

Paradigm Shift in Chronic Disease Management : Panel Management

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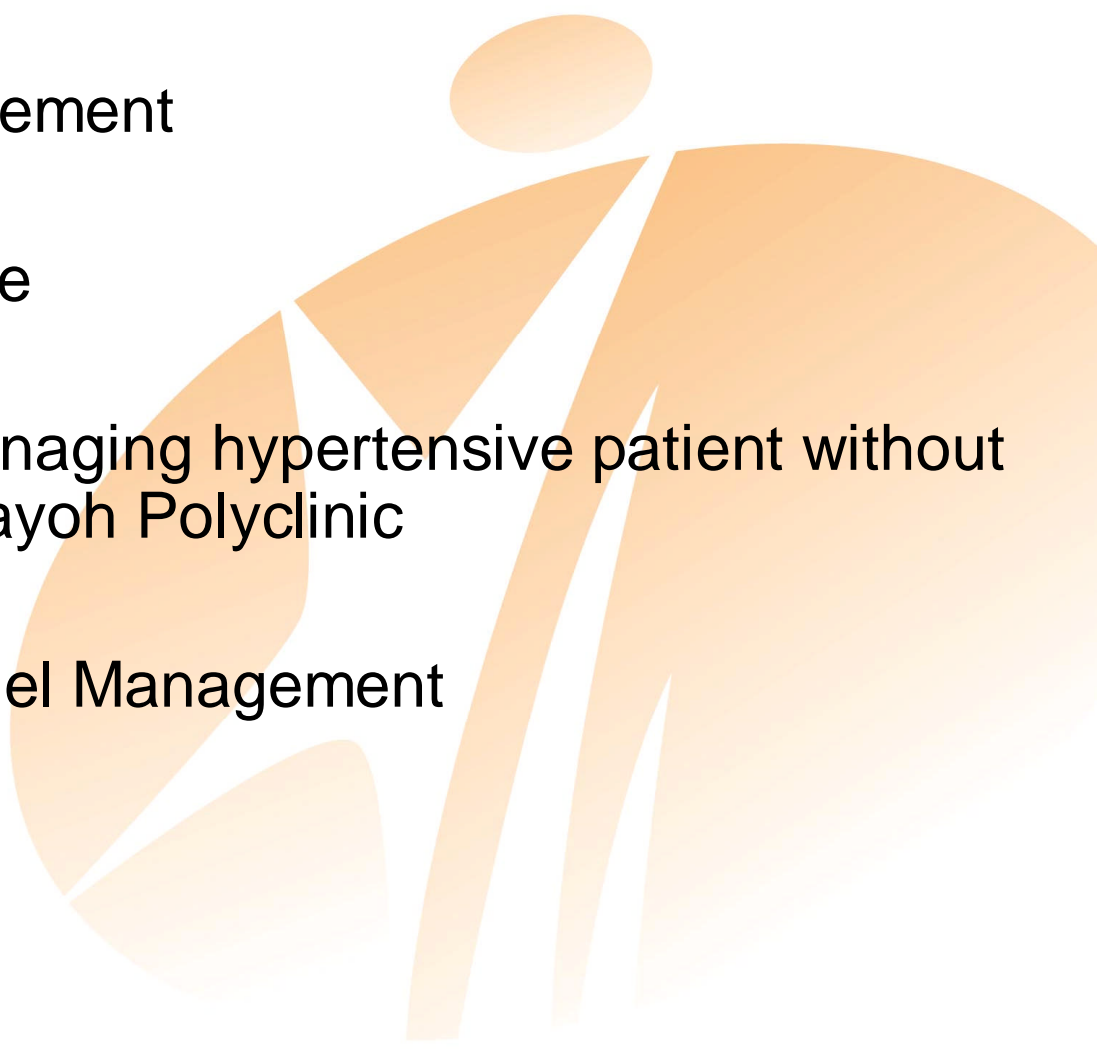
Ng Siam Eng

Toa Payoh Polyclinic

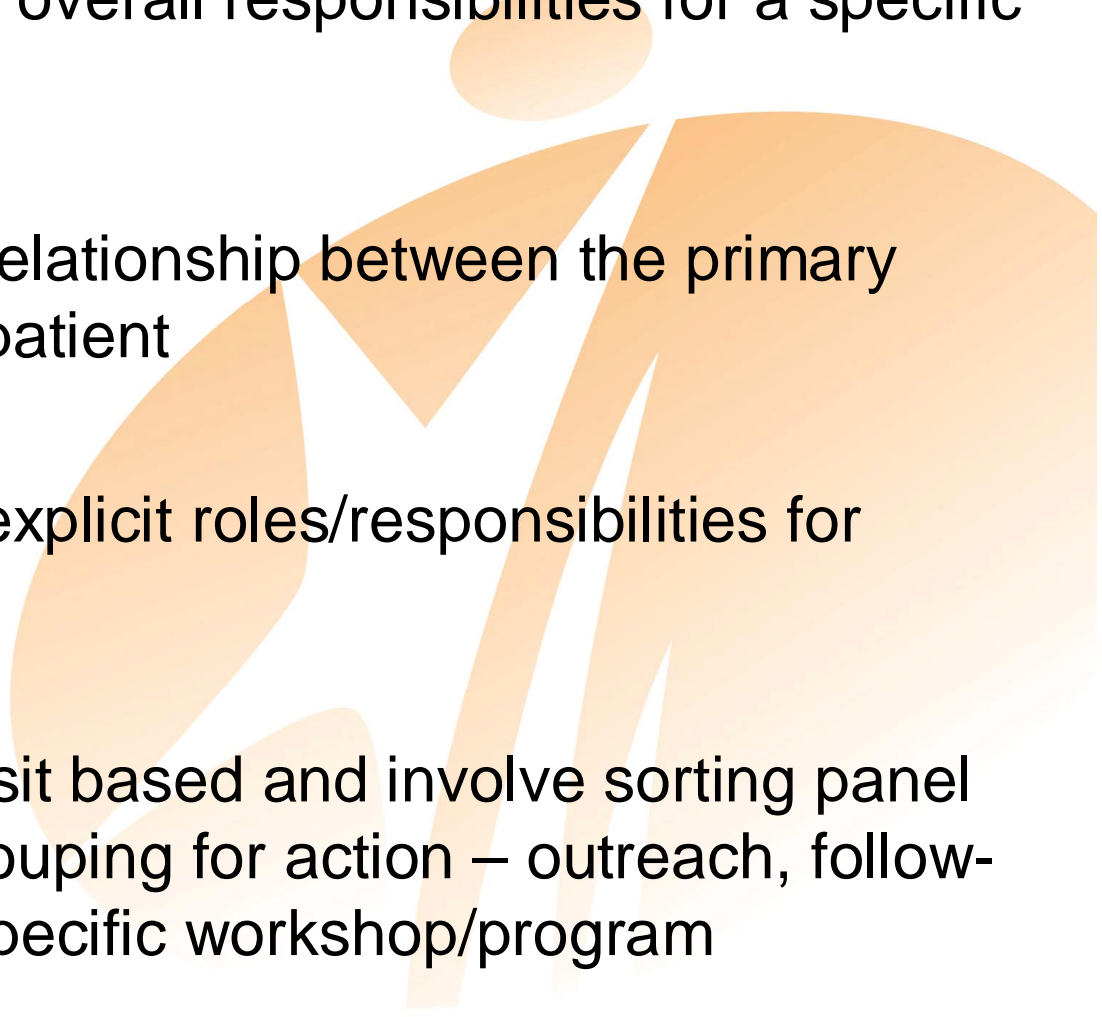


National Healthcare Group
POLYCLINICS

Outline

- Overview of Panel Management
 - Models of Panel Management
 - Shift in the model of care
 - Panel-based care in managing hypertensive patient without co-morbidities in Toa Payoh Polyclinic
 - Key components of Panel Management
 - Barriers and challenges
- 

What is Panel Management?

- Care delivery model that directly supports primary care physicians who have an overall responsibilities for a specific group of patients
 - Intended to extend the relationship between the primary care physician and the patient
 - Systematic – there are explicit roles/responsibilities for members of the team
 - Proactive – not entire visit based and involve sorting panel members into logical grouping for action – outreach, follow-up the enrollment into specific workshop/program
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Models of Panel Management

Type of model	PCP/MA	PCP/RN	PCP/ Pharmacist	PCP/Team
Who does outreach?	MA	RN	Pharmacist	Team: MA, RN, Pharmacist
How often PCP review patient?	Weekly	Once a month	Once a month	Once a month
Settings for PCP review/clinical decision making	PCP office	PCP office; PCP and RN collaboratively manage patient	PCP office; PCP and Pharmacist collaboratively manage patient	Conference room, 3-5 members of team collaboratively review and manage patient

Adopted from Kaiser Permanente

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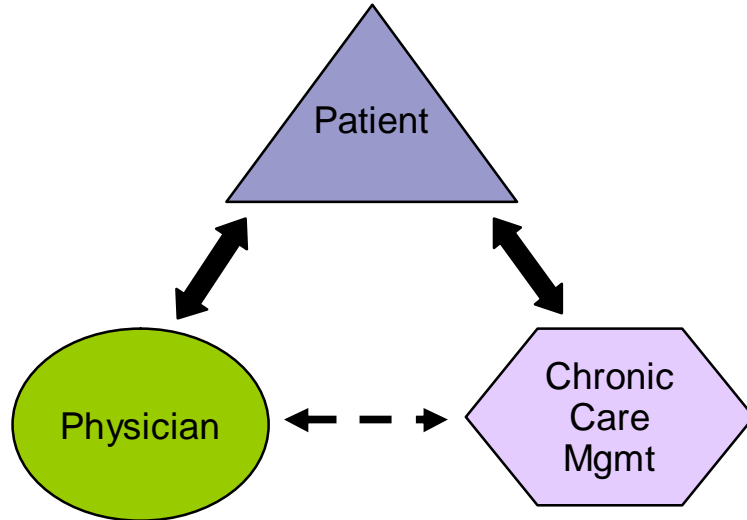
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Shift in Model of Care

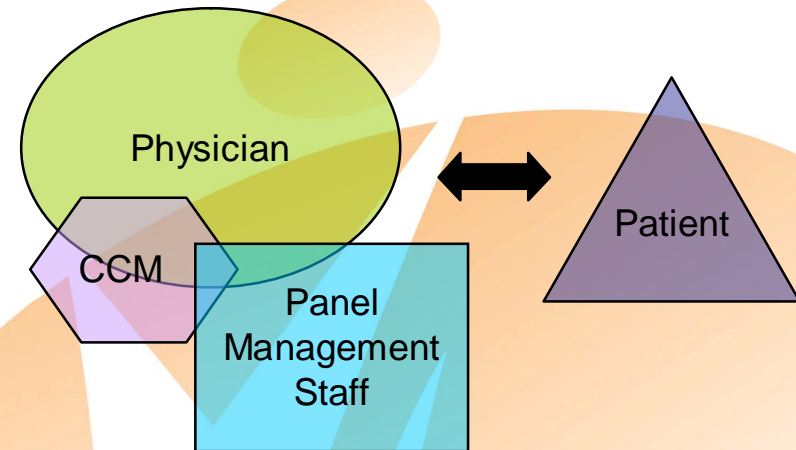
Current Model



Key Features of Model:

