ALAMEDA COUNTY SAFETY NET PANEL MANAGEMENT: TEAM CARE IN ACTION

Alameda County Safety Net Providers: Alameda County Medical Center and Alameda Health Consortium Clinics

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PANEL MANAGEMENT STANDARDS

AREAS OF REVIEW

I. PURPOSE OF STANDARDS

Panel management has been adopted by the organizations participating in the Alameda County Excellence (ACE)[1] program as a strategy for improving outcomes for people with chronic disease. This set of standards has been developed to document our common understanding of what the core and optional elements are that make up a panel management program. They are the result of a review of published literature, and input from the ACE Quality Improvement Workgroup[2] and the ACE Clinical Implementation Committee[3]. This document is intended to provide guidance for the Alameda County panel management programs to become the most effective they can be.

II. DEFINITION OF SERVICES

Panel management is an organized, population-based, data driven multidisciplinary team approach, in which a primary care team jointly plans and manages the care of clients with chronic disease, using a disease registry to identify clients' unmet care needs, to gather summary information for care interventions, and to communicate with clients. A disease registry to ensure that the entire patient population receives support as needed for disease care is the key element. Data analysis to guide strategies to improve care is conducted frequently during protected provider time with support staff. Additional **optional** elements include health coaching, use of physician-created standing orders for common problems, and active outreach and community involvement. Panel management can also optimize the use of non- provider staff in order to increase efficiency and improve staff relationships. When feasible, panel management allows clinical providers to advise support staff and share responsibility for care. **Panel management is not the job of one staff member; rather, it is a set of coordinated tasks performed by a whole team or program. This standard describes the core and optional components of panel management; the duties may be distributed in a variety of ways across the team.**

Key activities: (1) Maintain a chronic disease registry and reviews the panel at regular intervals; (2) Target clients for interventions based on selection criteria; (3) Conduct "messenger activities" regarding appointments, health maintenance, labs etc.; (4) Arrange and tracks referrals; (5) Communicate with primary care provider and other team members; (6) Follow up on primary care provider instructions;

[1] Alameda County Excellence (ACE) is the Coverage Initiative Program in Alameda County.
[2] The ACE Quality Improvement Workgroup is comprised of line staff (primarily panel managers, nurse managers, and quality improvement staff from the Alameda County CMSP/ACE network.
[3] The ACE Clinical Implementation Committee is comprised of medical directors and administrative leadership of participating organizations: Alameda County Medical Center, Asian Health Services, Axis Community Health, La Clinica de la Raza, LifeLong Medical Care, Native American Health Center, Tiburcio Vasquez Health Center, Tri-City Health Center, West Oakland Health Council, Community Health Center Network, Alameda County Health Care Services Agency and Alameda County Public Health Department.

and, (7) provide medication reconciliation. Other activities may include client self-management support (health coaching) and plan development, and outreach.

III. GOAL OF SERVICE

The goal of a panel management program is to improve the performance of predictable interventions, minimize declining health and ensure that all tasks related to preventive and chronic care (subject to client preference) are conducted in a timely manner. Panel management can prevent avoidable acute medical crises in individuals with chronic disease by reducing the number of clients who fall out of care and by reaching out to those clients whose chronic needs might not be systematically addressed. Panel management creates improved efficiency by allowing clinical providers to guide support staff as they carry out those tasks which can effectively be performed by non-licensed clinical team members.

IV. PANEL MANAGEMENT SERVICE DESCRIPTION

CORE Standards (1-10) Panel Management Activities

Panel management is not the job of one staff member; it is a set of coordinated tasks performed by a whole team or program. Panel management activities may be conducted by a wide range of team members, including enrollment workers, clerical staff, medical assistants, registered dieticians, chronic care specialists, health educators, pharmacists, nurses, primary care providers, social workers, case managers and others.

Each agency should provide or allow staff to attend necessary training and continuing education for panel management; trainings **may** include the following topics:

- Basic knowledge of chronic disease, with a focus on diabetes and hypertension
- Messenger and coaching skills
- Disease registry management
- Working with the community
- Use of data for improvement
- Quality improvement processes
- Relevant chronic disease updates
- Chronic care model implementation
- Team care
- Cultural competency

STANDARD	MEASURE
1. Staff maintains a chronic disease registry and reviews the panel at regular intervals. The registry is systematically and repeatedly reviewed to ensure that all tasks related to preventive and chronic care (subject to patient preference) are performed.[4]	1. i2i Tracks or other disease registry in operation.
2. Staff targets clients for interventions based on selection criteria.	2. Selection criteria documented at site.
3. Staff conducts "messenger activities" regarding appointments, health maintenance, labs etc. This includes active reminders, follow-ups, and encouragement to get existing clients to participate in care.	3. List of activities conducted.

[4] Bodenheimer, Thomas, N Engl J Med 359;20, www.nejm.org, Nov. 13, 2008.

STANDARD	MEASURE
4. Staff arranges and tracks referrals.	4. Evidence that referral appointments are made.
5. Staff communicates with primary care provider and other team members.	5. Evidence of protected time with a primary care provider and panel management staff.
6. Staff follows up on primary care provider instructions.	6. Documentation in client record on follow-up activities.
7. Staff regularly verify the client's most current list of medications and reconcile with the primary care provider's current orders.	7. Documentation of medication reconciliation in client record.
8. All staff with panel management responsibilities must have a written job description detailing their role and responsibilities with regard to panel management. Staff meets the minimum requirements detailed in the agency job description, including license if applicable.	8. Written job descriptions.
9. All panel management staff must be provided an opportunity to increase their knowledge, skills and abilities regarding the Chronic Care Model and quality improvement.	9. Staff trained in guidelines, standards of care and panel management activities. List of trainings attended by panel management staff. Participation in a continuous skill-oriented interactive training program or workgroup.
10. Supervision of the panel management staff is provided by an individual with appropriate clinical and supervisory experience at a minimum of once a month.	10. A sample of client's record/registry is reviewed by a supervisor of the panel management program at least annually to evaluate the staff's ability to manage the panel and identify strategies to improve care. Supervisor's résumé and annual review on record.

Other Panel Management Activities (optional): (Standards 11-16)

STANDARD	MEASURE
11. Staff encourage clients to access a range of healthcare services.	11. System in place to access relevant specialty services.
12. Staff assist clients to develop and implement a personal action plan that includes behavior changes with regard to diet and exercise, based on client goals.	12. Client goals and action plans documented; evidence of review of plan with client at each clinic visit.
13. Staff provide ongoing self-management education and/or referral to a support group.	13. Documentation of activities that are made available to clients.
14. Staff meet with primary care provider for case conference at least once a month to discuss panel activities and client needs.	14. Documentation of case conference.
15. Staff are trained to use standing orders for common problems such as high A1c.	15. Written standing orders that are in use are available for review. There is evidence that staff are trained and monitored in the use of standing orders.
16. Conducts outreach to new clients.	16. Description of outreach activities.

V. OUTCOMES OF SERVICE

Outcomes are benefits or other results (positive or negative) for clients or systems that may occur during or after their participation in a program. An indicator is a measure used to determine, over time, an organization's performance of a particular element of care. The indicator may measure a particular function, process or outcome. An indicator can measure: accessibility, continuity, effectiveness, efficacy, efficiency, and client satisfaction. Data collected should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.

The following indicators are recommended for Panel Management Services in order to measure the implementation of panel management services system-wide:

- Increase in the implementation of the core panel management activities.
- Number of panel management staff that attend trainings on the basics of the Chronic Care Model and quality improvement activities.
- Increase in the number of clients at target for approved ACE clinical measures.

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