/PCMH/PCMHPandPs.html

Practices should develop a policy statement on panel management that covers topics such as changing clinicians, assigning new patients to clinicians, and staffing models to support clinicians based on the number of patients assigned to the panel. A sample of Policies and Procedures is contained in Appendix C.

How Does a Practice Monitor Empanelment?

Practices should monitor the effectiveness of their empanelment process on a regular basis and report to individual care teams and the practice as a whole. Suggested metrics are:

- Percentage of patient visits to their designated clinician.
- Percentage of patient visits to clinicians other than their designated clinician.
- Percentage of total patients unassigned to a panel.
- Size of panel by clinician and how it compares to target panel size for the practice.
- Percentage of patients who are new.
- Percentage of patients reassigned to another clinician.
- Number of overbooked appointments per week.
- An access measure, such as 3rd Next Available Appointment per clinician (the average number of days between a request for an appointment and the 3rd available appointment for that clinician).
- Patient satisfaction survey with specific questions on access and satisfaction.
- Staff satisfaction with the empanelment process, including clinicians, other clinical staff, and office staff.

Note: this module is based on Module 20 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Wagner, EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. The Commonwealth Fund, February 2012. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf .

Appendix 31A. Empanelment Exercise

Name:

Date:

Information on patient visits to clinic in past year:

Patient	Provider 1	Provider 2	Provider 3
John	1*	3	1
Lisa	1	1*	1
Nancy	2*	0	0
Lucy	1*	4	5
Samantha	1	4*	5
Timothy	2	2*	4
George	1	3	2
Michael	1	1	1*
Bianca	0	0	2*
Carl	1*	1	2
* Last provider seen			

Where would you obtain these data for a practice?

Assign patients to a panel based on data above.

Patient	Provider 1	Provider 2	Provider 3
John			
Lisa			
Nancy			
Lucy			
Samantha			
Timothy			
George			
Michael			
Bianca			
Carl			

Appendix 31B.1. Panel Management Training

By Dr. Thomas Bodenheimer, M.D., M.P.H., and Amireh Ghorob, M.P.H.

© University of California San Francisco Center for Excellence in Primary Care, 2011. Used with permission.

Note: This document has been formatted for the Web. It has not been edited, except to correct typographical or grammatical errors.

Part 1: Introduction to Panel Management

What is panel management and population-based care?

Population-based care is a proactive approach to healthcare. By population we mean the panel of patients associated with a provider or clinic. Population-based care means that the provider or clinic is concerned with the entire population of its patients, rather than only those patients who happen to come in for appointments. The population might be only some of a provider's or clinic's patients; for example, the patients with diabetes or the patients with Hepatitis B.

Panel management is the way in which we do population-based care. Panel management uses the patient registry to monitor patient care.

What is a registry?

Effective panel management relies on the availability of accurate and complete information in a patient registry. The registry is a database that stores patient health care information. The registry is a list of the names of all the patients of a provider or a clinic, with medical information about each patient. The registry can be searched to give feedback to a clinic and a clinician on performance measures; identify patients overdue for mammos, paps, HbA1c or LDL blood tests, eye exams, etc. The registry can also identify patients not in control of HbA1c, LDL, or blood pressure, patients who need more coaching or more extensive planned visits with a RN or nutritionist.

Some information in a registry is entered electronically from a laboratory or from the electronic medical record of a clinic, for example, patient demographic information, diagnoses, and lab values such as HbA1c and LDL cholesterol. Other information may need to be input by someone in the clinic, for example, blood pressure, weight, and BMI.

Although many clinics have a registry available, often the registry is not used to its full capacity. That is why panel managers with protected time are needed to work the registry.

Who is a Panel Manager?

Ideally, a clinic team member (for example, a medical assistant) is trained to be a Panel Manager. The Panel Manager reviews the registry on a regular basis to makes sure that patients complete their preventive and chronic care tasks on time (pap smears, mammograms, HbA1c levels, etc), receive lifestyle counseling, and are prescribed and are taking medications. Panel Managers call and send letters and lab slips to patients who need lab work done and make appointments for eye exams, mammograms, pap smears, etc. In some cases, the panel manager works with clinicians to review patients' medications and contact patients to intensify medications based on the clinician's orders. The Panel Manager may also have the job to enter data into the registry (like blood pressures) and to keep the registry up to date.