- Physician care primarily reactive – visit based and responsive
- Care is silo
- Minimal communication and coordination among team

Panel Management

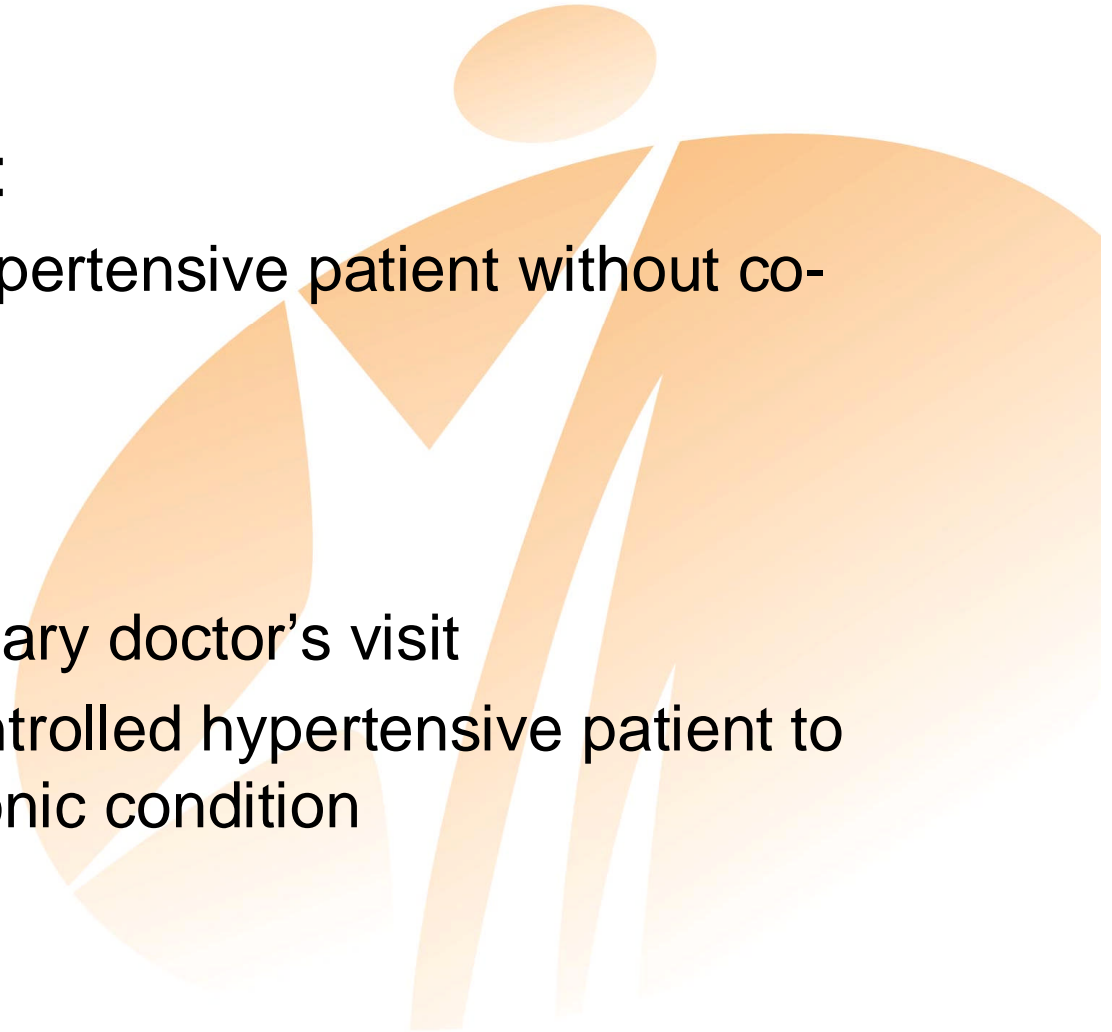


Key Features of Model:

- Physician and team proactive, accountable for clinical outcomes and patient satisfaction
- Systematized process for coordinating physician and panel management team activities
- Increased capacity & options for chronic care, leveraging physician time and ancillary staff support to extend physician

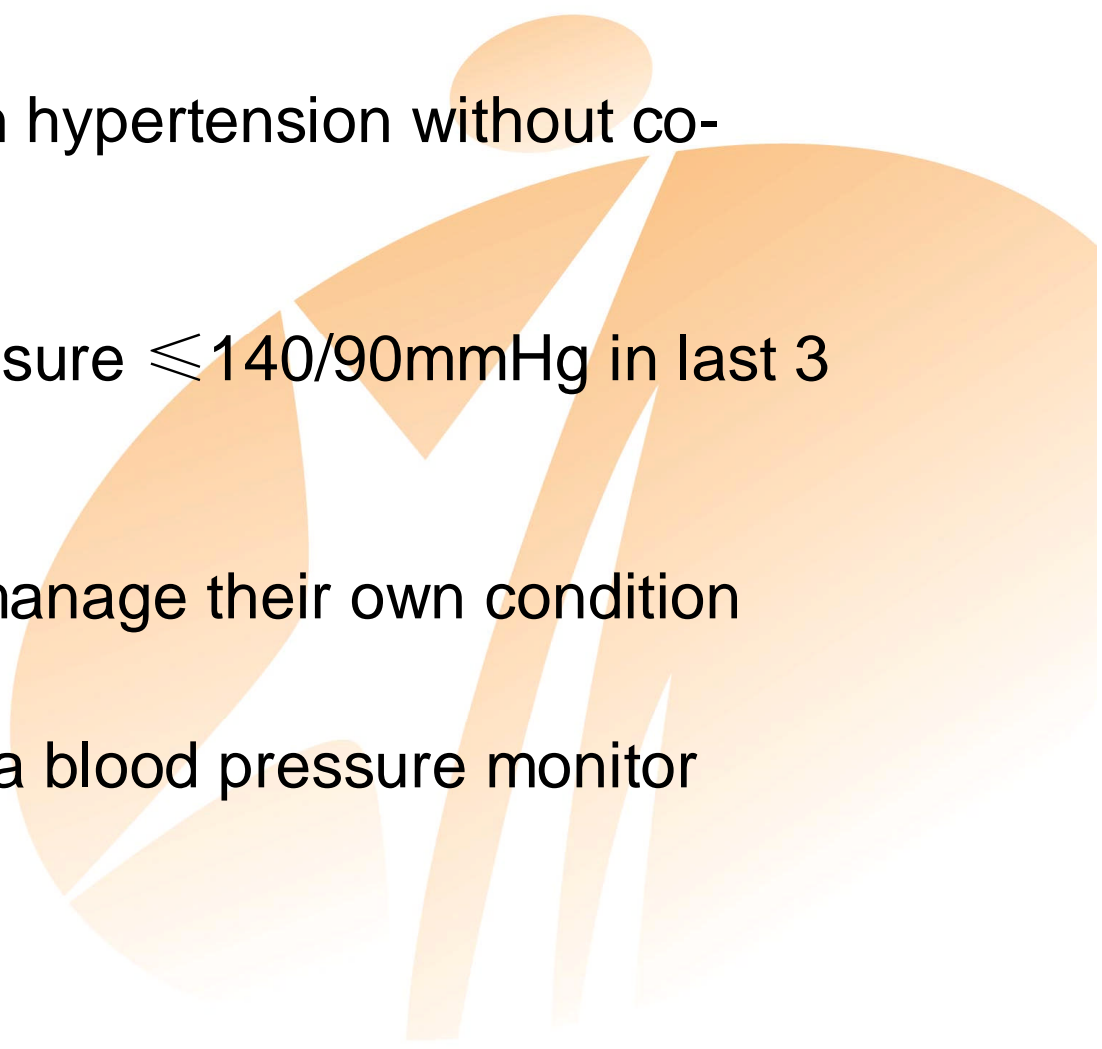
Panel Management Project in Toa Payoh Polyclinic

- Piloted PCP/PA model in June 2007
- Target population:
 - Well controlled hypertensive patient without co-morbidities
- Objectives:
 - Reduce unnecessary doctor's visit
 - Empower well controlled hypertensive patient to manage their chronic condition



Panel Management Project in Toa Payoh Polyclinic

The enrolment criteria are:

- Patient diagnosed with hypertension without co-morbidities
 - Patient has blood pressure $\leq 140/90$ mmHg in last 3 clinic visits
 - Patient wants to self-manage their own condition
 - Patient must possess a blood pressure monitor
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Roles and Responsibilities

1. Primary Care Physician

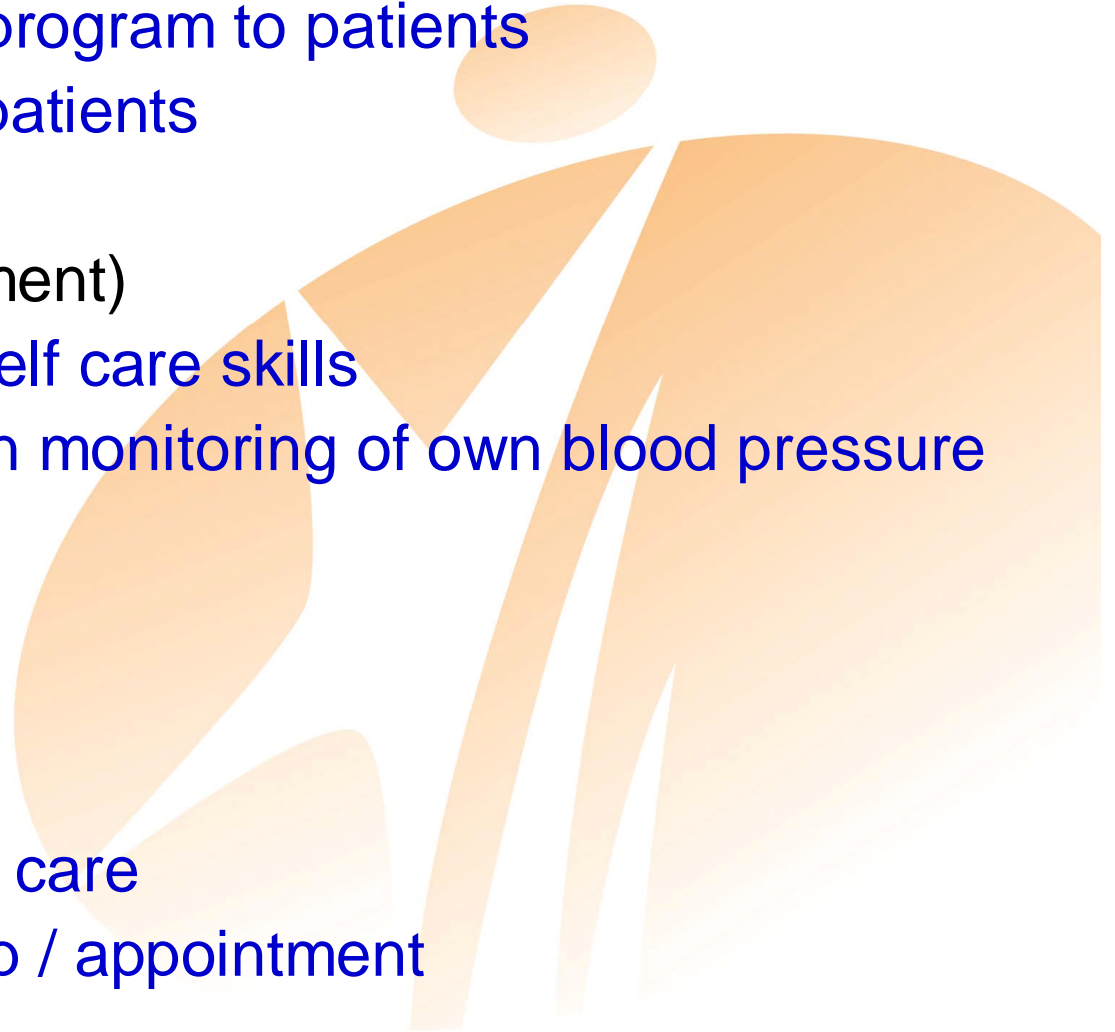
- Identify and explain program to patients
- Review progress of patients

