Panel Management Toolkit Recommendations

Purpose: To develop a standard approach to panel management (PM) across UW Primary Care clinics, with current resources. We aim to improve panel outcomes during an "interim period", before there is a standardized staffing model across all primary care clinics. During the interim period, we have chosen to focus on AWVs and diabetes as the first clinical areas in which to excel in PM.

General Panel Management

- **Empanelment & Panel Maintenance**
  - ☐ Clinics focus on empaneling all patients who come in to clinic for visits by consistently. PSRs and clinic staff ask patients about this and update Gen PCP field at each visit.
  - ☐ Population Health focus on unempaneled patients – encouraging engagement and empanelment
  - ☐ Clinic leadership follows standardized workflows to reassign all patients empaneled with departing providers
  - ☐ Other:

- **Panel Management**
  - ☐ New: Monthly PCP Panel Management meetings to review current panel care gaps & due for AWV
  - ☐ New: Regular review of Panel Management practices and metrics at PCP meetings
  - ☐ Train all new providers on Panel Management as a key component of UWM Primary Care
  - ☐ MA Forecasting for AWVs and closing Health Maintenance care gaps at upcoming visits
  - ☐ Daily PCP/MA huddles – including specific planning for how to close care gaps that day in visits
  - ☐ Train providers to habitually close gaps while patients are in clinic for other reasons
  - ☐ Other:

Annual Wellness Visits (AWVs)

- ☐ Designated clinic staff member follows up on "due for AWV" lists from HBI (distributed weekly by PHM)
- ☐ Train MAs to forecast opportunities to convert upcoming visits to AWVs (add on to E/M), and train on how to do this correctly to be recognized by PSR, PCP, and billing departments
- ☐ New: PHM includes GIMC and/or Harborview in monthly distribution of due for AWV lists
- ☐ New: Text alerts using ZipWhip when due for AWVs
- ☐ New: Caravan model will guide us in using RNs to furnish AWVs and bundle problem visits with AWV
- ☐ New: Schedule next year's AWVs by birthday month, for those eligible for AWV once per calendar year
- ☐ Other:

Diabetes

- ☐ New: Create customized Panel reports of Diabetes Care Gaps (A1C, Micro albumin, Statin, Foot Exam, Eye Exam, BP) and review at monthly PM meetings
- ☐ New: Use of RN CMs to call patients, follow-up on diabetes care gaps in a Diabetes RN visit, provide clinical education, and/or prompt visits with PCPs

Panel Management Toolkit Recommendations

- ☐ New: Create an AVS SmartPhrase for diabetic patients outlining annual frequency of diabetes gaps and clinical education around their role in following up on all of these.
- ☐ New: Pre-visits at the Lab to have diabetes testing done, in advance of a PCP visit to review results
- ☐ New: Develop A1C Lab Protocol – this would be a standing order for A1C at the lab, if patient is due
- ☐ New: Increase involvement of RDs in diabetes panel management
- ☐ New: Encourage provides to adopt an "Every patient, every time" approach to closing diabetes care gaps and/or making a follow-up visit to do so, whenever diabetic patients come in to the clinic
- ☐ Other: _____

Entity Name: _____

Panel Management Lead(s): _____

Date: _____