Module 20: Facilitating Panel Management

B. 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 health care. 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; and 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, and patients who need more coaching or more extensive planned visits with an 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 is 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 an FOBT?
2. As a team, write a colorectal cancer screening guideline to increase the colorectal cancer screening rate in this panel.

Sample Chronic Care Registry Report

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

1	2	3	4	5	6	7	8	9	10	11	12
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
Patient J	YES	1/5/2011	117	81	1/5/2011	112	1/5/2011	5.9	YES	YES	7/5/2010
Patient K	YES	7/24/2008	152	85	7/14/2008	157			NO		

Most current date that blood pressure measured

Most current date that LDL cholesterol measured

Most current date that HbA1c measured

Indicates the most recent date patient was asked about smoking

Chronic Care Routine Measures Table

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

Sample Preventive Medicine Registry Report

Preventive Medicine Routine Measures Table

1	2	3	4	5	6	7	8
Name	**Phone Number**	**Age**	**Sex**	**Date of Pneumovax**	**Date of FOBT**	**Date of Colonoscopy**	**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 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 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 65.

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. For instance, a care gap exists when a patient with poorly controlled diabetes has not had an HbA1c 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 an HbA1c of 7 or below, a care gap exists if the most recent HbA1c is greater than 7.

How does the panel manager know the guidelines that determine whether patient 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 patients with diabetes in poor control should have an A1c test every 3 months, and patients with diabetes in good control should have an A1c test every 6 months. Each clinic needs to decide whether they will use those national guidelines or create different guidelines. The guidelines (also called 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 standing 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 diabetes with HbA1c above 7 who have not had an HbA1c in 3 months. Send an HbA1c requisition to the lab for those patients, and send the standard HbA1c lab letter to those patients with a follow-up 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 would you get it to the lab?
2. How would the panel manager know which patients have an HbA1c goal of 8 rather than 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 outreach 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. Outreach 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 a 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 an 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 discretion 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 an FOBT in 2 years and has never had a colonoscopy. The medical assistant discusses having Ms. Phillips get an 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 say 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?