2. Care manager (Enrolment)

- Educate patient on self care skills
- Check competency in monitoring of own blood pressure
- Validate BP monitor
- Teach action plan

3. Panel Assistant





- Telephonic follow-up care
- Arrange for workshop / appointment



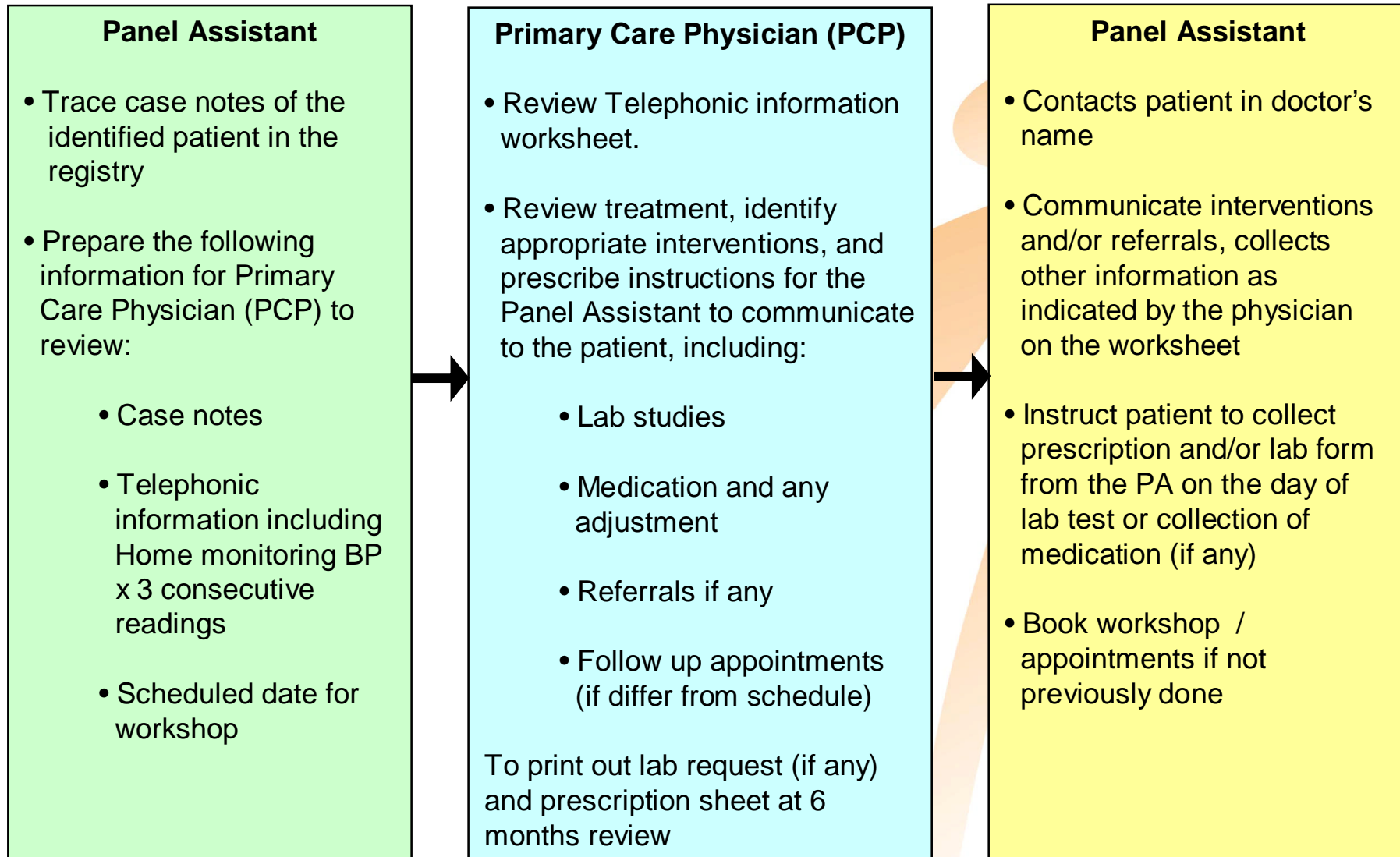
Action Plan

Blood pressure reading

Action to be taken

<p>Less than 140/ 90 少过/ Kurang dari</p> 	<p>Take blood pressure 3 times a week in the evening. 每个星期晚上测量血压3次。 Periksa tekanan darah 3 kali seminggu pada waktu petang.</p>
<p>140/ 90 to 150/ 95</p> 	<p>Take another blood pressure reading an hour later. 一个小时后再测量血压一次。 Periksa tekanan darah sekali lagi selepas 1 jam.</p>
<p>151/ 96 to 160/ 100</p> 	<p>Take another blood pressure reading an hour later. And subsequently twice a day for the next 3 days. 一个小时后再测量血压一次。接着连续3天内每天测量血压两次。 Periksa tekanan darah sekali lagi sejam kemudian. Sesudah itu periksa tekanan darah 2 kali sehari dalam 3 hari. Call the nurse if blood pressure remains persistently at this range for 3 days. Tel: _____ 如果血压持续3天在这个水平，打电话给护士。 Telefon jururawat jika tekanan darah anda tiada perubahan dalam 3 hari.</p>
<p>More or equal 161/ 101 超过或同等/ Seedikit lebih kurang</p> 	<p>Take another reading half an hour later. If blood pressure remains at this range, take another half an hour later. 半小时后再测量一次。如果血压持续天在这个水平，半小时后再测量一次。 Periksa tekanan darah setengah jam kemudian. Jika tekanan darah tiada perubahan, periksa lagi tekanan darah setengah jam kemudian. See doctor if (1) readings are above 160/100mmHg for 3 times or (2) feeling unwell. 如果血压高过160/100mmHg 3次,或者感觉不舒服, 请看医生。 Jumpa doktor jika (1) tekanan darah lebih dari 160/100mmHg 3 kali atau (2) bila rasa kurang sihat.</p>

How does it works?



Panel Management Worksheet



Patient Sticky Label

Panel Management Protocol

Date of enrollment : _____
 Date of review : _____
 Period of review : 3 months 6 months 9 months
 Status of review : Telephonic review Drop-in clinic

Target BP ≤ 140 / 90 mmHg

Last 3 consecutive Home BP readings :

Systolic: _____ Diastolic: _____ Date done: _____ Time done: _____

Systolic: _____ Diastolic: _____ Date done: _____ Time done: _____

Systolic: _____ Diastolic: _____ Date done: _____ Time done: _____

Review of medication and Lab result (CPRS)

Drop-In Clinic Visit

BP in clinic : Systolic: _____ Diastolic: _____ Time done: _____

Weight : _____ (kg)

Given prescription: Yes No NA

Given Lab form : Yes No NA

General Well-being of patient

Headache : Yes No
 Tiredness : Yes No
 Nausea : Yes No
 Vomiting : Yes No
 Shortness of breath : Yes No
 Restlessness : Yes No
 Blurred vision : Yes No
 Dizziness : Yes No

