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Panel Management

Focus on providing proactive, preventive care to improve the health of your patients.

AMA IN PARTNERSHIP WITH UCSF Center for Excellence in Primary Care

SGIM Society of General Internal Medicine *Creating Value for Patients*

CME CREDITS: 0.5

Thomas Bodenheimer, MD, MPH
Co-Director, Center for Excellence in Primary Care, University of California, San Francisco

Amireh Ghorob, MPH
Director of Practice Coaching and Training, Center for Excellence in Primary Care, University of California, San Francisco

David Margolius, MD
Chief Resident, Department of Medicine, University of California, San Francisco

How will this module help me utilize panel management in my practice?

1. Six steps to help implement panel management in your practice
2. Answers to questions and concerns you may have about implementation
3. Examples, exercises and quizzes to help you train your staff in panel management for preventive and chronic care

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduces the amount of time physicians spend delivering direct patient care. Panel management equips physicians and their teams with the techniques to monitor their patient populations so they can provide necessary preventive and chronic care to all patients, regardless of the frequency of visits. The team's dedication to proactively addressing chronic and preventive care will improve the health of their patients.

Panel management
Release Date: June 2015
End Date: June 2019

Objectives
At the end of this activity, participants will be able to:
1. Use a health maintenance template to identify the health indicators that are the focus of the practice's improvement efforts
2. Select and train staff to serve as panel managers
3. Develop an in-reach panel management process to close gaps in care and anticipate upcoming care needs
4. Develop a process to address gaps in care for patients who require out-reach panel management

Target Audience
This activity is designed to meet the educational needs of practicing physicians.

Statement of Need
Due to the popularity of fee-for-service payment models, many practices have become focused on increasing the volume of patients seen. This results in a practice where physicians and staff don't have the time to effectively monitor patients with preventive care needs and chronic conditions. Patients may fall out of care or be overdue for important chronic and preventive care milestones, such as immunizations, diagnostic testing and chronic condition management and follow-up.

The shift to outcome focused care will prepare practices for value-driven payment models, where patient health will become an important reimbursement indicator. Implementing panel management in the practice will not only help physicians and their staff provide better care for patients, but also meet these reimbursement targets. Panel management approaches have been effective in improving the proactive approach to delivery of care and lead to better health outcomes for the patient population. In this module, physicians and their teams will learn how to use panel management to proactively monitor patient health and close gaps in care, ultimately improving patient outcomes.

Statement of Competency
This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice, interdisciplinary teamwork and quality improvement.

Accreditation Statement
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement
The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Claiming Your CME Credit
To claim *AMA PRA Category 1 Credit*™, you must 1) view the module content in its entirety; 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

Planning Committee
Rita LePard – CME Program Committee, AMA

Ellie Rajcevich, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine Sinsky, MD – Vice President, Professional Satisfaction, American Medical Association and Internist, Medical Associates Clinic and Health Plans, Dubuque, IA

Krystal White, MBA – Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Author(s)
Thomas Bodenheimer, MD, MPH – Co-Director, Center for Excellence in Primary Care, University of California, San Francisco

Amireh Ghorob, MPH – Director of Practice Coaching and Training, Center for Excellence in Primary Care, University of California, San Francisco

David Margolius, MD – Chief Resident, Department of Medicine, University of California, San Francisco

Faculty
Thomas Bodenheimer, MD, MPH – Co-Director, Center for Excellence in Primary Care, University of California, San Francisco

Amireh Ghorob, MPH – Director of Practice Coaching and Training, Center for Excellence in Primary Care, University of California, San Francisco

David Margolius, MD – Chief Resident, Department of Medicine, University of California, San Francisco

Christina Harris, MD – Internal Medicine Clinician Educator, West Los Angeles VA

Peter Kaboli, MD, MS – Professor and Chief of Medicine, Iowa City VA Medical Center

Norifumi "Norris" Kamo, MD, MPP – Primary Care Physician, Downtown General Internal Medicine Clinic, Virginia Mason Medical Center

Andrea Sikon, MD, FACP – Chair, Department of Internal Medicine & Geriatrics, Medicine Institute Center for Specialized Women's Health, Women's Health Institute, Cleveland Clinic

Ellie Rajcevich, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine Sinsky, MD – Vice President, Professional Satisfaction, American Medical Association and Internist, Medical Associates Clinic and Health Plans, Dubuque, IA

About the Professional Satisfaction, Practice Sustainability Group
The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy," and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement
The content of this activity does not relate to any product of a commercial interest as defined by the ACGME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types
This activity is available to learners through Internet and Print.