A Panel Manager can enormously help clinicians and patients by doing this work, which makes the Panel Manager a key person on the health care team.

In order for primary care clinics to use health coaching and panel management, they need to train coaches and Panel Managers. More importantly, they need to guarantee coaches and Panel Managers protected time. Ideally, the same people serve as both panel managers and coaches. All Panel Managers need health coach training since they perform outreach to patients.

Panel Management and Chronic Care

Sample Chronic Care Registry

Look at the example of a chronic care registry report. Any search criteria can be used to create a registry report based on a particular panel of patients with particular characteristics (clinic, clinician, last blood pressure, LDL or HbA1c value). In this sample report, patients in Column 1 represent the panel. The columns 2-12 represent the information that was selected by the person doing the search.

Group Activity

Use the chronic care registry sample and routine chronic care measures table to answer the questions below.

1. How many patients are in this panel?
2. What information is available on each patient?
3. What are some reasons that some fields are blank?
4. Which patients have HbA1c > 7?
5. What does this mean?

6. How often should HbA1c be measured if the patient is at goal? And if not at goal?

7. Which patients have BP > 130/80?

8. What does this mean?

9. How often should BP be measured if the patient is at goal? And if not at goal?

10. Which patients have LDL>100 and are diabetic?

11. What does this mean?

12. How often should LDL be measured if a diabetic patient is at LDL goal? And if not at LDL goal?

13. Which patients have LDL>130 and are not diabetic?

14. What does this mean?

15. How often should LDL be measured if the patient not diabetic and is at LDL goal? And if not at LDL goal?

Team Activity

With your team, answer the questions below. Use the chronic care sample registry and routine chronic care measures table.

1. Review the values for patients A, B, C, and D.

    a. Which of these patients would you call to schedule a group blood pressure clinic appointment?

    b. Which of these patients need to get labs done now?

    c. Which of these patients are you most concerned about?

2. Review the values for patients H and K: Which of these patients are you most concerned about?

Role Play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be the Patient D from the Chronic Care Registry. The coach will make a mock phone call to the patient and try to arrange lab slip pick up and an appointment.

After doing the mock call, both participants will provide feedback about the coach's role using the Panel Management Checklist.

Switch roles and repeat the mock phone call.

Panel Management and Preventive Care

Sample Preventive Medicine Registry

Panel management is an important way to help deliver preventive medicine. Registries can be set up to look at dates of most recent cancer screenings and other preventive measures. Information in this sample registry is organized to allow panel managers to contact patients who are overdue for colorectal cancer screening, mammograms, and the pneumococcal vaccine.

Group Activity

Use the preventive medicine registry sample and the routine preventive measures table to answer the questions below.

1. Why are some of the fields blank?
2. Which patients are overdue for colorectal cancer screening?
3. Which patients are overdue for a mammogram?
4. Which patients should receive a pneumococcal vaccine?

Team Activity

Colorectal cancer screening usually means having a fecal occult blood test (FOBT) every year or a colonoscopy every 10 years.

1. How does the panel manager know that a patient needs a FOBT test?
2. As a team, write a colorectal cancer screening guideline to increase the colorectal cancer screening rate in this panel.

Appendix 31 B.2

Chronic Care Routine Measures Table

Sample Chronic Care Registry Report

SM = Self Management Indicates if an action plan was created.

Name	DOC SM	BP DATE	BP/s	BP/d	LDL Date	LDL	A1c DATE	A1c	DIABETIC	SMOKER	DATE ASKED IF SMOKES
Patient A	NO	2/21/2011	127	70	11/30/2010	93			NO	NO	11/20/2010
Patient B	YES	2/15/2011	110	55	2/15/2011	145	9/25/2010	11.3	YES	YES	2/15/2011
Patient C	NO	4/7/2010	158	87	4/11/2010	81	4/11/2010	6.7	YES	NO	3/15/2008
Patient D	YES	1/20/2011	148	95	12/14/2010	170	12/14/2010	8.9	YES	YES	12/12/2009
Patient E	NO	10/28/2010	129	72	12/10/2010	54	12/10/2010	9.6	YES	YES	3/30/2010
Patient F	NO	8/21/2010	125	88	4/20/2010	125			NO		
Patient G	YES	6/24/2010	149	85	4/16/2009	102			NO	NO	12/2/2008
Patient H	NO	3/5/2011	147	90	3/5/2011	81	3/5/2011	12.1	YES	NO	3/5/2011
Patient I	NO	1/29/2010	120	64	2/3/2010	65			NO	NO	12/22/2004