Well and no symptoms: Yes No
 Seen or inform Dr of symptoms: Yes N NA

Indicators of Self-Management

Adherence to medicine : Yes No NA

Tolerance to medicine : Yes No NA

Adherence to (low salt & low fat) diet : Yes No

Adherence to exercise : Yes No

Given Action Plan : Yes No

Know how to use Action Plan : Yes No

Attended CDSMP : Yes Date attended : _____

: No Date scheduled : _____

Next Telephone review : _____

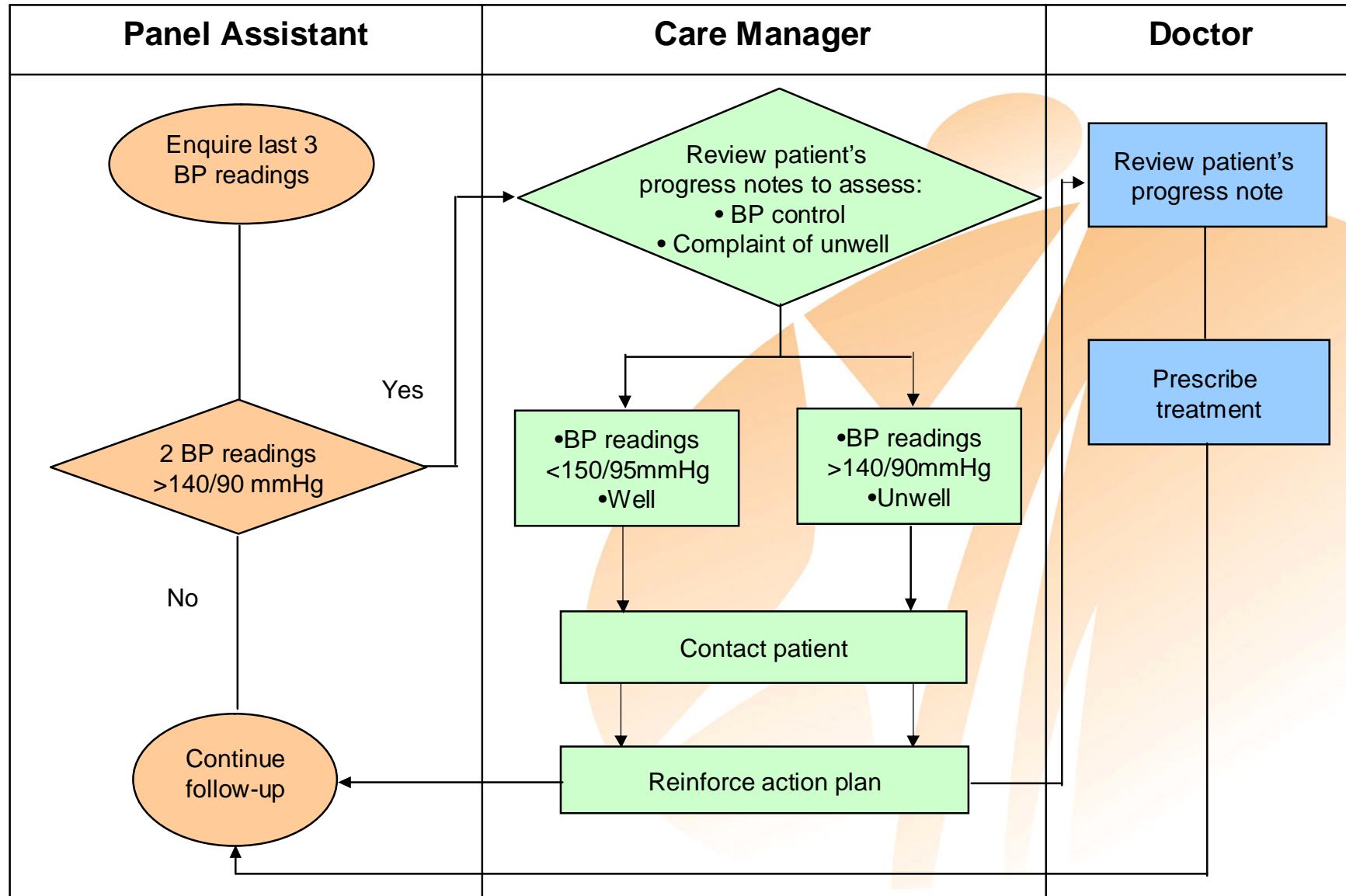
Drop-In Clinic visit : _____

Follow-up action (Dr's comment) :

 Physician's Signature Date

 Action completed by Date

Escalation Process (Telecare)