References
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Introduction

What is panel management?

Panel management, or population health management, ensures that all patients, not just those patients who come in for appointments, are getting the preventive and chronic illness care they need. For example, your practice may use panel management to ask, "Have all of our patients between 50 and 75 years of age received colorectal cancer screening at the appropriate time intervals? Have all of our patients with diabetes had laboratory tests for HbA1c, LDL cholesterol, and urine microalbumin at the appropriate times?" This approach leads to better health and outcomes for your patient population.

Six steps to implement panel management

1. Develop a registry
2. Use a health maintenance template
3. Adopt clinical practice guidelines
4. Select and train staff to serve as panel managers
5. Identify care gaps
6. Close care gaps through in-reach and out-reach

1 Develop a registry

A registry is a database with medical information about immunizations, cancer screenings and disease-specific lab results for the patients in your practice. The registry can be searched to identify patients overdue for mammograms, pap smears, colorectal cancer screening, immunizations, HbA1c and cholesterol blood tests or diabetic eye exams. The registry can also identify patients who do not have specific lab values, such as HbA1c, cholesterol or blood pressure, under control. Registries can be used to generate reports to help track if each clinician's patients are meeting these preventive and chronic care measures. Your practice's electronic health record (EHR) may include a registry function, but it is more common to use a separate registry program.

Panel management: *Panel* refers to the patient panel, or the patient population of the individual physician or practice. Panel management is the process of monitoring the patient population for important preventive and chronic care milestones based on guidelines determined by the practice.

Q&A

How do I use panel management if my practice does not have an EHR or a separate patient registry program?

You can still use panel management without a separate program or EHR. Common Microsoft programs, such as Excel or Access, can be used to monitor patients with a simple patient registry.

To set up an Excel- or Access-based patient registry that is unique to your practice, use billing data and chart audits to identify patients with health conditions that you would like to track. For example, search for patients by ICD-9 codes or health maintenance data for conditions such as diabetes or hypertension. Include these patients and select health indicators related to the condition of interest in your registry (e.g., for patients with diabetes the date of the last eye exam and most recent HbA1c, etc). Use visual cues or color-coded cells to flag overdue laboratory tests or visits. Flagging will help you proactively and more effectively implement panel management and improve the health outcomes of your patients.

2 Use a health maintenance template

Many EHRs have a health maintenance screen with a list of routine preventive and chronic care tests such as mammograms, immunizations and HbA1c tests. The EHR health maintenance functionality can be programmed to:

- Prompt physicians and staff to screen patients for diseases and for recommended services based on their age, sex, diagnosis, etc. (e.g., pap smears, mammograms and colorectal cancer screening)
- Remind physicians and staff to provide preventive care services to patients, such as immunizations
- Help physicians and staff better manage patients with chronic conditions (e.g., HbA1c tests and eye exams for patients with diabetes).

3 Adopt clinical practice guidelines

Your practice should decide on clinical practice guidelines for preventive and chronic care services and use them to establish target levels for selected health indicators. Most practices use evidence-based national guidelines. Determine which targets your practice will set for each indicator.

4 Select and train staff to serve as panel managers

You will want to train nurses, medical assistants (MAs) and/or reception staff in panel management. An initial time investment will lead to better care for your patients and improved efficiency in your practice. Some practices may start with training a couple key staff members who then train their counterparts as the new process is adopted throughout the practice.

Q&A

Our staff hasn't had this amount of responsibility before and our physicians are reluctant to entrust this work to them. What should we do?

Start with staff members who are energized and can act as champions for change. When they enthusiastically motivate patients to receive needed immunizations or get screening tests, they can win

over those in your practice who are reluctant to change. You will know that the culture is changing when you no longer hear your staff saying, "These are the doctor's patients," but instead saying, "These are our patients."

How can we train our nurses, MAs and/or receptionists in panel management?

This toolkit contains resources you can use for training purposes, including suggested scripts for practicing health coaching, discussion questions and a registry quiz to test understanding of the data in a registry. Also included are teaching exercises for creating out-reach phone scripts and out-reach letters your staff can use with patients.