Chronic Care Routine Measures		
Routine Measure	Frequency	Goal
HbA1c	Every 3 months if not at goal Every 6 months if at goal	HbA1c < 7% Frail patients: HbA1c < 8%
Blood Pressure	Every 3 months if not at goal Every 6 months if at goal	Systolic < 130 Diastolic < 80 (BP <130/80)
LDL	Every 3 months if not at goal Every year if at goal	Diabetics and/or CHD: LDL < 100 All other: LDL < 130
Smoking	Every year	"No"

Sample Preventive Medicine Registry Report

Preventive Care Routine Measures

1 Name	2 Phone Number	3 Age	4 Sex	5 Date of Pneumovax	6 Date of FOBT	7 Date of Colonoscopy	8 Date of Mammogram
Patient A	(415) 555-0179	76	F	12/22/2007	5/11/2008	10/24/1995	12/15/2005
Patient B	(415) 555-0134	55	M		7/21/2009		
Patient C	(415) 555-0110	65	M				
Patient D	(650) 555-0189	52	F		8/14/2010		9/30/2008
Patient E	(415) 555-0143	53	F		12/6/2010		12/18/2010
Patient F	(415) 555-0123	58	F				5/28/2009
Patient G	(650) 555-0112	55	M				
Patient H	(650) 555-0150	42	F	6/10/2009			10/21/2010
Patient I	(415) 555-0175	68	M	2/3/2008	7/28/2010		
Patient J	(415) 555-0120	62	M			3/27/2007	
Patient K	(415) 555-0130	75	F	7/14/2010		1/17/2002	8/22/2004

Preventive Care Routine Measures Table

Preventive Medicine Routine Measures Table

Routine Measure	Who should get it?	Frequency
Pneumococcal vaccine	Adults > 65 years old	Once*
Colorectal Cancer Screening	Adults 50-75 years old	FOBT once a year or Colonoscopy every 10 years
Mammograms	Women 50-74 years old	Every 2 years

*Patients with diabetes and some other conditions need the vaccine once before age 65 and once after age

Appendix 31B.3. Panel Management Training

Part 2: Creating clinical practice guidelines

How are clinical practice guidelines (standing orders) created that inform the panel manager when a care gap exists?

A care gap exists when a patient is overdue for a service that should be done periodically. F instance, a care gap exists when a patient with poorly controlled diabetes has not had a HbA test in over 3 months.

A care gap exists when a patient is above goal for a particular disease. For example, if a patient's goal for diabetes control is a HbA1c of 7 or below, a care gap exists if the most re HbA1c is greater than 7.

How does the panel manager know the guidelines that determine whether pa is overdue for a service or whether the patient's disease is in poor control?

The national guidelines, created by the American Diabetes Association, indicate that patient with diabetes in poor control should have an A1c test every 3 months, and patients with dia in good control should have an A1c test every 6 months. Each clinic needs to decide whethe they will use those national guidelines or create different guidelines. The guidelines (also c standing orders) need to be established and put into writing by the medical director or by the agreement of all the clinicians. Panel managers need to be trained to understand those standi orders.

Team Activity

Read the example standing order below. With your team, answer the questions that follow

Panel managers should check the registry every month and identify all patients with diabet with HbA1c above 7 who have not had a HbA1c in 3 months. Send a HbA1c requisition to t lab for those patients, and send the standard HbA1c lab letter to those patients with a follow phone call in 2 weeks for those patients who have not yet gone to the lab.

1. You are the panel manager. How would you fill out the lab requisition and how woul you get it to the lab?

2. How would the panel manager know which patients have a HbA1c goal of 8 rather t 7?

Group Discussion

Discuss reasons behind exceptions to routine follow-up.

Team Activity

Activity 1: Create a standing order to increase the percentage of patients completing colorectal cancer screening at your clinic.

Activity 2: Create a standing order to improve health outcomes for diabetes patients at your clinic.

Key messages

1. Some patients are exceptions to standing orders.
2. Each clinic must figure out a way to identify patients who should not receive the routine follow-up.
3. **Decisions on which patients are exceptions should be made by clinicians, not by panel managers**.

Part 3: Outreach

What is out-reach and how is it provided?

