

Best Practices for Effective Panel Management Meetings

Purpose: Guidance on how to effectively prepare, facilitate, and follow-up from Team-Based Panel Management Meetings

Before the Meeting

- Clinic Manager blocks time for PCP, Panel Manager, and other invitees to attend one-hour meeting, once per month
- Panel Manager runs “Patients on <X> Provider’s Panel” Report in advance of meetings, with filters selected to narrow panel to clinical areas for discussion
 - For 2020 implementation, Panel Manager runs “PCP Diabetes Panel” report for the PCP and “Saves As”/Favorites prior to meeting
- Panel Manager receives and reviews monthly list of “Due for AWV” patients and flags cases for discussion
 - Prioritize patients whose last AWV was **>10 months ago**, or who have **never had an AWV**

During the Meeting

- All required invitees attend meeting and arrive on time
- Room is configured so that all attendees can view a shared screen with prepared panel reports pulled up at start of meeting
- Panel Management meeting focus area will be consistent across UWM Primary Care.
 - For 2020, meetings will focus on Diabetes Care Gaps and Medicare Advantage Annual Wellness Visits
- Panel Manager facilitates review of PCP Diabetes Panel (or other clinical area chosen for discussion). PCP, RD, RN, or other clinician attendees comment on case and make recommendations for follow-up.
 - See “Maximizing Use of Diabetes Panel” tips below
- Panel Manager documents high level points of discussion and recommended next steps in a Telephone Encounter using .PANELMANAGEMENTMTG and routes to identified staff for follow-up
 - Documentation Guidelines:
 - If there is individual review of a specific patient and clinic decision-making involving provider, please document in Epic.
 - If there is batch review of a group of patients, ex: “Send eCare/Letter to all patients with a “No” in *Retinal Exam Complete?* column asking them

to come in for a visit” -- then no TE documentation is required. The letter/eCare will serve as documentation that this action occurred.

- If Panel Manager does not have time to complete documentation during the meeting, notes can be taken during meeting and Epic documentation can be done after the meeting
- Examples of actionable follow-up items from panel management case review include:
 - Schedule patient for Follow-up Visit (with PCP, Flex APP, ARNP, or RN)
 - PCP to provide feedback on how to best engage specific patients in follow-up care
 - Schedule patient for Staff Visit
 - Contact patient and ask them to come into the Lab to complete overdue lab work
 - Send eCare or mail a Letter reminding patient of upcoming health maintenance item due
 - Consult with Diabetes Care Center (endocrinologist)
 - Refer to Nutrition Counseling or Diabetes Education Classes (RD)
 - Refer to Chronic Care Management (RN)
 - Refer to Behavioral Health Integration Program (BHIP)
 - Provide resources to patient related to food insecurity, travel, or other as related to patient’s care gaps
 - Remove patient from PCP panel (if it is known that the patient is no longer receiving care in the local clinic)
- Panel Manager acts as timekeeper during meeting, ensuring that both Diabetes Care Gaps and high priority patients on “Due for AWV” list is reviewed with PCP during the meeting

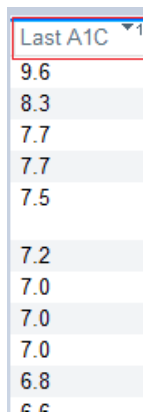
After the Meeting

- Panel Manager documents high level points of discussion and recommended next steps in a Telephone Encounter using .PANELMANAGEMENTMTG and routes to identified staff for follow-up
 - This can also be done during the panel management meeting
- Clinic staff assigned follow-up items (i.e. PSR, MA, RN, RD, Health Navigator) outreach to patients as requested.
 - Respond to Panel Manager with outcome of patient outreach.
- PCP/MA:
 - Follows up with patients in-clinic to complete action items identified during meeting, engage patient in ongoing care, and closing gaps in clinic as appropriate.

- Daily huddle to look at Health Maintenance due for scheduled patients and adopt an “every patient, every time” approach to closing care gaps when patient is already in the clinic
- For 2020, prioritize closing Diabetes Care Gaps for diabetic patients.
- UWNC Lab staff checks for Microalbumin and A1C value in the last 6 months, whenever patient is in lab for a different reason

Maximizing Use of Diabetes Panel Report in Panel Management Meetings

- Click on any Column Name to display the values ascending or descending, and sort the rest of the report according to that column



Ways to sort Report to maximize discussion and action planning in Panel Management Meeting:

- **Sort by Last A1C Value** to organize patients from highest to lowest recent A1C score
 - Make a plan with PCP for how to address patients with high A1C scores or what type of visit to schedule for those overdue for A1C lab
 - Consider Referral to Nutrition or Referral to Diabetes Education for patients with high A1C values. If RD is attending panel management meeting, seek their guidance about what makes most sense for each patient.
- **Sort by Last Date of Microalbumin** and create list of patients who have not had lab in >1 year; make plan to schedule for lab visit
- **Sort by Retinal Exam Met/Not Met** and make list of patients who can be outreached to come in to clinic for a retinal camera exam
- **Sort by “Next Appointment With PCP:** For all patients with a PCP scheduled in the next 2 weeks, updated Appointment Notes to indicate which diabetes gaps can be closed or discussed at the upcoming visit.

Note: The data on this report may have a 1-2 week lag. For example, the “Last Appointment Date” column may not reflect visits in the past 7-14 days. To validate data on this report you can click on the patient’s name/row to open the full patient chart for review.