AMA | STEPSforward™

Panel Management

Use Patient Care Registries to Provide Comprehensive Preventive Care

Developed in partnership with SGIM Society of General Internal Medicine Creating Value for Patients and UCSF Department of Family & Community Medicine Center for Excellence in Primary Care

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How Will This Toolkit Help Me?

Learning Objectives:

1. Identify the benefits of using a panel management strategy
2. Demonstrate how to use a health maintenance template to identify gaps in care
3. Describe how in-reach and out-reach panel management processes can help your team close gaps in care and anticipate upcoming care needs

Introduction

What Is Panel Management?

A patient panel is the patient population of an 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.

Why Panel Management?

Panel management is a proactive approach to ensuring that *all* patients whom a physician or practice cares for—not just those who come in for appointments—receive preventive care. 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 HbA_{1c}, cholesterol, and renal function at the appropriate times?"* This approach leads to better health outcomes for your patient population.

Video 1.

Watch how Marshfield Clinic Achieved Panel Management

Population health management is used to identify opportunities for new policies and better patient care. Health care team members from the Minocqua Center and Bellin Health Center discuss the importance of conducting periodic reviews of clinical practices that will ensure patient needs are both met and anticipated. The overall goal is to manage visits and close the care gaps.

Six STEPS to Implement Panel Management

1. Develop a Registry
2. Choose which Clinical Practice Guidelines to Adopt

1

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, cervical cancer screening, colorectal cancer screening, immunizations, glycated hemoglobin A_{1c} (HbA_{1c}), cholesterol tests, or **diabetic** eye exams. You can also use the registry to identify patients who do not have specific values, such as HbA_{1c}, 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.

A Qualified Clinical Data Registry (QCDR) is a "Centers for Medicare & Medicaid Services-approved entity that collects clinical data on behalf of clinicians for data submission."[1] As of 2021, there were more than 140 QCDRs approved by the Centers for Medicare & Medicaid Services (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 very low or no cost beyond a setup fee. *(Please note that the number of QCDRs changes 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 using standard 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 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 (eg, for patients with diabetes, the date of the last eye exam and most recent HbA_{1c}). Use visual cues like color-coded cells to flag overdue laboratory tests or visits. Flagging will help you proactively identify patients in need of preventive care visits and help your practice effectively implement a panel management system to improve your patients' health outcomes.

2 Choose Which Clinical Practice Guidelines to Adopt

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. Be sure to check if your practice has a dominant payer that requires the use of their specific preventive and chronic care guidelines. Determine which targets your practice will set for each indicator.

3 Develop a Health Maintenance Template

Based on your chosen clinical practice guidelines, work with your organization's IT team to customize your EHR health maintenance functionality. Many EHRs have a health maintenance screen with a list of routine preventive and chronic care tests, such as mammograms, immunizations, and HbA_{1c} tests. Examples of EHR functions include:

- Prompts for physicians and other care team members to screen patients for diseases and recommended services based on their age, sex, diagnosis, etc. Prompts should be individualized and not appear for patients whose care is up to date.
- Reminders for physicians and other care team members to provide preventive care services (eg, immunizations) to patients.
- Reminders for screening in specific chronic conditions (eg, eye exams for patients with diabetes).

If your practice does not use an EHR or if your EHR does not have a health maintenance template, you can customize or create your own visit prep checklist that can serve some of the same functions. Incorporate the visit prep checklist and a review of the patient records into your team's pre-visit planning routine.

4 Select and Train Team Members to Serve as Panel Managers

Train nurses, medical assistants (MAs), and/or the reception team 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 team members, who then train their counterparts, facilitating adoption of the new process throughout the practice.

This toolkit 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. Click on this page's Resources tab to access all of this toolkit's downloadable tools in one place.

Q&A

How should panel managers be chosen?

Start with team 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 team saying, "These are the doctor's patients," but instead saying, "These are *our* 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 HbA_{1c} greater than the recommended target (known as an outcome care gap). Your team can use select indicators to identify care gaps from the registry or from the EHR health maintenance screen. These resources below can help you teach your team how to identify these gaps.

Example Chronic Care Registry Report
Use this document to learn how to identify care gaps within a chronic care registry.
(MS WORD, 50 KB)

Example Preventive Care Registry Report
Use this document to learn how to identify care gaps within a preventive care registry.
(MS WORD, 45 KB)

Care Gap Checklist
This document can help you keep track of preventive care screenings and vaccinations your practice is monitoring. *Clinical guidelines change frequently. Consult your practice's clinical guidelines and procedures then update this download accordingly before using.
(MS WORD, 49 KB)

6 Close Care Gaps Through In-Reach and Out-Reach Methods

In-Reach

In-reach is a panel management method for patients who are physically present in the office.

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 appointment, the team 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, new patients and those patients who are overdue for their annual appointments are scheduled for an additional wellness visit as part of in-reach efforts to close care gaps.

