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

Roles of the Primary Care Provider (PCP)
o Champion team-based panel management within the clinic
  o This enables the team to best support the PCP and the patients on their panel
  o Work with clinic team on empanelment and panel maintenance to ensure that panel is up-to-date
  o Daily huddle with MA to review forecasting how to close care gaps in clinic that day
  o Extra emphasis on Diabetes Gaps (A1C, BP, Microalbumin, Retinal Exam) in 2020
o “Manage up” other members of the care team and encourage patients to engage with team-based care services
o During Panel Management Meeting:
  o Attend all panel management meetings as scheduled
  o Provide team with clinical guidance on what follow-up action(s) is best suited to the particular patient
  o Offer feedback on how to best engage specific patients on panel
o After the Panel Management meeting:
  o 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
  o 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
o Registered Dietician (RD)
  o Give input on treatment plan for diabetic patients
  o Recommended referral to Nutrition Counseling and/or Diabetes Education classes
o Registered Nurse (RN)
  o Give input on treatment plan for diabetic patients
  o Recommend for Chronic Care Management or RN Diabetes Management
o Social Worker (SW)
  o Give input on treatment plan for behavioral health patients
  o Recommend community resources to support complex patients
  o Recommend Referral to BHIP or Referral to Social Work as indicated