Team-Based Panel Management Roles & Responsibilities

Roles of the Panel Manager

- Point person in-clinic for questions related to panel management workflows, best practices, reports, and documentation
    - Train other support staff on running panel reports, as needed
- Before Panel Management Meetings
    - Work with clinic manager to ensure all team members are available to attend
    - Prepare report(s) to organize panel management meetings
        - For Diabetes focus, see Job Aid for running "Diabetes Panel Report" in Epic
        - For AWV focus, see "Due for AWV" list sent by Pop Health. Sort by PCP and due date.
        - For other focus, Run "Patients on <X> Provider's Panel" Epic report and set custom filters
- During Panel Management Meetings
    - Decide meeting priorities
    - Time-keeper during meeting to ensure diabetes panel & AWV patients (i.e. those who are difficult to schedule) are reviewed with PCP and team
    - Document meeting discussion and all clinical decisions
    - Create a Telephone Encounter for each patient reviewed
    - Use .PANELMANAGEMENTMTG to document decisions, action items, and roles
- After Panel Management Meetings
    - Route Panel Management note to staff responsible for follow-up (MA, PSR, RD, RN, PCP, HN)
    - Clinic Managers are asked to work with Panel Manger to allow time for documentation after each meeting

Roles of the Clinic Chief

- Champion process of team-based panel management and encourage use of standardized workflows and tools
- Announce roll-out of new panel management practices and UW Medicine Primary Care priority focus areas, beginning April 2020
    - Diabetes Care Gaps
- Medicare Advantage AWVs
- Review quality and gap closure data with individual providers, on a monthly basis
- Ensures PCPs participate in panel management meetings and activities

Roles of the Clinic Manager

- Coordinate scheduling of monthly panel management meetings and blocking schedules of attendees at the designated time
- Reinforce panel management activities as an expected job duty for involved clinic staff
- Pull and share monthly quality data, by clinic and provider level. Review regularly with Clinic Chief and share with back office staff.

- Ensure Panel Manage role has sufficient dedicated time for panel management tasks (i.e. meeting prep, documentation, and tracking follow-up items)
- Ensure Clinic Lab is following new lab protocols for Diabetes Care Gaps

Roles of the Primary Care Provider (PCP)

- Champion team-based panel management within the clinic
  - This enables the team to best support the PCP and the patients on their panel
  - Work with clinic team on empanelment and panel maintenance to ensure that panel is up-to-date
  - Daily huddle with MA to review forecasting how to close care gaps in clinic that day
  - Extra emphasis on Diabetes Gaps (A1C, BP, Microalbumin, Retinal Exam) in 2020
- "Manage up" other members of the care team and encourage patients to engage with team-based care services
- During Panel Management Meeting:
  - Attend all panel management meetings as scheduled
  - Provide team with clinical guidance on what follow-up action(s) is best suited to the particular patient
  - Offer feedback on how to best engage specific patients on panel
- After the Panel Management meeting:
  - Follow-up on closing care gaps as discussed when patient comes in to clinic for follow-up
    - Example: if patient is brought up for Diabetes visit with PCP, follow plan to prescribe insulin and place Referral to Nutrition Counseling
  - Partner with patients to identify barriers to gap closure, and inform care team of patient's particular needs (i.e. transportation, anxiety)

Roles of other Team Members

- Registered Dietician (RD)
  - Give input on treatment plan for diabetic patients
  - Recommended referral to Nutrition Counseling and/or Diabetes Education classes
- Registered Nurse (RN)
  - Give input on treatment plan for diabetic patients
  - Recommend for Chronic Care Management or RN Diabetes Management
- Social Worker (SW)
  - Give input on treatment plan for behavioral health patients
  - Recommend community resources to support complex patients
  - Recommend Referral to BHIP or Referral to Social Work as indicated