Panel Management:

A new approach to delivering community-based, preventive care using an electronic health record and shared outreach workers

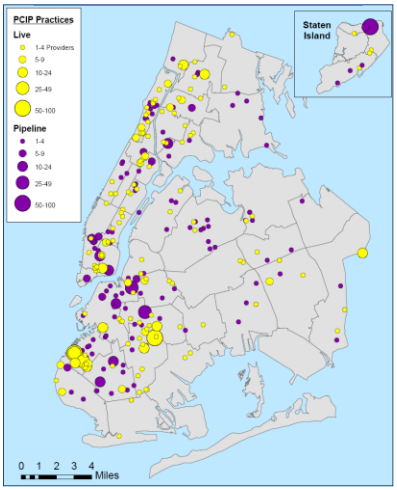
NYC REACH
Regional Electronic Adoption Center for Health
NYC Health

Primary Care Information Project (PCIP)

Mission: Improve the quality of care in medically underserved areas through health information technology (HIT)

•Founded in 2005 as a bureau of the NYC Department of Health and Mental Hygiene

•2,642 providers enrolled
•2,196 providers live on an EHR
•82 NCQA recognized Medical Homes



NYC REACH
Regional Electronic Adoption Center for Health
NYC Health

NYC Reach

Mission: Ensure that at least 4,543 NYC providers adopt and use carefully selected HIT solutions in such a way that improves health, engages patients, improves care coordination and population health and ensures privacy and security of health data.

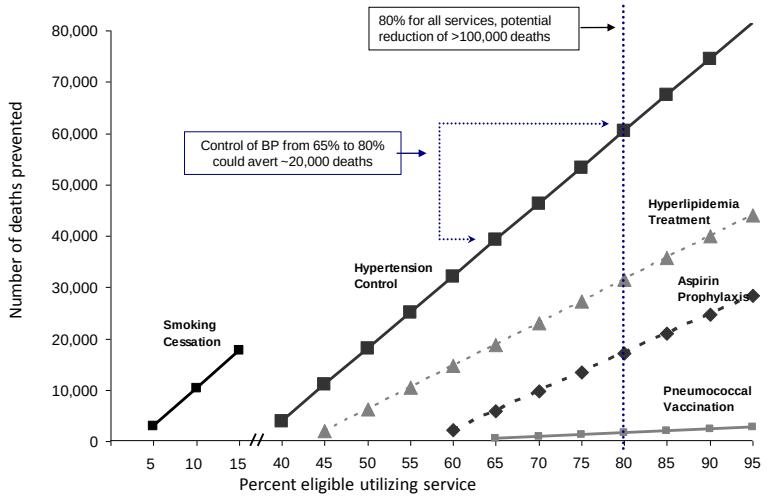
•Founded in March 2010 as a Health IT Regional Extension Center

•3 preferred vendors
•3 meaningful use partners
•721 providers enrolled (556 count towards target)

eClinicalWorks
GREENWAY
MDLand
MedLink
NEXTGEN HEALTHCARE
ECLIPSYS The Outcomes Company

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

National Estimates of Deaths Averted



Source: Farley TA, Dalal MA, Mostashari F., Frieden TR, Am J Prev Med. 2010 Jun;38(6):600-9

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

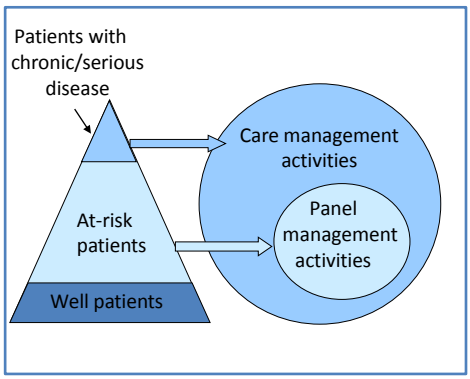
PCIP / NYC Reach Programs

EHR Adoption	Meaningful Use of EHR	Pay for Quality & Prevention	Patient Engagement	Public Health
• Provider outreach • Implementation support • Extension agent collaboration (HHC, Maimonides)	• Quality improvement visits • EHR Training (Super Users) • Health information exchange	• Health eHearts • Health eQuits • Recognition and Incentive Programs (Bridges to Excellence, Patient Centered Medical Home)	• PCMH training and assistance • Panel Management • Text messaging pilot • Personal health record (PHR) project	• Disease tracking • Provider alert pilot • Immunization / disease reporting • Provider portal project

