Panel Management

Provide Preventative Care and Improve Patient Health

AMA IN PARTNERSHIP WITH

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How will this module help me?

1. Identifies six steps to help implement panel management in your practice.
2. Provides answers to common questions and concerns you may have about panel management.
3. Shares examples, exercises, and quizzes to increase your team’s understanding of the need for preventive care.
Introduction

What is panel management?
Panel management, or population health management, is a proactive approach to ensuring that all patients whom a physician or practice is responsible for receive preventive care, not just those who come in for appointments. 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 screenings at the appropriate time intervals?” or, “Have all of our patients with diabetes had laboratory tests for HbA1c, cholesterol, and renal function at the appropriate times?” This approach leads to better health 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.

Develop a registry.

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

Qualified Clinical Data Registries (QCDRs) are a “Centers for Medicare & Medicaid Services-approved entity that collects clinical data on behalf of clinicians for data submission.” As of 2018, there were more than 140 QCDRs approved by CMS for physicians to use for reporting quality measures. More than 30 QCDRs are sponsored by a state or medical society that may offer their members use of the QCDR at no or very low cost beyond a setup fee.

(Please note that the number of QCDRs change annually.)
Q&A

How can I manage my patient panel if my practice does not have an EHR or a separate patient registry program?

You can manage your panel without an EHR or separate patient registry program by using common spreadsheet software to create a simple patient registry that monitors patient information. To create a patient registry that is unique to your practice, use billing data and chart data to identify a specific patient population or health condition that you would like to track. For example, search for patients by using ICD-10 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 identify patients in need of preventative care visits, and will help your practice effectively implement a panel management system to improve the health outcomes of your patients.

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). Prompts should be individualized and not appear for patients who are up to date.
- Remind physicians and staff to provide preventive care services to patients (e.g., immunizations).
- Help physicians and staff better manage patients with chronic conditions (e.g., HbA1c tests and eye exams for patients with diabetes).

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. Many practices use evidence-based national guidelines that are created and updated by specialty societies. If this is your first effort at panel management, start with a pilot project. It is important to choose an attainable clinical practice guideline agreed upon by all physicians within the practice. Celebrate success and lessons learned. Be sure to check if your practice has a dominant payor that requires use of their specific preventive and chronic care guidelines. Determine which targets your practice will set for each indicator.
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. The initial time investment will lead to better care for your patients and improved efficiency in your practice. Some practices may start by training a few key staff members, who then train their counterparts to adopt the new process throughout the practice.

Q&A

Our team members haven'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 module contains resources you can use for training purposes, including suggested scripts for practicing health coaching, discussion questions, and registry quizzes to test understanding of the data in a registry. Also included are teaching exercises for creating out-reach phone scripts, letters, and email templates that your team can use with patients.

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 module.
Teaching Exercise: Chronic Care Registry
Use this document to learn how to identify care gaps within a chronic care registry.

(MS WORD, 58 KB)

Teaching Exercise: Preventative Care Registry
Use this document to learn how to identify care gaps within a preventative care registry.

(MS WORD, 53 KB)

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

In-reach
In-reach is a panel management method for patients who are physically present in the office. In some practices, doing in-reach is protocol, 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, they are discussed with the patient and orders are queued up in the EHR for the physician to validate and submit.

Teaching Exercise: Having an In-Reach Discussion
Use this document to read in-reach discussions that your practice can use.

(MS WORD, 44 KB)

Out-reach
Out-reach is a panel management method 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 panel managers can identify them 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 follow up with patients personally. 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 care team knows the patient they are contacting.

Teaching Exercise: Writing an Out-Reach Letter
Use this template to create out-reach letters for the patients in your practice.

(MS WORD, 44 KB)

Teaching Exercise: Making an Out-Reach Phone Call
Use this script to learn how to make out-reach phone calls to patients in your practice.

(MS WORD, 45 KB)
Q&A

Can we use standing orders to increase efficiency?

Yes. For example, if a patient is overdue for a mammogram, the MA or nurse can talk to the patient, enter the mammogram order, and help the patient make the appointment. This discussion between the patient and nurse or MA 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, based on state law.

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

A patient with a urinary tract infection visits the practice. 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 during the visit, then arranges for these to be addressed before the patient leaves the office. The training and licensure of the panel manager will determine their scope of practice, based on state law.

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 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 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 care team can review the patient’s chart to identify care gaps and discuss them with the patient during the visit. Using pre-visit planning tools and checklists will help the care team manually identify gaps and upcoming preventive care needs.

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 outcomes and the health of your patients.
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, such as pre-visit laboratory testing, pre-visit planning, and expanded rooming, to help you simplify your workflow and let you focus on providing more proactive care. Once you and your team feel ready, start to think about developing your out-reach approach.

There is no "one size fits all" solution.

One “best” way to approach panel management does not exist; different practices and organizations succeed with various approaches to both in-reach and out-reach. Some practices empower reception staff to schedule appointments if they see that patients need preventive care or are overdue for their lab testing based on their last HbA1c. Others have MAs 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 miss 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.

STEPS in practice

1 Panel Management Case Report: Bellin Health System

At Bellin Health System, James Jerzak, MD, is piloting a new team-based care model. His team 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 determines 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 electronic health record. 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, Jami can provide them based on standing orders.

When Dr. Jerzak enters the examination room, Jami does a brief handoff, 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. Jami 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. Team members working in registration are empowered to use their “best practice alert” to notify patients of overdue tests or services, and to 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.

**Panel Management Case Report: Marshfield Clinic Minocqua Center**

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

To address out-reach panel management, all team members 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 other care team members at the clinic, such as nurses, medical assistants, and unit coordinators, to effectively manage their own I-lists based on their area’s priorities. Nurses, medical assistants, and unit coordinators use their I-lists 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 to a quality improvement and patient safety committee.

**Panel Management Case Report: Erie Family Health Center**

A 62-year-old man who had not been to the doctor in three years came to see Jeff Panzer, MD, 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 conducted 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.

**Learning Objectives**
1. Identify the benefits of using a panel management strategy
2. Use a health maintenance template to identify gaps in care
3. Describe how in-reach and out-reach panel management processes can help staff close gaps in care and anticipate upcoming care needs

**Article Information**

**AMA CME Accreditation Information**

**Credit Designation Statement:** The American Medical Association designates this enduring material activity for a maximum of .50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Target Audience:** This activity is designed to meet the educational needs of practicing physicians, practice administrators, and allied health professionals.

**Disclaimers:** Individuals below who are marked with an asterisk contributed towards Version 1 of this learning activity.

**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, quality improvement and informatics.

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Renewal Date: February 22, 2016; May 23, 2019

Glossary

panel management: The panel is 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.

Disclosure Statement:

Unless noted, all individuals in control of content reported no relevant financial relationships.

References