After the panel manager has identified care gaps, outreach is done by mailings and phone calls to close the gap. Out-reach is the best option for patients who do not have appointments in the near future.

Outreach Letter

Below are two example letters. We will read each letter and discuss.

Example 1

Dear Mr. Rojas,

We need you to come to the lab for an A1c blood test. Our records show you are overdue for this lab. Please come in or call me as soon as possible.

Sincerely, Diana

Group Discussion

Is this a good letter? Why or why not?

Example 2

Dear Mr. Rojas,

Dr. Alvarez asked me to write you because it is time for you to have another lab test for your diabetes. This test is called A1c. This measures your average blood sugar for the past 3 months. The last time we checked your A1c, it was too high, meaning that your diabetes was not in good control. We repeat this test every 3 months if your A1c is high.

An up-to-date A1c can guide our work together to help you take care of your diabetes.

You can go directly to the lab. I have sent the lab a slip with your information. Should you need help or have questions about the test, please call me.

Best wishes, Diana from Dr. Alvarez' team

Group Discussion

Is this a good letter? Why or why not?

Outreach Phone-Call Script

Below are two example phone-call scripts. We will read each script and discuss.

Example #1

Hello Mr. Rojas, this is Diana. [Hello, who is this?]

Oh, I sent you a letter 2 weeks ago about getting new labs, but it looks like you didn't go. We need you to go to the lab because it is really important for your health. [I haven't gone because I haven't had a chance yet.]

Could you go to the lab tomorrow to get your A1c test? [No, I work tomorrow]

But it is very important for your health that you go. Don't you want to take care of your diabetes? [No.]

Group Discussion

Is this a good phone call? Why or why not?

Example #2

Hello Mr. Rojas. This is Diana, calling from Dr. Alvarez' office.

[Oh, hello]

Is this a good time to talk? [Yes]

How are you today? [I am doing OK.]

Dr. Alvarez asked me to call you because it is time for you to have lab test for your diabetes. The test is called A1c. Do you know what the A1c test is? [No]

It is a measure of your average blood sugar for the past 3 months. [Oh yeah, my sugar test]

Do you remember what your last test showed us? [It was too high?]

That's right, the last time we checked your A1c, it was too high, meaning that your diabetes was not in good control. If it is okay with you, we'd like you to come in to get a new A1c test so we have a guide to help you take care of your diabetes. Would that be OK? [Yes, I can come in. Where do I go?]

Just go to the lab. I have sent a lab slip to the lab so they know that you will be coming. When do you think you could come? [Next Wednesday, when I don't have work]

Great. Do you have an appointment with Dr. Alvarez anytime soon? [No]

It would be good to have an appointment a week or two after the lab test. Let's help you set up an appointment now.

Group Discussion

Is this a good phone call? Why or why not?

Role play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be a patient. Use the scenarios below to do outreach. Do scenario 1 and then switch roles and do scenario 2.

Scenario 1: Ms. Gonzalez is a patient who has diabetes, A1c of 9.5, and has not had an A1c test for 6 months. Ms. Gonzales is motivated to improve her diabetes but does not understand her disease very well. Make a phone call to ask the patient to come to the lab for an A1c test.

Switch roles.

Scenario 2: Mr. Rojas has diabetes, A1c done 1 year ago of 10.2. He has not had an appointment for 5 months. He appears resistant about caring for his diabetes. Make a phone call to ask the patient to come to the lab for an A1c test.

Part 4: In-reach

What is in-reach and how is it provided?

In-reach is for patients who do have an appointment soon and for patients who drop in for care. In-reach takes advantage of the patient being in the clinic to try to close the care gap.

In-reach can be done regardless of what the patient has come to the clinic for. During an eye appointment, a podiatry appointment or a social work visit (or any other visit), the optometrist, podiatrist, or social worker would look at the screen and see what can be done to close the care gap.

In-reach works best if the electronic medical record has a panel management screen that indicates whether a patient has a care gap (for example a woman 60 years old who has not had a mammogram for 3 years) or is in poor control of a chronic condition (for example a patient with high LDL cholesterol who has not had a cholesterol blood test in 2 years). With this electronic panel management tool, in-reach can be done by the medical assistant during the rooming process. For example, if the patient is overdue for a mammogram, the medical assistant writes a mammogram order and makes an appointment for the patient to get a mammogram.

