Improving Patient Care through Panel Management

Jenna Corneille, MSW, LICSW
Don Grabowski

THE HEALTH CENTER

HEALTH CARE THE WAY IT OUGHT TO BE

History

The Health Center has been the only health care practice serving a rural six town area in Central Vermont since 1973

- Cabot - Marshfield
- Calais - Plainfield
- East Montpelier - Woodbury

We also serve the area surrounding these six towns

The Health Center became a Federally Qualified Health Center (FQHC) in 2007

Medical Services

All of our services are provided from
birth through end-of-life care

- 4 Physicians, 4 Physician Assistants, Registered Dietician/Certified Diabetes Educator, Community Resources (Social Work, Outreach, Panel Management, VCCI)
- We admit and manage our patients' inpatient care at the Central Vermont Medical Center
- We provide 2,750 visits each month
- 240 annual admissions to the hospital
- 30 nursing home patients

Other Services

- **Dental** – 14 operatories providing dental, hygiene and oral surgery, 2 operatories in the dental van

  Behavioral Health – 1 behavioral neurologist, 2 psychiatrists, 5 counselors/therapists

- **Community Resources** – benefits support, health insurance support, health and wellness coordinator, care coordination

- **Lab** – In-house and refer labs

- **340B Pharmacy** – in-house and by mail

- **Physical Therapy** – In-house

Community Resources

Patient assistance including:

- Applying for health insurance
- Housing Issues
- Referral for legal assistance
- Safe Sex Education
- Migrant Farm workers support
- Transportation
- Liaison with external supports
- Referral for financial counseling
- Educational system navigation
- Telemedicine support
- Assess and address barriers to care
- Non-clinical controlled substance support
- Vermont Chronic Care Initiative imbedded RN Care Manager

- Food insecurity
- Worker's Comp application
- Family issues
- Applying for benefits
- Interpreters
- Paying for medication
- Anonymous HIV Testing
- Patient advocacy
- Literacy assistance

Quality Improvement Committee

A Multidisciplinary team that meets weekly to identify, plan and implement Quality Improvement activities based on patient needs, clinic needs, UDS, PCMH and Meaningful Use

Patient Centered Medical Home

- **Imbedded Care Coordination by an MSW/LICSW - CHT**
  - Panel Management
  - ER use follow-up
  - Hospital discharge follow-up
  - Express Care use follow-up
  - Care Coordination
  - Smoking Cessation
  - Health Coaching
  - Assess and address barriers to care

- **Imbedded Vermont Chronic Care Initiative (VCCI) Support**

- **2 Community Resource Outreach Staff**
  - Insurance applications
  - Advance Directives
  - Benefits assistance navigation
  - Assess and address barriers to care

Panel Management Players

- Quality Improvement Committee meets weekly to discuss panel opportunities and track performance of active panels
- Committee is supported by Blueprint Practice Facilitator twice a month
- Committee is supported by VITL Meaningful Use staff
- Committee includes clinical staff, IT staff, CHT, COO (responsible for organization's quality program), non-clinical support staff, Community Resources

How a Panel is Developed

The Quality Improvement Committee brainstorms panels based on:

- UDS, PCMH and MU needs
- Clinician recommendation
- Areas of interest to staff
- Areas identified as needing improvement
- Public health needs
- Clarifying a perceived clinical assumption

How a Panel is Developed

The committee identifies panels which they believe may benefit from outreach, then it is discussed with provider staff for input and buy-in regarding:

- The usefulness of the Panel
- Outreach Activities
- Evidence-based Services Needed
- Desired Outcomes
- Appropriate Metrics

Panel Activities

Once provider staff provides their input, the committee will then:

- Run test panel reports to do a preliminary assessment of the data quality
- "Clean" the data if necessary – death, transferred care, etc.
- "Fix" the Electronic Health Record if necessary – update templates, data-mapping, etc.
- Train staff if a documentation issue is identified
- Determine outreach activities
- Determine panel schedule
- Advise staff within the organization who may be affected

Panel Activities

- Outreach calls
- Outreach letters
- Chart flags
- Provider awareness
- Staff training – administrative and clinical
- Provider consensus-building regarding our standards of care based on evidence based guidelines
- Tighter scheduling protocol – “No one leaves without their next appointment scheduled”

Communication With Patients

- Periodic newsletter – printed and emailed
- Electronic – email, Front Porch Forum - announcements, classes, etc.
- Mailings – panels, general information, etc.
- Classes – self-management, illness specific- such as diabetes series, migraine, cooking, advance directives
- Groups
  - Diabetes
  - Tai Chi
  - Men's Health
  - Meditation
  - Didgeridoo for Sleep Apnea
  - Boot Camp
- Web-based Mindfulness App

Panel Oversight

Periodically review "Panel Dashboards" at Quality Improvement Meeting. Monthly report:

	Jan	Feb
DM A1c >9; scheduled as recommended	x	x
# contacted	2	3
# scheduled		2
# up to date/total	18/26	26/35
% up to date - at beginning of running panel	69	74
# off the list	1	2
# new to the list	0	3
DM No visit 6m	x	x
# contacted	4	8
# scheduled	1	3
# up to date	474/498	457/486
% up to date	95	94
DM denom	498	486

Panel Oversight

Periodically review "Panel Dashboards" at Quality Improvement Meeting. Quarterly report:

Panel	Q2 2014	Q3 2014
DM No A1c 6m		x Sept
# contacted		44
# on panel		73
# scheduled		13
Kid Lead	x	x
# contacted	1	2
# up to date	23/25	25/28
% up to date	92	89

Panel Management Challenges

- EHR data quality
  - Data entry issues
  - Mapping issues
  - Data management issues
  - Issues with ease of reporting
  - Information from external sources – unknown or not searchable

- Demand outstrips supplies – capacity issues
  - Vaccines – limited by number available
  - Scheduling – enough appointments available to meet the needs of the outreach activity?

- Patients who do not follow-up regardless of outreach

Panel Management Challenges

- Progress is slow! It takes time to significantly impact chronic condition outcomes
- Coordination of the differing needs of UDS reporting, PCMH and MU
- Patients who come in due to an outreach and do not receive the full outreach service
- Patients who leave without a follow-up appointment scheduled
- Program development and provider buy-in

Panel Outcome Examples

- Significant improvements in:
  - Zosta vaccination rate
    - November 2013 – 203 needed
    - March 2014 – reduced to 163
  - Gardasil completed series
    - Girls - 71% vs. the national average of 38%
    - Boy – 60% vs. the national average of 14%
  - Cervical cancer screening rates
    - 2012 – 74%
    - 2013 – 82%
  - People with diabetes who have an A1C >9
    - April 2014 – 42
    - September 2014 - 34

What We Learned

- Work that is done is not always documented properly so the data cannot be tracked and credited towards our clinical outcomes
- Patient feedback regarding outreach is mostly positive
- Providers were slow to embrace to concept of panel management until they recognized the usefulness of this work
- Patients can benefit from non-provider support
- Imbedded CHT model has been our key to success

Results We Believe Our Efforts Impacted

- Low Emergency Room use
- Low use of Specialists
- High % of generic drug use
- Low use of imaging
- Low rate of hospital admissions and readmissions
- Lower ***total*** healthcare system cost per patient
- High rate of patient satisfaction