5 Identify care gaps

A gap in care exists when a patient is overdue for a service that should be done periodically (known as a process care gap) or when a patient is not meeting the goal range for a particular disease or condition, such as having an HbA1c greater than the recommended target (known as an outcome care gap.) Care gaps of selected indicators are identified from the registry or from the EHR health maintenance screen. Training on how to identify these gaps is provided as part of this toolkit.

DOWNLOAD Teaching exercise: chronic care registry

DOWNLOAD Teaching exercise: preventive care registry

6 Close care gaps through in-reach and out-reach

In-reach

In-reach is panel management for patients who are physically present in the office. In some practices in-reach is done regardless of the reason for the visit. During visit preparation or at the time of patient rooming, the nurse or MA reviews the EHR health maintenance screen. If care gaps are identified, s/he will discuss them with the patient and queue up orders in the EHR for the physician to validate and submit.

DOWNLOAD Teaching exercise: having an in-reach discussion

Q&A

Can we use standing orders to increase efficiency?

Yes. For example, if the patient is overdue for a mammogram the MA or nurse talks to the patient, enters the mammogram order, and helps the patient make the appointment. This discussion between the nurse or MA and the patient follows your practice's standing orders. In some settings care provided by established standing orders does not require physician signatures for each test. The training and licensure of the panel manager will determine their scope of practice.

Can you give an example of an in-reach approach to panel management?

A patient with a urinary tract infection visits the practice. During this visit, in addition to addressing the primary reason for the visit, the MA or nurse reviews the health maintenance screen and identifies any overdue immunizations or cancer screenings. The nurse or MA administers overdue immunizations and schedules the cancer screenings for the patient before s/he leaves the office. The training and licensure of the panel manager will determine their scope of practice.

We find it easier to check for preventive care gaps once a year at the annual wellness visit. Is this okay?

Yes. Some practices routinely manage preventive care gaps during annual comprehensive care visits and thus do not need to repeat this work at interval visits. By systematically addressing them at a dedicated visit, staff can close multiple care gaps during a single patient encounter, eliminating the need to contact the patient several times throughout the year. In these practices, in-reach at interval appointments is reserved for new patients and those patients who have missed their annual appointments.

My EHR does not have a health maintenance template. How can we use in-reach to manage care gaps for patients in our practice?

Prior to the patient's visit, your staff can review the patient's chart to identify care gaps and discuss them with the patient at the time of visit. Using a visit prep checklist will help the care team manually identify gaps and upcoming preventive care needs.

Out-reach

Out-reach is panel management for patients who rarely come to the office or who have fallen out of care. These patients still need preventive and/or chronic care and are identified by panel managers using the registry. The panel managers generate lists of patients with care gaps and then send mailings, email messages or place phone calls asking patients to come into the office to close these gaps. Some panel managers even make home visits to personally follow up with patients. Much of the communication can be done by sending computerized reminders to patients, and panel managers can follow up by phone with patients who do not respond. Out-reach is most effective when the staff person knows the patient they are contacting.

DOWNLOAD out-reach letter
DOWNLOAD out-reach phone call

AMA Pearls

Start small

Transitioning your practice mindset and approach from providing episodic care at appointments to a more proactive approach to managing your patients' health can seem daunting. Start with in-reach panel management and use complementary tactics to ease the transition. Complementary tactics such as pre-visit laboratory testing, pre-visit planning and expanded rooming can help you simplify your workflow and let you focus on providing more proactive care through an in-reach approach.

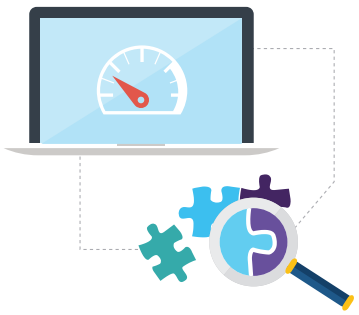
Once you and your team feel ready, start to think about developing your out-reach approach. Please see additional STEPS Forward educational modules for more information on tactics that complement panel management.

There is no "one size fits all" solution

One "best" way to approach panel management does not exist; different practices and organizations have succeeded with various approaches to both in-reach and out-reach. Some practices empower reception staff to schedule appointments if they see that the patient needs preventive care or is overdue for their lab testing based on their last HbA1c. Others have medical assistants or nurses who address care gaps or schedule upcoming preventive appointments during the rooming process. Some practices have care managers or health coaches contact patients when they have missed appointments or are overdue for preventive or chronic condition management. Assess your practice and your resources, and create a model that will work best for you and your patients.

