TBC

Team Based Care

Population Management

Proactively identifying gaps in care and reaching out to patients overdue for treatment or preventive services.

Key Changes

- **Ensure** patients are linked to a specific provider and team (see Empanelment).
- **Decide** which patient populations and data elements to track.
- **Create** consensus among providers to follow selected evidence-based guidelines.
- Regularly **generate** actionable and trusted reports at the team level.
- **Select** and **train** population management staff.
- **Develop** and **document** criteria that specify who/when/how to take action.

Examples

- Ask staff which populations are most difficult to manage.
- Review current clinical outcomes to define high risk, high volume and or high cost sub-populations. Look for populations where you are meeting patient needs and/or clinical outcomes.
- Select a single sub-population to address.
- Set aim and measure for sub-population management.
- Choose evidence-based care algorithm for target sub-population.
- Providers review algorithms and endorse selected plan in a group meeting.
- Identify and resolve causes of clinical inertia.
- Create patient focus group to review plan and give feedback on tests of change.
- Develop new workflows and explicit roles for population tracking and outreach.
- Design tracking system that does not use the appointment schedule or medication refills.
- Develop script for staff to contact patients to educate and complete care plan.
- Test PDSAs of outreach scripts and workflows incorporating patient feedback.
- When process is stable, consider adding other sub-populations leveraging learning from early successes.

Primary Care Team Guide Assessment-Related Questions

Medical Assistant (MA)

	Components	Level D	Level C	Level B	Level A
9	MAs in our practice…	mostly take vital signs and room patients. 1☐ 2☐ 3☐	perform a few clinical tasks beyond rooming patients such as reviewing medication lists or administering a PHQ-2. 4☐ 5☐ 6☐	perform a few clinical tasks and collaborate with the provider in managing the panel (reviewing exception reports, making out-reach calls). 7☐ 8☐ 9☐	Collaborate with the provider in managing the panel, and play a major role providing preventive services, and services to chronically ill patients such as self-management coaching, or follow-up phone calls. 10☐ 11☐ 12☐

Registered Nurse (RN)

10	RNs in our practice…	are not part of the core practice team. 1☐ 2☐ 3☐	mostly triage phone calls and do injections or other procedures. 4☐ 5☐ 6☐	Manage transitions within and across levels of care (home care, hospital, specialists). Provide specific intensive care coordination and management to highest risk patients. 7☐ 8☐ 9☐	Provide care management for high risk patients and collaborate with providers in teaching and managing patients with chronic illness, monitoring response to treatment, and titrating treatment according to delegated order sets in independent nurse visits 10☐ 11☐ 12☐

Population Management

	Components	Level D	Level C	Level B	Level A
15	Registry information on individual patients…	is not available to practice teams for pre-visit planning or patient outreach. 1☐ 2☐ 3☐	is available to practice teams but is not routinely used for pre-visit planning or patient outreach. 4☐ 5☐ 6☐	is available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states. 7☐ 8☐ 9☐	is available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states. 10☐ 11☐ 12☐

How Primary Care Teams Achieve the Quadruple Aim