If there is no electronic medical record with a panel management screen, medical assistants can review the chart during the rooming process to determine if the patient has a care gap (preventive or chronic care) and try to close the care gap.

Do panel managers always implement standing orders exactly as the orders are written?

For effective panel management to take place, panel managers need to exercise some clinical judgment. For example, you can have a standing order that says every patient with diabetes needs a LDL-cholesterol test every year, but what does this really mean? If a patient comes in for an appointment in September 2010 and the last LDL was in November of 2009, does the panel manager wait until November 2010 to order an LDL or should he/she order one now even though the patient received an LDL test 10 months ago?

Group Discussion

Should panel managers have some disgression or should they only implement the standing orders exactly as written?

Role play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be the patient. Use the scenarios below to do outreach. Do scenario 1 and then switch roles and do scenario 2.

Role play #1: Ms. Phillips is 60 years old and has not had a FOBT test in 2 years and has never had a colonoscopy. The medical assistant discusses having Ms. Phillips get a FOBT.

Switch roles

Role play #2: Mr. Johnson comes in for a podiatry appointment. Mr. Johnson has diabetes with A1c done 3 weeks ago that is 9.6. Clinical practice guidelines agreed upon by the clinic leadership says that patients with A1c levels above 8 should get a one-hour appointment with a health coach. The medical assistant in the podiatry clinic has seen the panel management screen and knows that Mr. Johnson has a care gap about his diabetes control.

Part 5: Implementing panel management

How do panel managers get the training and the time to meet their responsibilities to their patients?

Each clinic's leadership after consulting with clinicians and staff needs to decide its panel management priorities. This partly depends on which conditions are entered in the registry. Some registries only include patients with diabetes; it would be difficult for a clinic with only a diabetes registry to do panel management for preventive care.

If the registry includes patients with diabetes, hypertension, hepatitis B, cervical cancer screening (PAP smears), breast cancer screening (mammograms), and colorectal cancer screening, then the clinic would need to decide its priorities based on how many patients are at risk for these different conditions and how much panel management time is available.

Panel managers need training for those conditions the clinic has decided are its priorities. The clinic leadership, or a quality improvement committee, may change priorities from month to month and make sure that the panel managers are trained to carry out each new priority.

Team Discussion

What types of patients can your clinic focus on? Based on this focus, create your clinic's priorities.

Models of Panel Management

There are two models of panel management that can be implemented to provide time for panel managers to do their work. One is the **specialized panel manager model.** In this model, one or two people (usually medical assistants) are trained to be full or half-time panel managers. During their panel manager time, they do *not* do medical assisting. The panel managers are responsible for the panel management of all patients in the clinic who need panel management.

The other model is the teamlet model. In this model every medical assistant in the clinic is trained to be a panel manager, and every medical assistant spends part of their time doing panel management. Each clinician is paired up with a medical assistant – who is also a panel manager -- in a two person team, called a teamlet. The teamlet, not just the clinician, is responsible for a panel of patients. The responsibility of the medical assistant/panel manager is to provide the panel management only for that panel of patients.

Team Discussion

1. Which of these models do you prefer for your clinic?
2. What are some barriers to implementation?
3. What are the solutions to these barriers?

Appendix 31 C. Sample Policies and Procedures

Community Clinic	**Policy File Name:**
	Page 1 of 4
Policy Title: Panel Assessment and Maintenance	Original Date: Revision Date(s):
	Approval Date:
Manual: Clinical	Effective Date:
	Policy Created/Revised By:

Purpose

To link each primary care patient with a Primary Care Provider (PCP).

Goal

To increase patient and provider satisfaction, improve continuity of care, and improve delivery of care.

Procedural Steps:

1. PCP Assignment Roles and Responsibilities

Clinic Manager:

- Reviews PCP assignments for team providers monthly.
- Addresses discrepancies in PCP assignment and unassigned patients seen by team provider.
- Tracks visits with PCP versus other providers ("Continuity Report").
- Determines whether panel is open/closed based on ideal panel size provided by the IT Panel Support.
- Follows up on patient requests to change providers.

IT/Data Analyst:

- Provides Clinic Managers an Ideal Panel Size report on a quarterly basis.
- Provides Clinic Managers an Actual Panel Size report on a monthly basis.
- Provides Clinic Managers with a monthly report of unassigned patients.
- Provides a PCP Discrepancy report that tracks visits with PCP versus other providers ("Continuity Report").
- Informs the Call Center, AMD, DOO, Clinic/Nurse Managers, and CMO of closed panels.