Patient's Profile

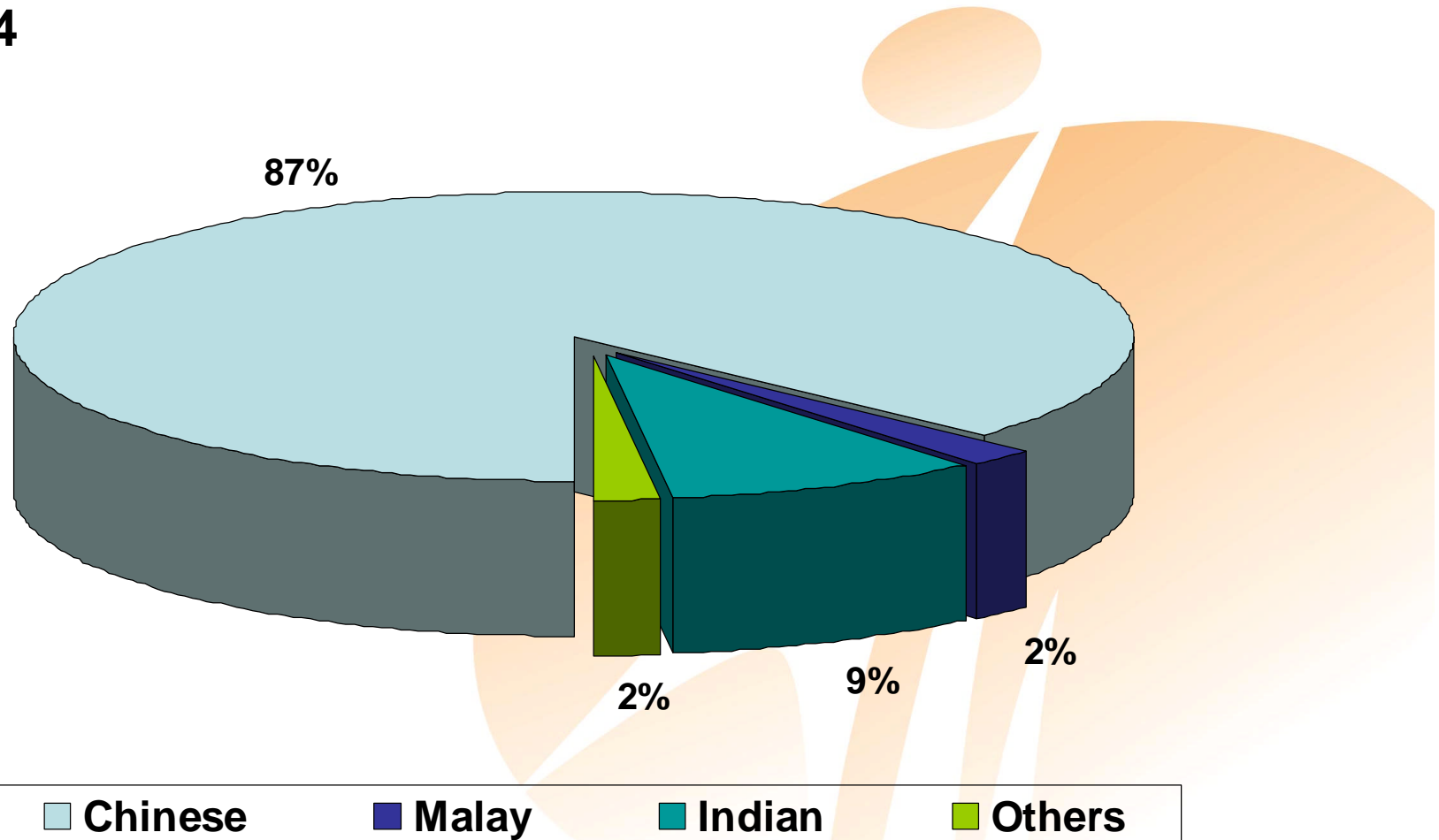
Jun – Dec 2007

A total of 54 patients enrolled

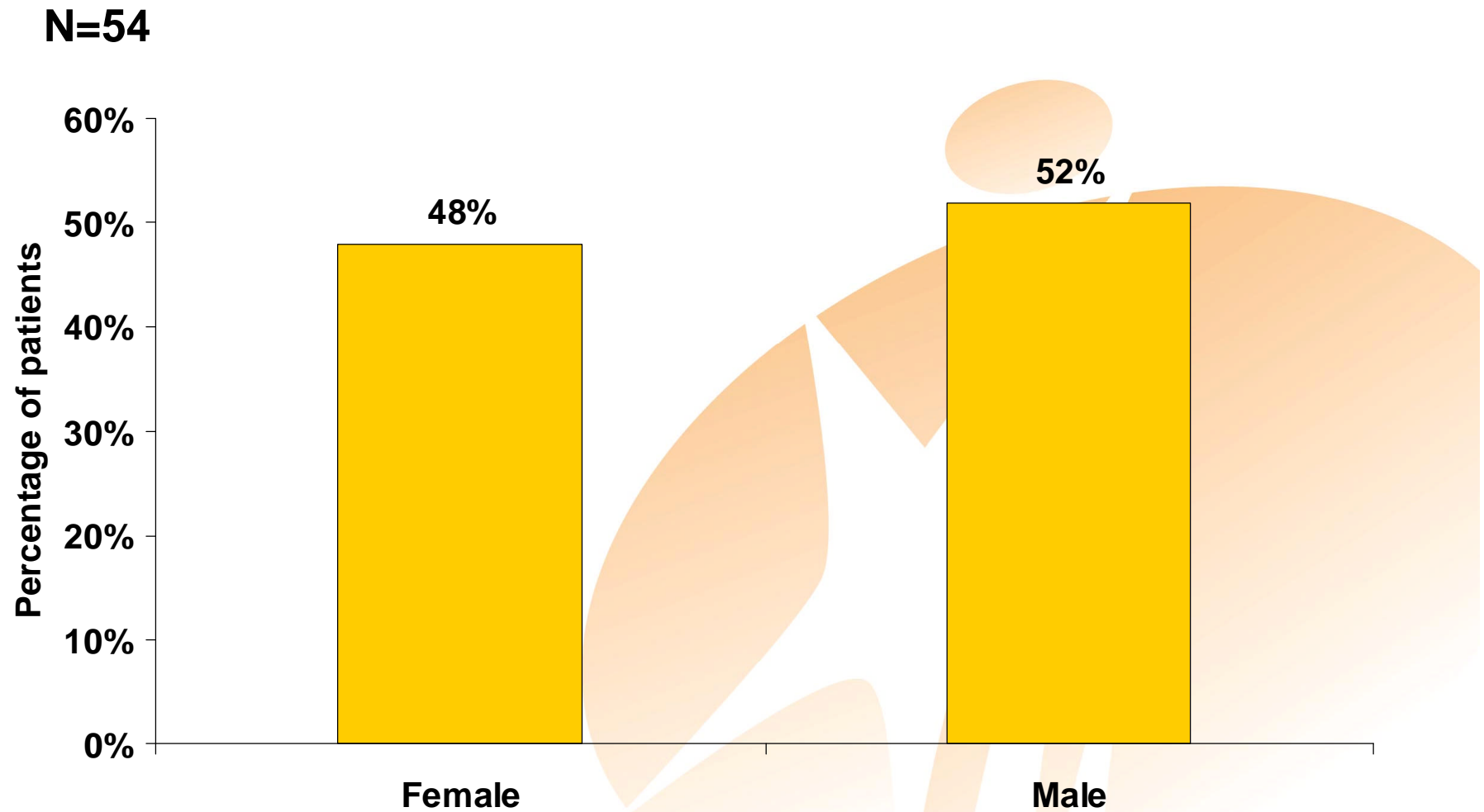


Race

N=54

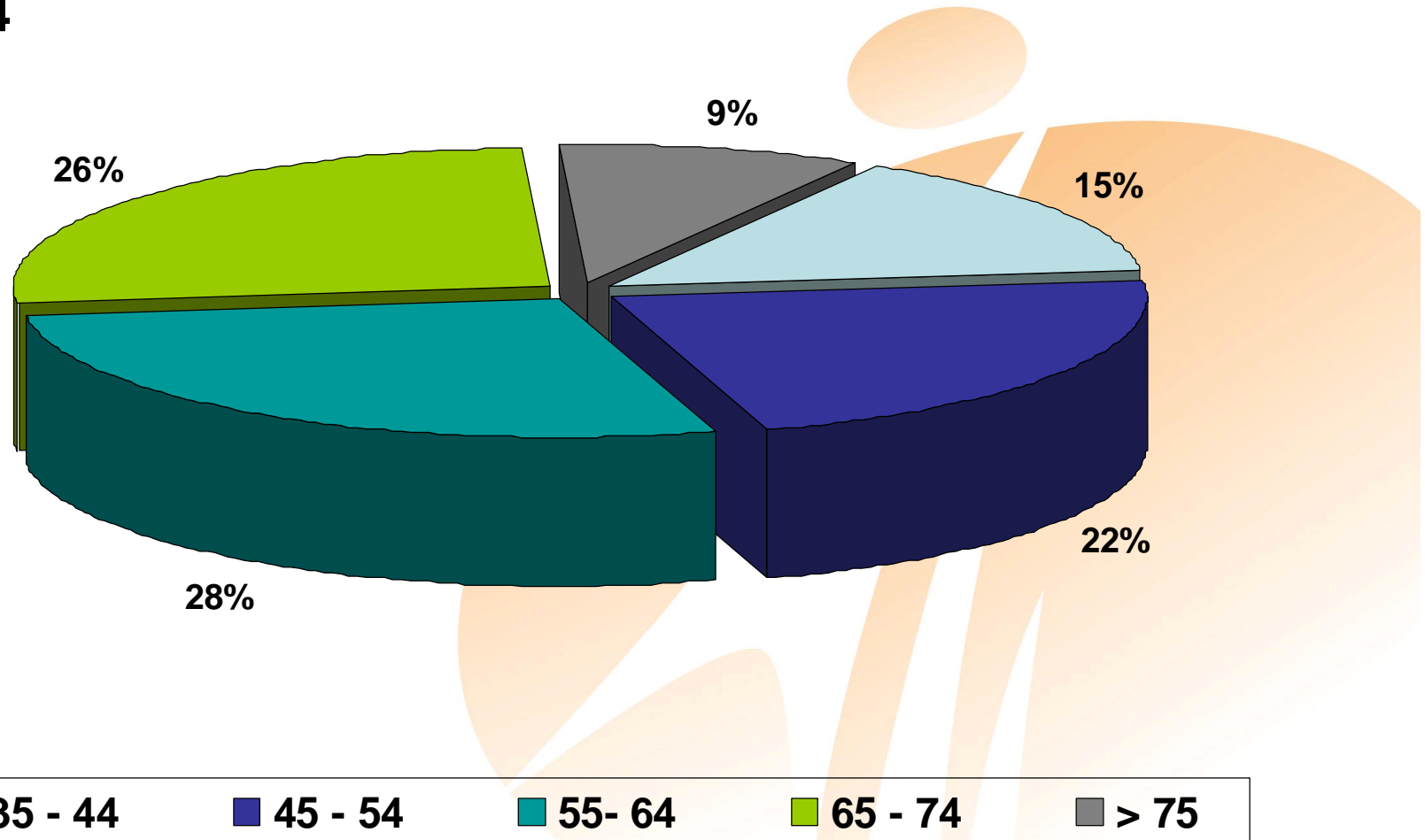


Gender



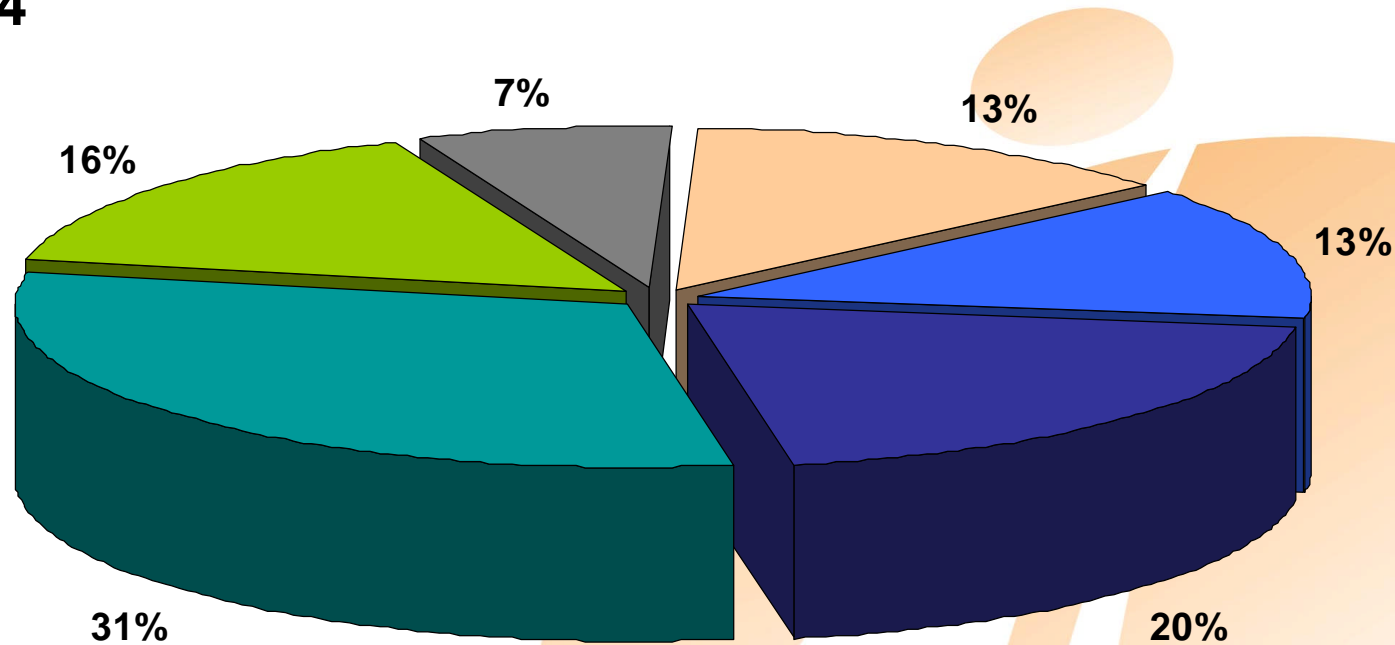
Age group

N=54



Educational level

N=54



■ Nil

■ Primary

■ Secondary

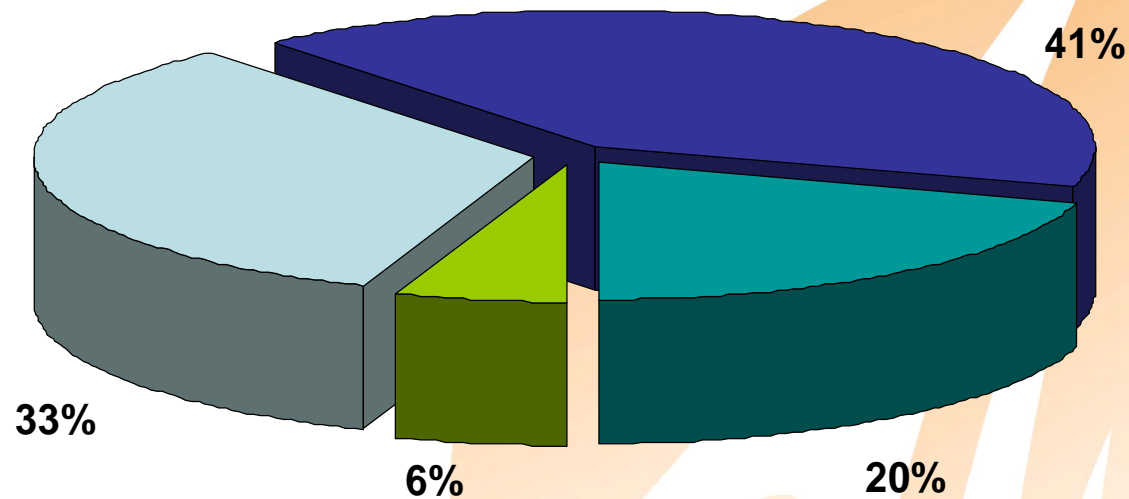
■ JC / Pre-U / Diploma

■ University

■ No response

Progress of Follow-up and Outreach

Number of patients completed telephonic follow-up from Jun to Dec 2007 (N=54)



Completed 6 - month follow-up

Completed 3 - month follow-up

Awaiting follow-up

Drop-out



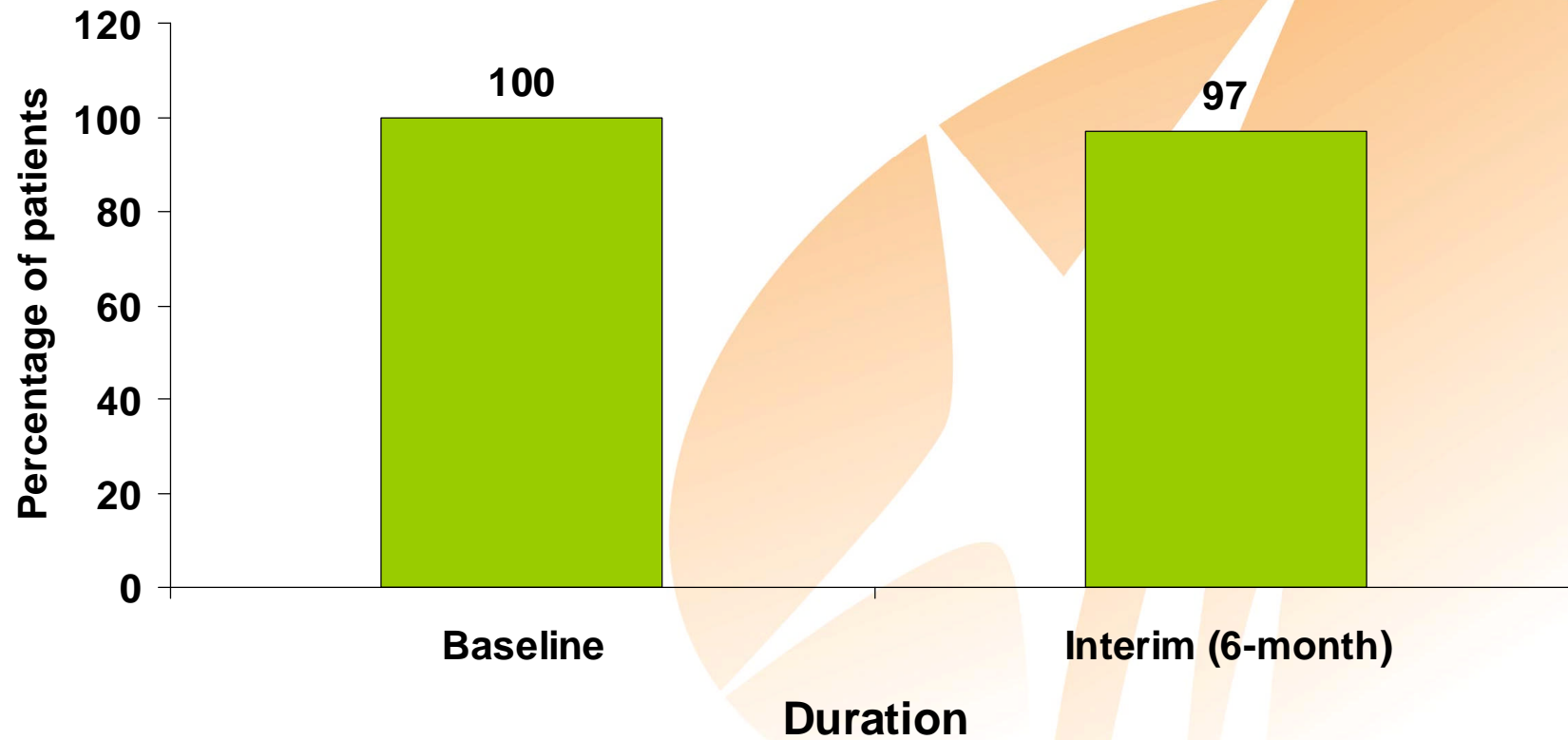
Preliminary Outcome

Baseline & Interim (6 - month)

