Building Capacity Block by Block: Panel & Population Management

How are grantees improving panel & population management??

Improving in-reach and/or outreach
- Creating chronic disease registry reports to target high-risk patients for outreach
- Creating or modifying tools to improve use and quality of registries
- Clearly defining team roles and establishing standard processes for in-reach and outreach

Using self-management tools to manage high-risk populations
- Piloting self-measured blood pressure programs and/or evaluating readiness to do so
- Considering texting software to promote post-ED/hospitalization follow-up & self-management messaging to chronic care patients
- Creating structures for follow-up visits for self-management goals

Using medication protocols like PHASE-on-a-Page to manage diabetes and HTN
- Supporting use of protocol by financially incentivizing PCPs based on BP control rates
- Working with endocrinology to develop a DM algorithm and align it with formularies
- Talking with providers at each site about medication protocols & management
- Applying HTN protocols to huddle reports
- Using in-house pharmacies to enhance medication fill rates and/or looking into mail delivery of medications

Linking blood pressure work with social determinants of health (SDOH) to increase impact
- Linking black/African American HTN equity work to tobacco cessation since 55% of their black patients smoke
- Developing SDOH plan of action with health plans and another PHASE grantee in same county
- Implementing self-measured blood pressure monitoring program specific to black/African American patients with HTN

What is the range of panel & population management scores by question?
At mid-initiative (May 2018), there was a wide variety of capacity across health centers and clinics. (N=62 health center organizations and hospital sites).
See reverse side for full wording of the eight questions in this domain.

 Patients assigned to specific practice panels
In-reach: Patients overdue for preventive care are identified & addressed
In-reach: Patients overdue for chronic care are identified & addressed
Outreach: Patients overdue for preventive care are contacted & asked to come in
Outreach: Patients overdue for chronic care are contacted and asked to come in
Self-management support provided by care teams trained in patient empowerment
Clinical care management services for high risk patients are systematically provided
Visits are organized to address both acute & planned care needs

How have panel & population management domain averages changed over time?
14 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend:
- Decrease
- No change
- Increase
Length of arrow = amount of change over time

Level of capacity *Score (scale 1-12)
A (highest) 10-12
B 7-9
C 4-6
D (lowest) 1-3
<table>
<thead>
<tr>
<th>PHASE Building Blocks Assessment: Panel &amp; Population Management</th>
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<tbody>
<tr>
<td><strong>28. Patients</strong></td>
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<tr>
<td>...are not assigned to specific practice panels.</td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>29. A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)</strong></td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>30. A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)</strong></td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>31. When patients are overdue for preventive care (e.g., cancer screenings) but do not come in for an appointment</strong></td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>32. When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment</strong></td>
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<tr>
<td><strong>Score</strong></td>
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<tr>
<td><strong>33. Self-management support</strong></td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>34. Clinical care management services for high risk patients</strong></td>
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<td><strong>Score</strong></td>
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<tr>
<td><strong>35. Visits</strong></td>
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Adapted by the Center for Community Health and Evaluation for Kaiser Permanente’s PHASE initiative with permission from Center for Excellence in Primary Care (CEPC) and Building Clinic Capacity for Quality (BCCQ) Program, October 2016.

Scale: Level D: score of 1-3 (lowest capacity) || Level C: score of 4-6 || Level B: score of 7-9 || Level A: score of 10-12 (highest capacity)