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Panel Management Overview

Panel management represents a proactive approach that involves analyzing a practice's entire patient panel, identifying patients who are not adequately managed or receiving recommended care, and reaching out to them.



Different from case management:

- Lower level interventions to a larger group of patients
- Can be performed by less skilled staff
- Conducted on-site and integrated into practice

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Need for Panel Management

- Nearly half of all Americans have one or more chronic diseases, and 7 of 10 deaths in the U.S. are from chronic diseases[1]
- Physicians treat patients who come to their offices, but rarely identify and reach out to their patients who do not come into the office for recommended care
- Patients can fall through the cracks and miss routine preventative care necessary to properly manage chronic diseases
- Phone calls have been shown to be more effective than letters for outreach to patients with diabetes[2], and automated phone calls may suffer from a similar lack of patient interaction

1. Chronic Diseases and Health Promotion. 2009. (Accessed August 17, 2010, at http://www.cdc.gov/chronicdisease/overview/index.htm.
2. Denberg, et al. A patient outreach program between visits improves diabetes care: a pilot study. Int J Qual Health Care. 2009 Apr;21(2):130-6.

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Panel Management Activities

Identify patients who are in need of additional care and reach out to them:
- Due for follow-up care (e.g., follow up diabetes care)
- Due for routine visits (e.g., annual physical)
- Due for screenings and preventive services (e.g., mammograms, flu vaccine)

Track labs and referrals and close the loop on documentation:
- Reminds patients to act on referrals
- Tracks missing documentation from referral center

Operate on-site, integrated into the practice:
- Requires access to practice's electronic health records
- Communication must be aligned with practice's goals and principles

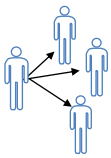
Prevention outreach specialists have some medical familiarity, do not need clinical expertise:
- Algorithms are pre-defined and outreach is scripted
- Can be done by bachelor level staff

Appropriate for a broad range of patients, but can also be selectively applied to target populations (e.g., patients with hypertension, diabetes)

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Pilot Design

1 Prevention Outreach Specialist (POS) working with 3 small practices



Visit each practice 1 day per week

- Run registry queries
  - BP Control, Cholesterol Control
  - Influenza Vaccination
  - Asthma and Allergy
- Contact patients
- Schedule appointments
- Follow-up on missing results and documentation

Evaluate approaches to logging calls and tracking results

Identify patient visits within 90 days of outreach call

Transition Panel Mgmt. techniques to practice staff and ongoing program

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Panel Management at PCIP

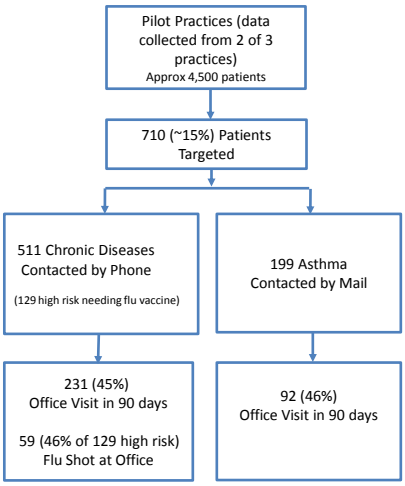
- Small medical practices, particularly in underserved areas, often don't have the tools, financial resources or trained staff to conduct patient outreach
- PCIP's existing relationships with hundreds of small practices (avg. size:1.8 providers) make it a third party that's trusted to protect patient and practice data
- In contrast to insurance companies, PCIP's mission encompasses the health of all of the patients at a practice

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Pilot Project Results

Key Findings:

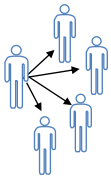
- Embedding outreach worker is feasible
- ~15% high-risk patients identified w/o return visits (individual practices ranged from 15% to 29%)
- ~45% with follow-up gaps returned for visit (individual practices ranged from 37% to 66%)



NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Program Design

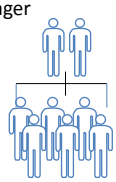
Each of 6 Prevention Outreach Specialists (POS) works with 4 to 8 small practices



Visit each practice 1 day per week or on alternate weeks:

- Run registry queries
- Contact patients
- Schedule appointments
- Follow up on missing results and documentation

POS reports to an operations manager and a program manager



Program Manager:

- Reviews algorithms, works with physicians to maintain buy-in

Operations Manager:

- Assists with training, monitoring and assessment of program

Effectiveness of panel management is tracked

- Operational measures from practices used to monitor progress on a weekly and monthly basis
- Provider satisfaction is monitored through periodic surveys
- Formal evaluation to identify impact

Support for PCIP's Panel Management program is provided by a grant from Pfizer

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Identifying At-Risk Patients

- All patients with a BMI of 30 or greater with a diagnosis of DM who were not seen in the past 6 months and no future appointment in the next 1 month.
- All patients with HTN with DM with a BP reading of 130/80 or greater who were not seen in the past 3 months and no future appointment in the next 1 month.
- All patients with HTN w/o DM w/o CKD and a BP reading of 140/90 or greater who were not seen in the past 3 months and no future appointment in the next 1 month.
- All patients with Hyperlipidemia who were not seen in the past 6 months and no future appointment in the next 1 month.
- All patients with IVD who were not seen in the past 6 months and no future appointment in the next 1 month.

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Proposed Evaluation - Formative

Research Questions:

- What are the barriers to and facilitators of implementation?
- What are the perceptions of physicians, office staff, and POSs about the utility or burden of this program?

Design:

- Surveys of physicians and staff at 3 time points (beginning, middle, end)
- Interviews with a sample of physicians and staff at similar time points
- Evaluation of interviews by researchers

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Proposed Evaluation - Quantitative

Determine whether panel management in PCIP practices lead to better continuity and higher quality of care.

Design:

- Randomized controlled trial within program practices comparing panel management to usual care
- Secondary comparison group consisting of patients at non-program practices
- Data collection at 24 months into the program (Sept. 2012)
- Measures
  - Operational
  - Quality (Process / Outcome)

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Challenges

Recruitment

- Practices require space and resources to accommodate POS
- Coordination needed with other ongoing PCIP initiatives (e.g., Health eHearts)
- Need to match languages between panel manager and patient population

Operations

- Practices have differing burden of at-risk patient populations
- eClinicalWorks (eCW) software not designed to track outreach efforts in detail
- Site specific eCW customizations and usage necessitates tailoring of registry queries at each practice

Evaluation

- Difficult to recruit comparison practices
- Randomization of patients requires multiple manual steps
- Clinical data held in database at practice – quality measures not centrally accessible at patient level

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Opportunities

- Creates new entry level employment opportunities with room for job growth
- Increased efficiency from pre-visit planning may boost availability of primary care physicians
- Program could be financially sustained by payers, foundations and potentially even physicians
- Intervene with patients before chronic conditions become critical, improving health and reducing hospitalizations

NYC REACH Regional Electronic Adoption Center for Health | NYC Health

Contacts

Panel Management Program Manager:
Dan Gottlieb – dgottlie@health.nyc.gov

Data Analyst:
Sungwoo Lin - slim1@health.nyc.gov

PCIP Executive Director of Medical Quality:
Dan Halevy – dhalevy@health.nyc.gov

PCIP Director of Health Care Quality Information:
Sarah Shih – sshih@health.nyc.gov

NYC DOHMH Assistant Commissioner – PCIP:
Amanda Parsons – aprasons@health.nyc.gov

NYC REACH Regional Electronic Adoption Center for Health | NYC Health