Blood Pressure

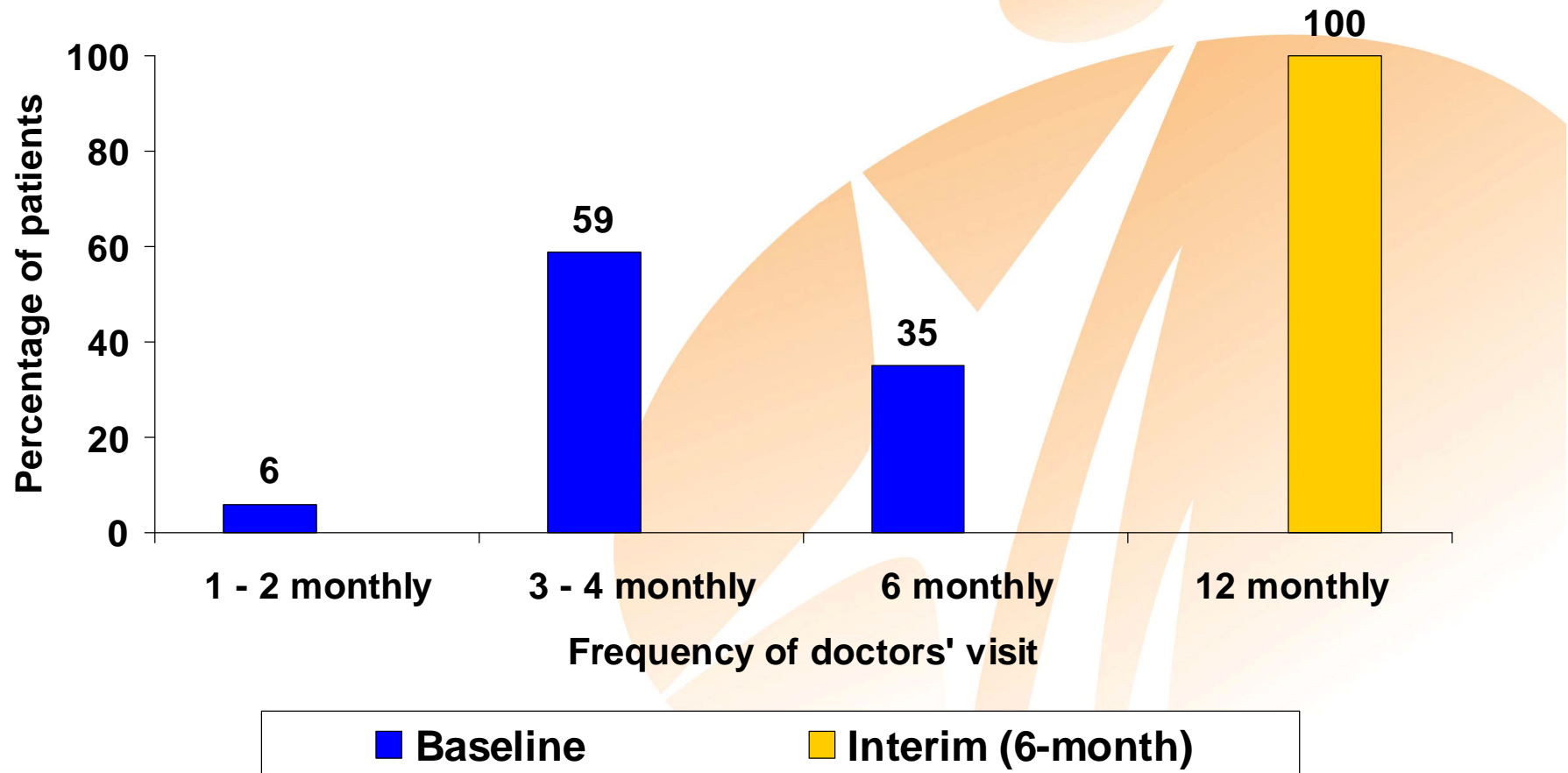
Percentage of patients who have BP maintained within target ($\leq 140/90$ mmHg)

N=17



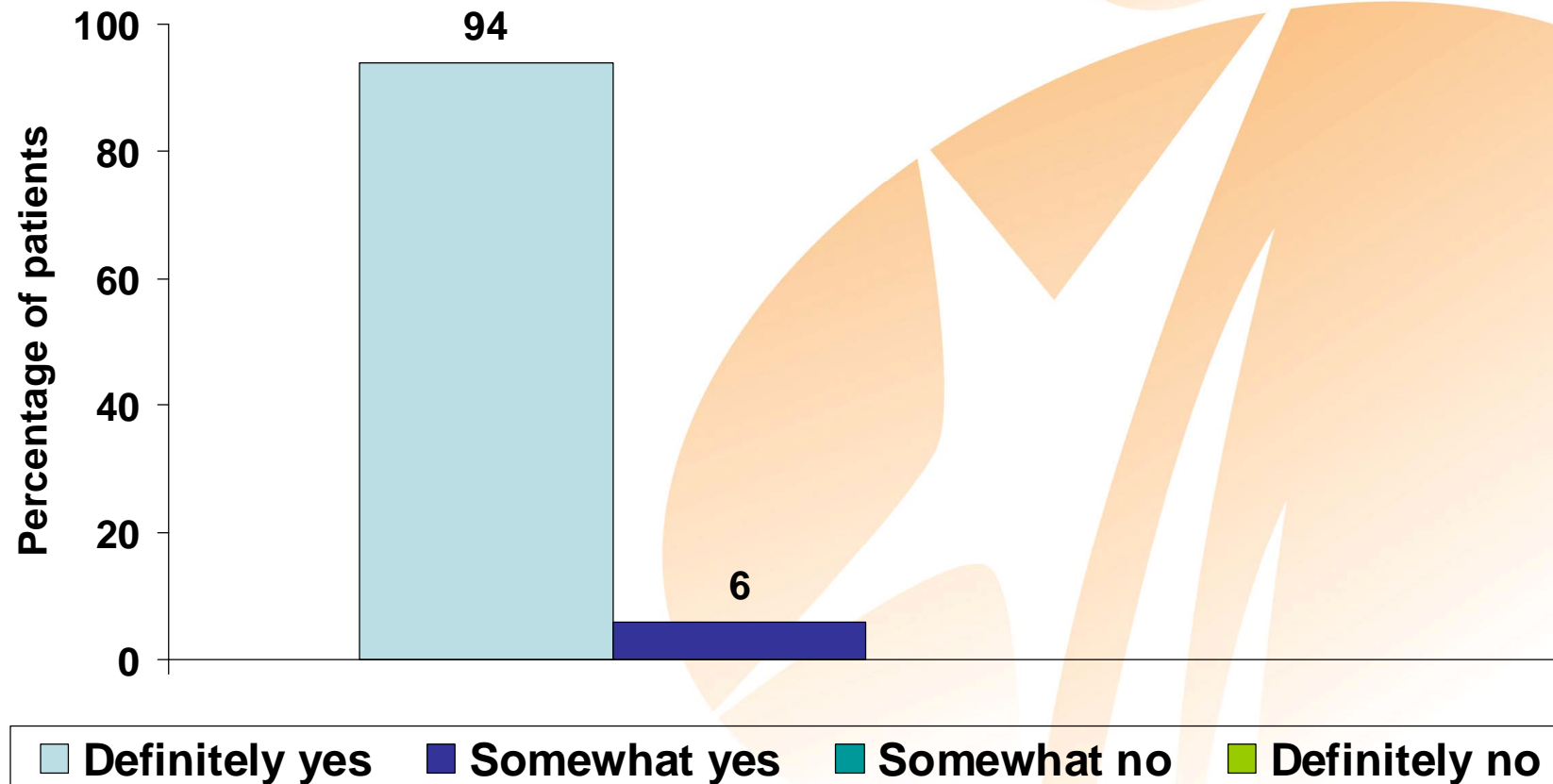
Patient Satisfaction Survey

How often do you see the doctor for your hypertension?
(N=17)



