



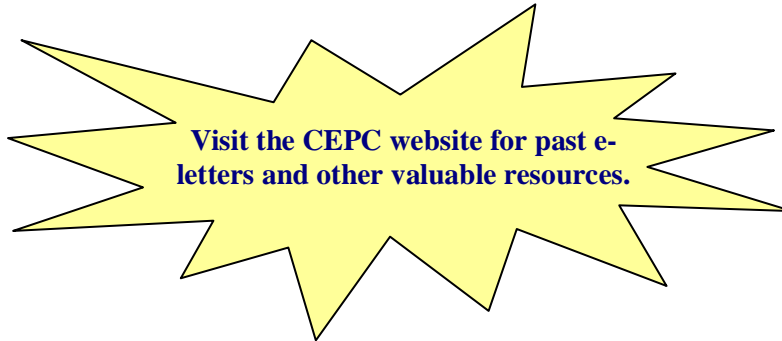
*A collaboration between the Department of Family and
Community Medicine, University of California, San Francisco,
and
The Permanente Medical Group*

Primary Care e-Letter

February 2008, Issue 15

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Panel management: a powerful tool to improve primary care

A visit to Kaiser/Permanente's Richmond, California facility

In 2002, Kaiser/Permanente's Richmond facility (KP/Richmond) had the poorest diabetes and cardiovascular care quality measures in the Northern California region. Many KP/Richmond patients are economically disadvantaged. Yet by 2004, the Richmond facility's diabetes and cardiovascular measures were among the highest in the region. How did KP/Richmond do it?

The answer is: panel management.

In January 2008, a group from San Francisco General Hospital visited KP/Richmond and learned how the facility initiated panel management, a primary care innovation that has spread to the entire Kaiser/Permanente Northern California region.

In 2002, KP/Richmond had a great deal of clinical data through the chronic conditions registry. But the data was not being effectively utilized to assist physicians in caring for patients. Panel management means the *systematic* and *repetitive* review of the *entire* population of patients with particular chronic conditions. At KP/Richmond, panel management was instituted specifically for patients with diabetes and cardiovascular disease.

To periodically review the 7,000 patients with these conditions, KP/Richmond created a new type of caregiver – the Panel Management Assistant (PMA). Each of the 4 PMAs is linked with 8-9 physicians. From the registry, PMAs print out 10 laboratory and medication data on 10 individual patients; these data sheets are called “tools.” Each physician is given 15 minutes of protected time twice

a week to review 10 tools (thus each physician reviews the status of 20 diabetes/cardiovascular patients each week). The physician writes on the tool what they want done for the patient, and when they want to review the patient again. The PMAs implement these physician orders. The process is analogous to a hospital physician writing orders for an in-patient, with an RN implementing the orders.

For example, if a patient's tool indicates that the patient on Metformin has an elevated HbA1c the physician may order a second diabetes drug. The PMA calls the patient, explains what the physician is advising, and faxes the prescription to the pharmacy. If the patient needs to be started on insulin, the PMA calls the patient and invites the patient to attend a nurse-run insulin start class. PMAs can initiate certain things themselves such as referrals for eye exams, or preventive services such as mammogram and pap smear appointments.

In this way, physicians can handle the chronic disease issue of a large number of patients in a short space of time (10 patients in 15 minutes), thereby removing chronic disease management from the physician visit. This allows patients to achieve better control, and when patients do visit their physician it allows the visit to address the patient's agenda since the chronic disease issues have been dealt with through the panel management system.

For patients in good control, the physician indicates on the tool that a re-review is needed in 6 months or a year. The computer system reminds PMAs to initiate these re-reviews. For patients with major adherence issues, patients who do not come in for lab work or pharmacy refills, physicians often ask for monthly re-reviews. For patients with a mildly elevated HbA1c, LDL cholesterol or blood pressure, re-review would be done in 3 months.

How are PMAs trained for their job? In KP/Richmond, medical assistants can apply for the PMA job, and if they are chosen, they no longer function as medical assistants. Panel management works because PMAs are dedicated full-time to their work. They receive training in how to use the registry, how to interact with the physician in using the tools, and how to interact with the patients by phone. They attend 6 patient education classes on diabetes and they study videos and patient education literature. They have customer service training, and they are chosen to be PMAs because they care deeply about patients and have strong communication skills. Some of what a PMA does can be trained; some is based on the inner convictions of the person. Once the PMA is ready to begin calling patients, the new PMA listens to an existing PMA talking with patients, and then the PMA-trainer listens to the new PMA talking with patients. After a number of mentored phone calls with feedback to the trainee, the new PMA is ready to call patients on her own.

What takes place during the phone calls? PMAs inform patients about what the physician would like the patient to do. PMAs, initially using scripts but over time graduating from the scripts to their personal experience, explain the reasons for the physician's recommendation and attempt to answer patients' questions using patient education materials. If patients disagree with the physician's advice, the PMA may attempt to persuade the patient, or may arrange a physician telephone visit or perhaps a pharmacist telephone visit. Over time, patients get to know their PMA and begin to establish trust with the PMA. Sometimes this process triggers a culture change on the part of patients, who may become more involved in their condition and may welcome PMA calls. A survey of patients demonstrated overwhelming support for the panel management system.

PMAs must also be able to interact persuasively with physicians. If a physician – often due to competing priorities – fails to review his or her tools, the PMA needs to nudge the physician, but without fracturing the PMA-physician relationship. The panel management system tracks how many

tools a physician has reviewed, and if physicians regularly fail to review their tools, they may find themselves in the office of the chief of medicine.

KP/Richmond recently implemented its new electronic medical record. This is likely to change how the panel management workflow takes place, but the concept does not change.

Two slogans illuminate the panel management innovation:

Move as many chronic care processes as possible out of the physician-patient visit.

Primary care practices need systems to track and *systematically* and *repetitively* review the *entire* population of patients with chronic conditions.

[Kaiser/Permanente's panel management article](#)