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

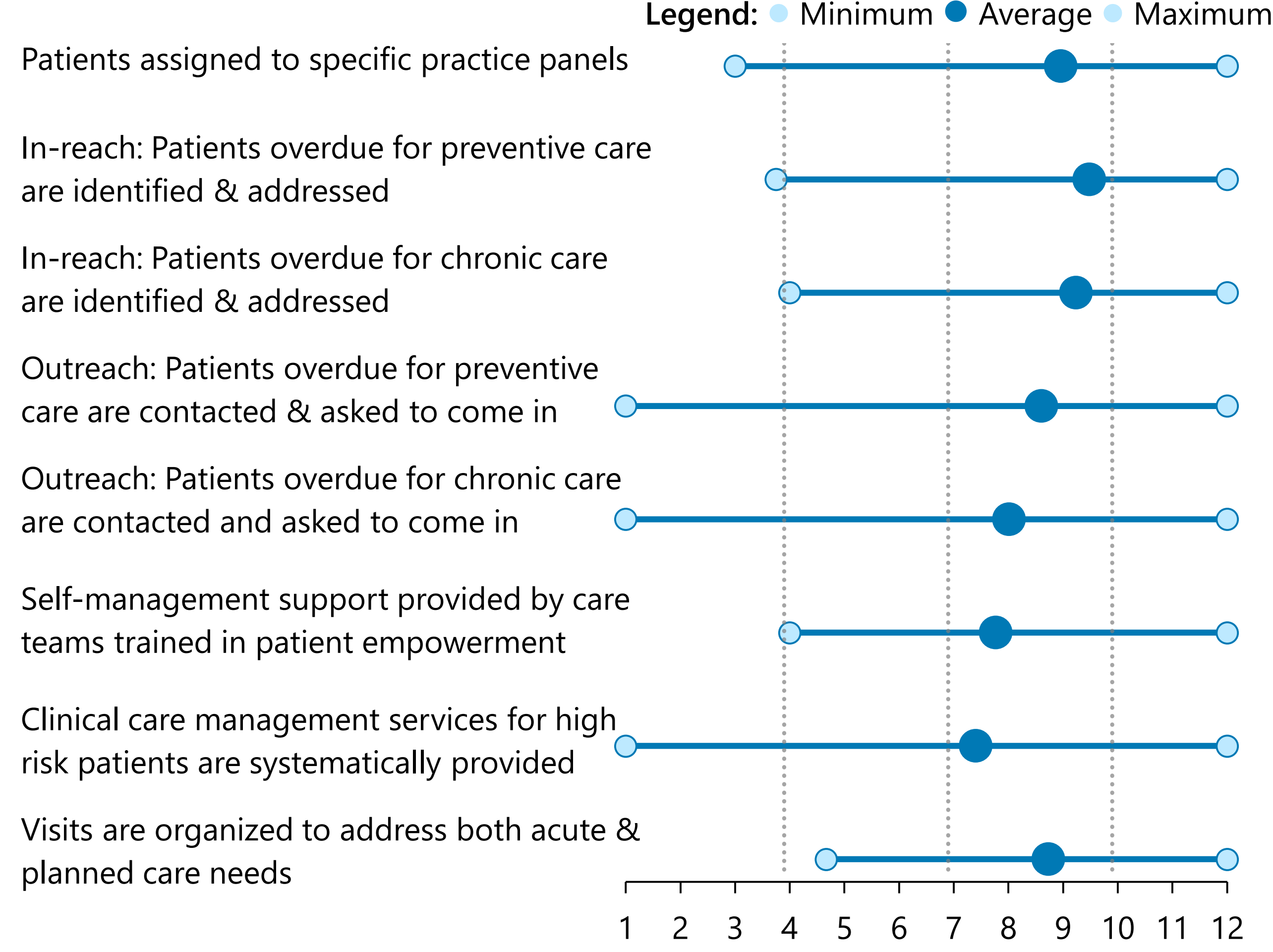
Linking blood pressure work with social determinants of health (SDOH) to increase impact

- 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.

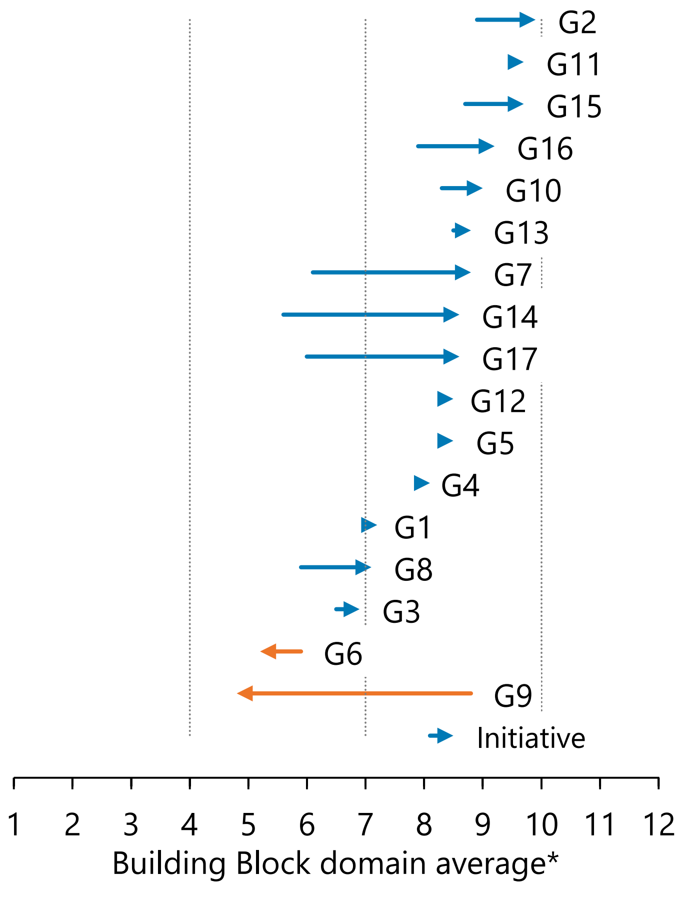


How have panel & population management domain averages changed over time?

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

PHASE Building Blocks Assessment: Panel & Population Management

	Level D	Level C	Level B	Level A
28. Patients	...are not assigned to specific practice panels.	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
29. A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	...will only get that care if they request it or their provider notices it.	...might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
30. A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)	...will only get that care if they request it or their provider notices it.	...might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
31. When patients are overdue for preventive (e.g., cancer screenings) but do not come in for an appointment	...there is no effort on the part of the practice to contact them to ask them to come in for care.	...they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	...they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	...they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
32. When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment	...there is no effort on the part of the practice to contact them to ask them to come in for care.	...they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	...they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	...they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
33. Self-management support	...is limited to the distribution of information (pamphlets, booklets).	...is accomplished by referral to self-management classes or educators.	...is provided by goal setting and action planning with members of the practice team.	...is provided by members of the practice team trained in patient empowerment and problem solving methodologies.
Score	1 2 3	4 5 6	7 8 9	10 11 12
34. Clinical care management services for high risk patients	...are not available.	...are provided by external care managers with limited connection to practice.	...are provided by external care managers who regularly communicate with the care team.	...are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
Score	1 2 3	4 5 6	7 8 9	10 11 12
35. Visits	...largely focus on acute problems of patient.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	...are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
Score	1 2 3	4 5 6	7 8 9	10 11 12

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)