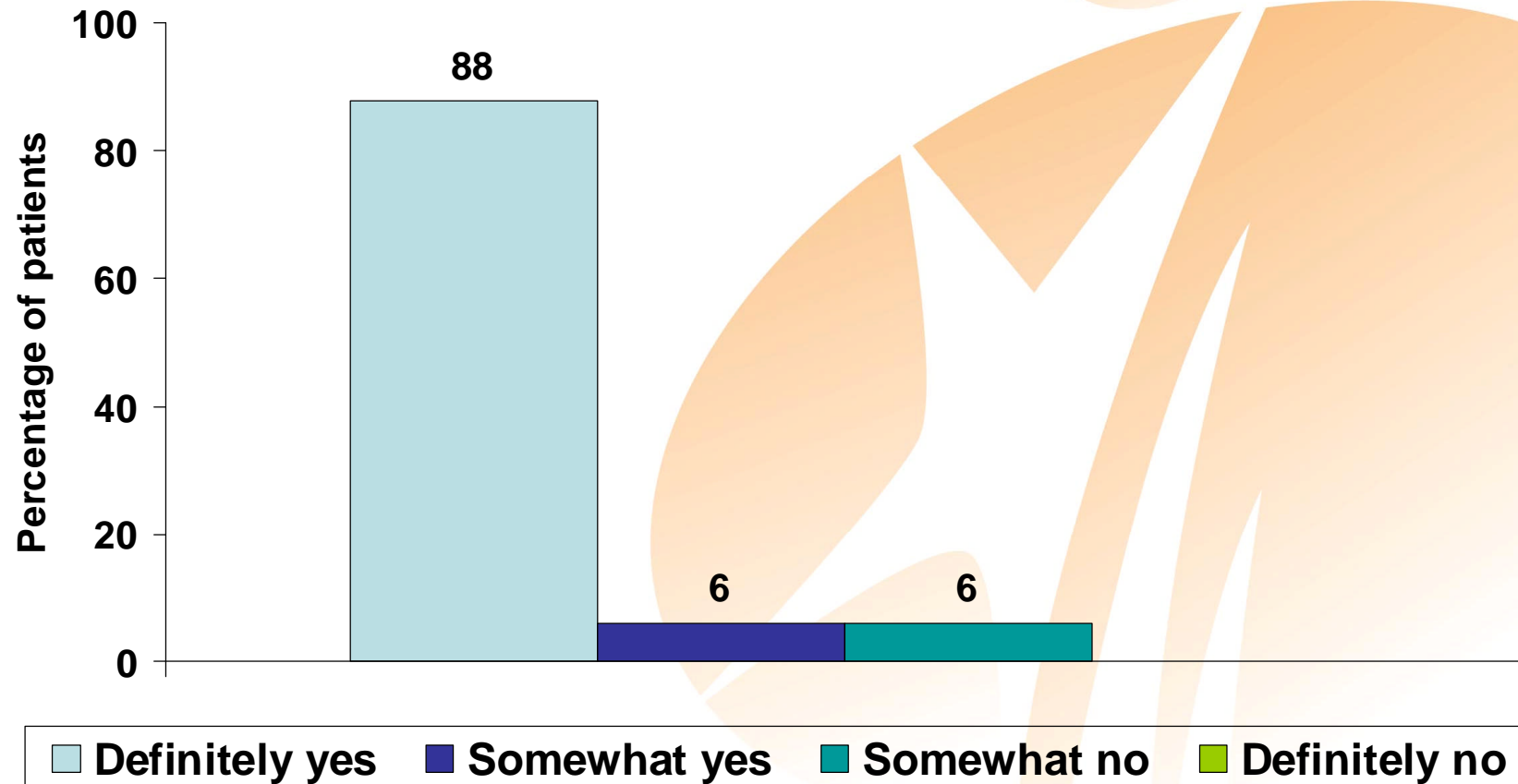
Patient Satisfaction Survey

Have your frequency to the doctor reduce after enrolment into the program? (N=17)



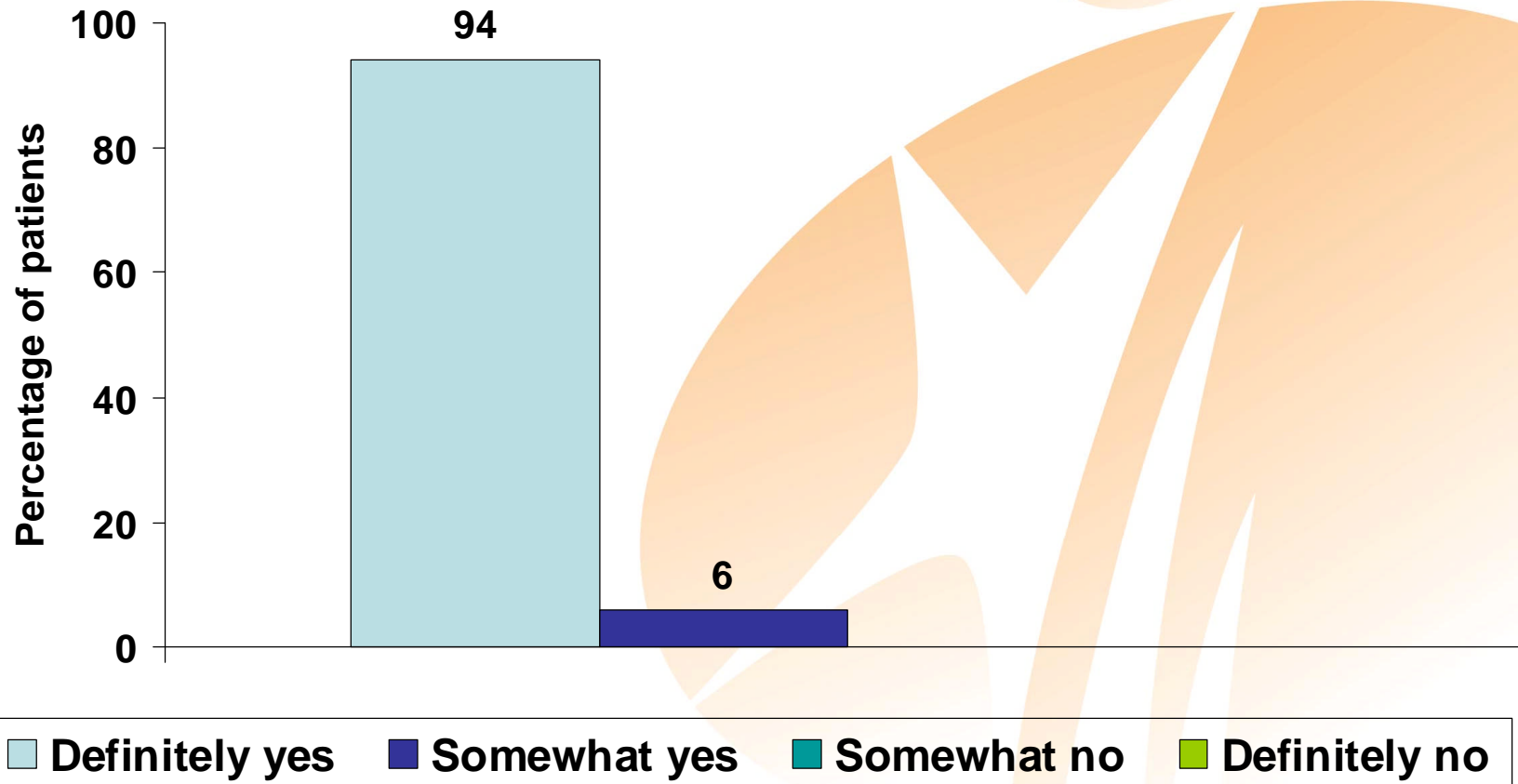
Patient Satisfaction Survey

Have your travelling and consultation expenses reduce after enrolment into the program? (N=17)



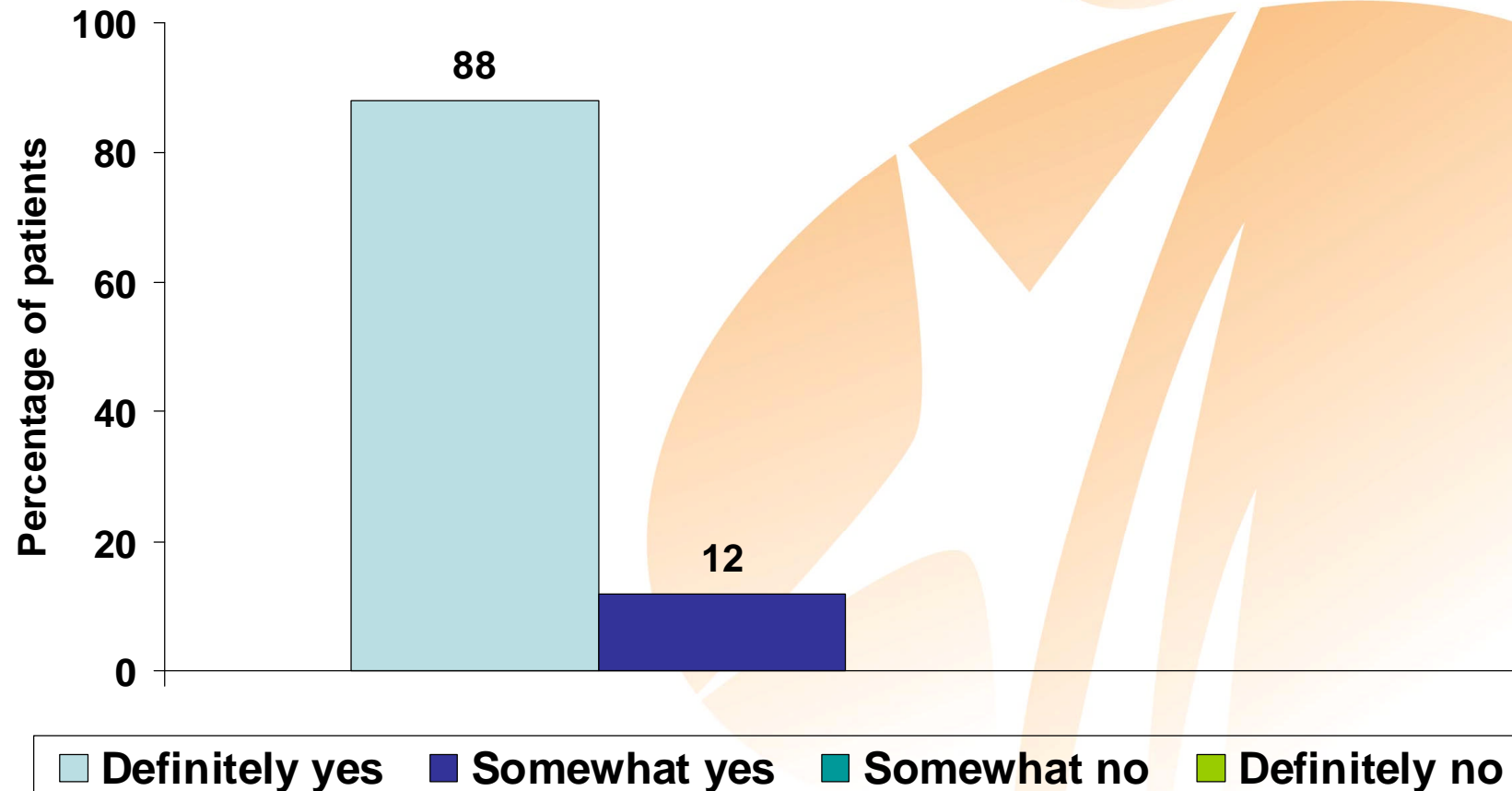
Patient Satisfaction Survey

Did the program provides you with the information in self-managing your blood pressure? (N=17)