In other practices, in-reach is part of appointment protocol, regardless of the reason for the visit. During visit preparation or at the time of patient rooming, the nurse or medical assistant reviews the EHR health maintenance screen. If care gaps are identified, the team member discusses these with the patient and queues up the appropriate orders in the EHR for the physician to validate and submit. For example, a patient with a urinary tract infection visits the practice. In addition to addressing the primary reason for the visit, the medical assistant 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 panel manager's training and licensure will determine their scope of practice, based on state law.

Teaching Exercise: Having an In-Reach Discussion
Use this document to read in-reach discussions that your practice can use.
(MS WORD, 43 KB)

Out-Reach

Out-reach is a panel management method for patients who rarely come to the office or have fallen out of care. These patients still need preventive and chronic care, and panel managers can identify them using the registry. The panel managers generate lists of patients with care gaps and then contact the patients by mail, email, or phone to ask them to come into the office to close these gaps. Some panel managers even make home visits to follow up with patients personally. Panel managers can automate much of the initial communication by sending computerized reminders to patients, then follow up by phone with any patients who do not respond to the initial communication. 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, 45 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, 46 KB)

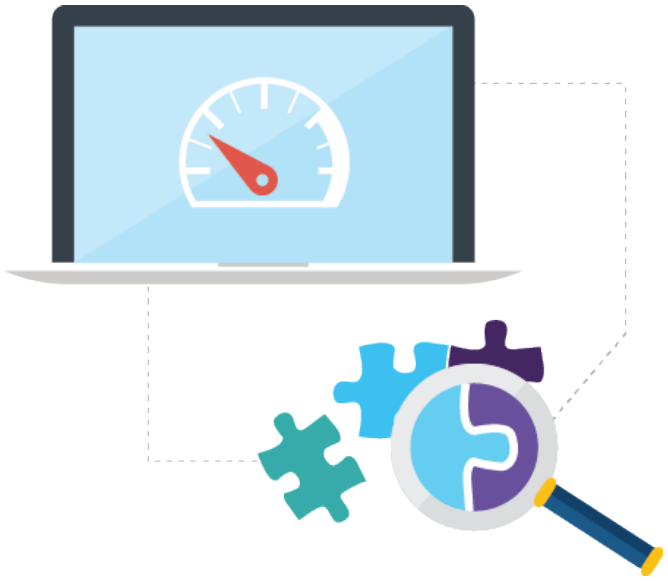
Q&A

Can we use standing orders to increase efficiency?

Yes. For example, if a patient is overdue for a mammogram, the medical assistant or nurse can talk to the patient, pend the mammogram order, and help the patient make the appointment. This discussion between the patient and nurse or medical assistant follows your practice's standing orders. In some settings, care provided by established standing orders does not require physician signatures for each test. The panel manager's training and licensure will determine their scope of practice, based on state law.

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

Before 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 toolkit, you can close gaps in care to improve outcomes and the health of your patients.

AMA Pearls

Start small.

It can see daunting to transition your practice mindset and approach from providing episodic care at appointments to a more proactive approach to managing your patients' health. 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 their reception team 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 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 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.

Further Reading

Journal Articles and Other Publications

- Ortiz DD. Using a simple patient registry to improve your chronic disease care. *Fam Pract Manag.* 2006;13(4):47-52. http://www.aafp.org/fpm/2006/0400/p47.html
- Savarimuthu SM, Jensen AE, Schoenthaler, A. et al. Developing a toolkit for panel management: improving hypertension and smoking cessation outcomes in primary care at the VA. *BMC Fam Pract*, 176 14 (2013). doi:10.1186/1471-2296-14-176
- Paige NM, Apaydin EA, Goldhaber-Fiebert JD, et al. What Is the optimal primary care panel size?: a systematic review. *Ann Intern Med*. 2020;172(3):195-201. doi:10.7326/M19-2491
- Sinsky CA, Brown MT. Optimal panel size: are we asking the right question? *Ann Intern Med*. 2020;172(3):216-217. doi:10.7326/M19-3673

Websites

- Practice facilitation handbook: Module 20. Facilitating panel management. Agency for Healthcare Research and Quality. Reviewed December 2018. Accessed February 18, 2021. https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod20.html
- Panel management processes: tracking patients with complex needs. Patient Centered Primary Care Institute. March 15, 2016. Accessed February 18, 2021. http://www.pcpci.org/resources/webinars/panel-management-processes-tracking-patients-complex-needs
- Panel management. UCSF Center for Excellence in Primary Care. 2013. Accessed February 18, 2021. https://cepc.ucsf.edu/panel-management

Article Information

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References:

1. Robeznieks A. Use a Qualified Clinical Data Registry to boost Medicare bonus. American Medical Association. July 26, 2018. Accessed February 18, 2021. https://www.ama-assn.org/practice-management/payment-delivery-models/use-qualified-clinical-data-registry-boost-medicare
2. Lawrence RS. Encyclopedia of public health: health maintenance. Encyclopedia.com. Accessed March 2, 2021. https://www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/health-maintenance