Nurse Manager:

- Whenever a provider leaves, the NM will coordinate a Transition Team Meeting consisting of the following staff: Billing Manager, Clinic Manager, Data Analyst, AMD/CMO, and Call Center lead to: evaluate patient needs in collaboration with team; reassign patients to other clinic providers according to panel capacity; and notify affected patients.

2. Assigning Patients

New Patients

Call Center:

- Schedules patient visit for next available/open provider panel.
- Call all new IPA enrollees with a followup letter if there is no response to schedule initial assessment visit with their assigned PCP.

Front Desk Specialist:

Registration-related duties:

- Assigns PCP in practice management system when new patient checks in during first appointment.
- Registration/Discharge places PCP label on medical chart with Provider/Team name.
- Provides the Patient Handbook to new patients.

Discharge-related duties:

- Confirms assignment with patient. If patient requests different provider or if provider requests change, facilitates change of assignment only to an open panel. (Please refer to PCP Assignment Change.)

Unassigned Patients Previously Seen

Front Desk Specialists:

Registration-related duties:

- Based on the four-cut method, determines who their PCP is and makes the assignment in the practice management system.
- Assigns to PCP using the “four-cut” method unless patient requests different assignment.
- Confirms PCP assignment at check-in.
- If patient requests PCP change, staff will immediately contact the Clinic Manager.

Discharge-related duties

- Reviews PCP assignment and confirms with patient and provider, and changes assignment as indicated.

- If request is made to change to a Panel that is already full, immediately contact the Clinic Manager.
- Confirms PCP assignment when making appointments.
- Confirms PCP assignment with new patients.
- Resolves discrepancies with provider assignment for established patients, contacts Clinic Manager.
- Changes PCP assignment upon request by provider or management team.

3. PCP Assignment Change

Patient who wants to change PCP assignment within the same clinic:

- Discharge and/or Registration staff: Facilitates the PCP change (in practice management system), unless the panel of the provider the patient is requesting is full. If the patient or provider does not agree with the request for change, defer to Clinic Manager and AMD as needed.
- Inform the patient and providers of the change through email.
- Clinic Manager: If patient has a provider preference regarding gender, then change can be made; otherwise, consults with current PCP. If transfer is approved, confirms acceptance by new PCP (should include PCP-PCP communication).

Patient requests transfer to PCP at different clinic:

- Discharge: Will make change to an open PCP panel at patient's desired location.
- Clinic Manager: Consults with current PCP. Reviews patient's history (# of PCP changes, no-shows, number of clinic transfers).
- Provider: Notes request to change on the discharge form and will consult with the referring provider, if available or known.
- Discharge staff: Informs patient of new PCP and ensures PCP reassignment in practice management system.

PCP requests transfer to a different clinic:

- Discharge: Will make change to an open PCP panel at patient's desired location.
- Clinic Manager: Consults with current PCP. Reviews patient's history (# of PCP changes, no-shows, number of clinic transfers).

4. Patient Notification of Provider Transfer or Termination

In the event of a provider transfer or termination, each clinic site will take responsibility for notifying patients.

CMO and AMD:

- Notifies Clinic Manager, Nurse Manager, IT, Billing Manager, and Call Center Manager of the provider leaving within 2 weeks of receiving notice.

Information Technology Panel Support Staff:

- Provides the Clinic Manager a list of patients assigned to the provider, patient letters, and optional mailing labels, if needed.
- Upon request, provides PCP/team with panel list.

Call Center:

- Eligibility will provide the IPA Disenrollment list to Clinic Managers on a monthly basis. (Note: The list produced will be from the month prior.)

Clinic Manager:

- The manager will ensure that the computer is updated with the revised PCP information. Standard personalized letters will be sent from the provider to notify patients of the transfer or termination. Patients should be told that the clinic will notify them when their PCP has been replaced. Until reassignment occurs, patients will be seen by the appropriate provider as determined by the clinic manager in coordination with the other providers at the site.
- Will inactivate account of disenrolled IPA patient in practice management system.

Billing Manager:

- Assigns PCP a new provider number in practice management system when a new PCP is hired or when caseload needs to be reassigned to new provider. Clinics will be responsible for reassigning the patient to a new PCP within the clinic site.