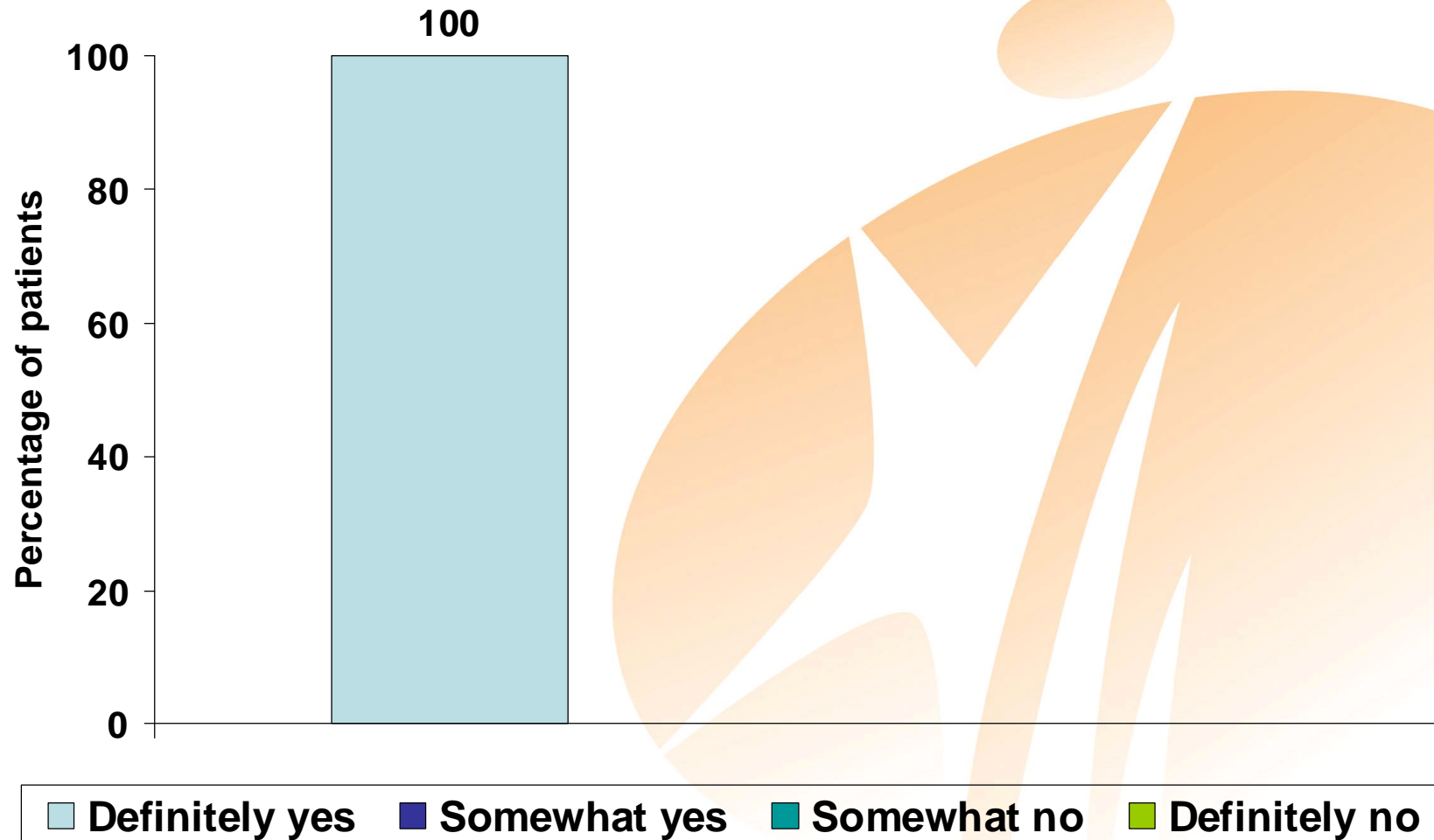
Patient Satisfaction Survey

Did the program provides you the confidence in self-managing your blood pressure? (N=17)

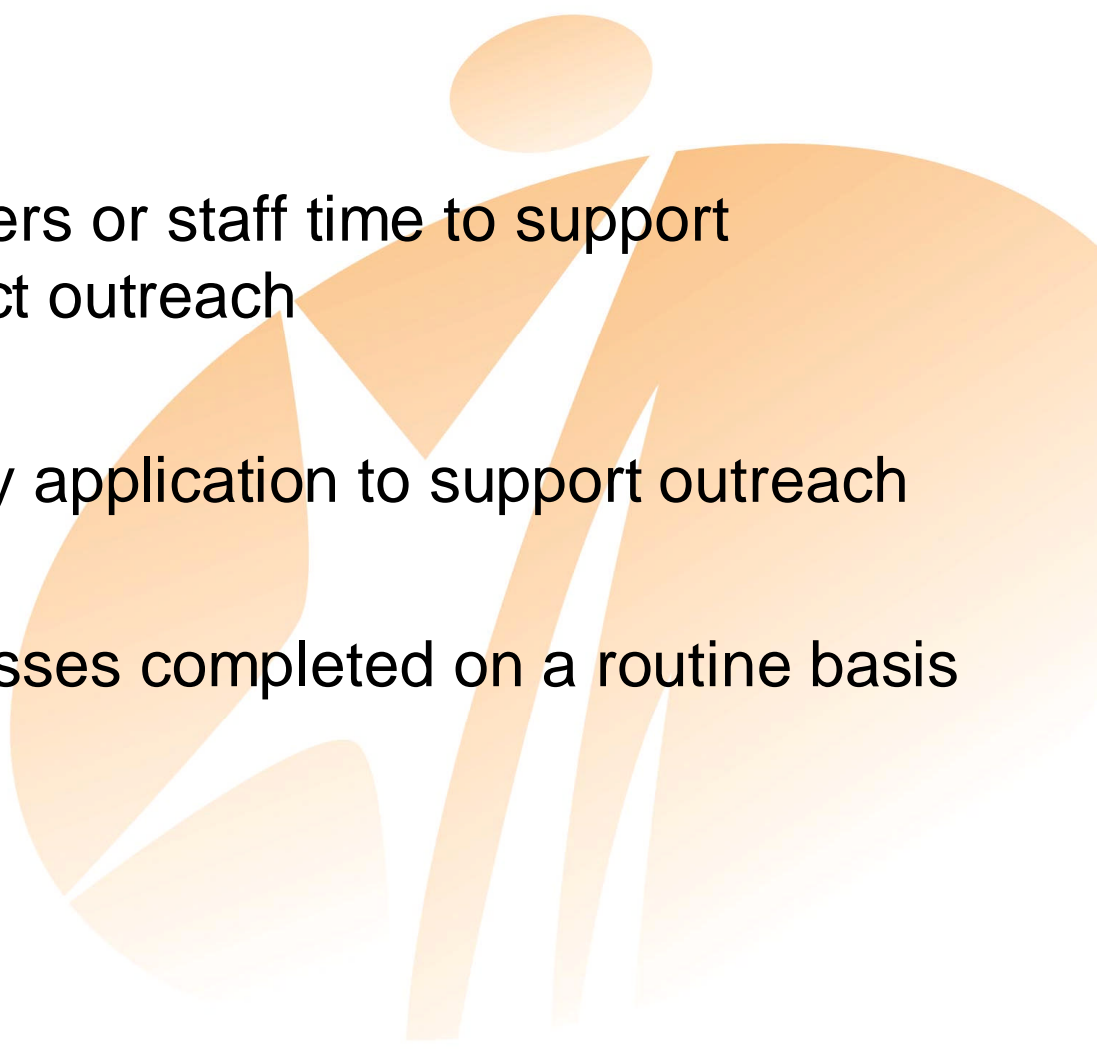


Patient Satisfaction Survey

Overall did you benefit from the program? (N=17)

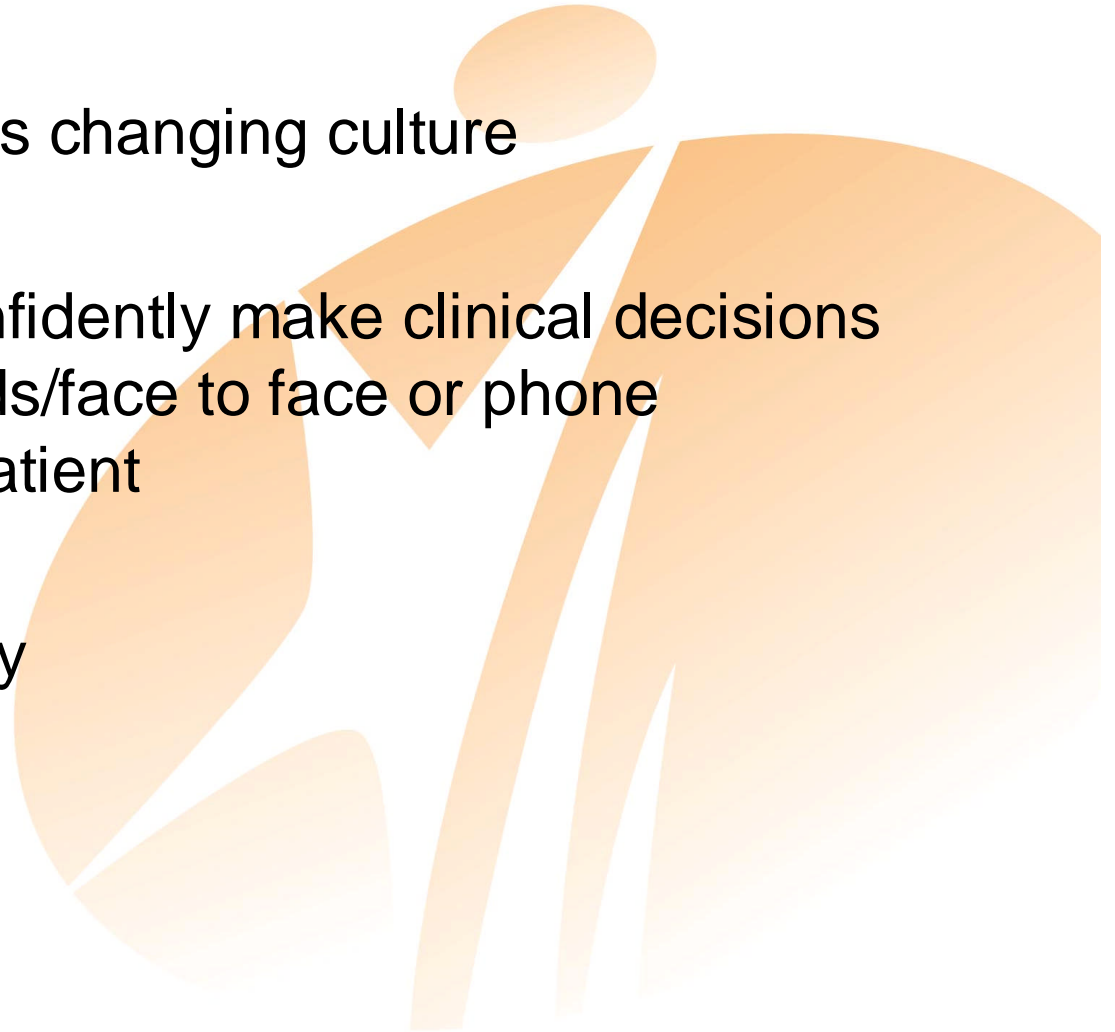


Key Components in Panel Management

- Dedicated physician time for directing clinical decision making
 - Dedicated staff members or staff time to support physicians and conduct outreach
 - Information-technology application to support outreach
 - Structured work processes completed on a routine basis
- 

Barriers & Challenges

- Practice requires shifting of roles and responsibilities
- New approach involves changing culture
- Tension of PCP to confidently make clinical decisions without medical records/face to face or phone communication with patient
- Physician sustainability





Thank You



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