Conclusion

Panel management can assist your practice in monitoring the preventive and chronic care needs of your patients. With the approaches and training resources provided in this module, you can close gaps in care to improve patient outcomes and the health of your patients.



STEPS in practice

1 How's it working in Green Bay, WI?

At Bellin Health System, Dr. James Jerzak is piloting a new team-based care model. His medical assistant, Jami, rooms his patients and prepares them for the visit. During the rooming process, Jami performs in-reach panel management. In diabetic and prediabetic patients, Jami assesses the patient's lab results to see how well the HbA1c is controlled. She also takes their blood pressure and is able to determine whether it appears to be under control. She reviews the patient's chart to see if there are any upcoming screenings that are due or will be due before the patient's next appointment. If the patient has upcoming or overdue care needs, Jami can see yellow and red flags in the EHR. If the patient needs a mammogram, colonoscopy or other preventive screen, she will schedule it for the patient during rooming. If the patient needs any immunizations, she will be able to provide it based on standing orders. Jami does a brief handoff to Dr. Jerzak, telling him why the patient came in for the appointment and any concerns related to blood pressure, lab results, diagnostics or hospitalizations since the last appointment. She stays in the room during the visit to document it for Dr. Jerzak, making notes of education to provide to the patient and prompting Dr. Jerzak to discuss the patient's high blood pressure reading that was uncovered during rooming.

Jami and Dr. Jerzak are not alone in using panel management to improve the health of their patients. Staff members who work in registration are empowered to use their "best practice alert" to notify patients of overdue tests or services and schedule necessary appointments when patients call for any reason. Bellin Health System plans to augment their out-reach approach as their team-based care model spreads throughout the organization.

2 How's it working in Minocqua, WI?

At the Marshfield Clinic Minocqua Center, Dr. Rick Fossen has been working with his nurse, Breanne, in a team care model. Breanne uses the EHR to identify chronic and preventive care needs that are either upcoming or overdue for the patient. For complex patients, she involves Leah, the unit coordinator, to assist with scheduling appointments and follow-up care.

To address out-reach panel management, all staff are trained to use an intervention list or "I-list" to identify "in-between health" needs of the practice's entire patient population, such as chronic and preventive services that patients need in-between visits. A team of clinical nurse specialists proactively monitor the I-list and reach out to patients to address any care gaps. The team of clinical nurse specialists also train clinic staff, such as nurses, medical assistants and unit coordinators, to effectively manage their I-lists based on their area's priorities. Nurses, medical

assistants and unit coordinators use their I-list to reach out to patients to address care gaps and schedule necessary appointments. The unit priorities are identified through localized practice councils, comprised of physicians, nurses, medical assistants, unit coordinators and clinical nurse specialists that report up to a quality improvement and patient safety committee.

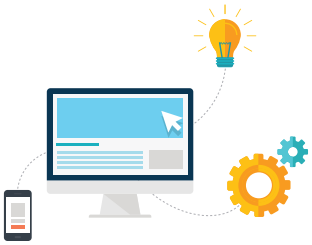
3 How's it working in Chicago, IL?

A 62-year-old man who had not been to the doctor in three years came to see Dr. Jeff Panzer at Erie Family Health Center. At the patient's first appointment, a medical assistant followed the practice's clinic protocol for in-reach panel management. By the fourth visit, the patient was diagnosed with diabetes, kidney disease, rheumatoid arthritis, gout and fatty liver. Dr. Panzer started the patient on several new medications and fast-tracked him into the care of a rheumatologist. All things considered, Dr. Panzer felt good about the care that he and his team were providing to the patient. Then, Dr. Panzer received the patient's abnormal stool test result. The patient had blood in his stool, and a subsequent colonoscopy revealed that he had colon cancer. Using the practice's standard clinical protocol and in-reach approach, the medical assistant was able to conduct this life-saving preventive care without Dr. Panzer having to order the test himself. Thanks to the medical assistant, the cancer was caught early, and the patient made a full recovery.

To demonstrate completion of this module and claim *AMA PRA Category 1 Credits*™, please visit:
www.stepsforward.org/PanelManagement

Get implementation support

The AMA is committed to helping you implement the solutions presented in this module. If you would like to learn about available resources for implementing the strategies presented in this module, please call us at (800) 987-1106 or click here to send a message to StepsForward@ama-assn.org



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