Using a Diabetes Panel Management Tool

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Kaiser Medical Center-Richmond is one of Kaiser-Permanente's oldest locations and serves a diverse, multicultural population heavily impacted by diabetes. Over the last 3 years our team consisting of a Diabetologist, Project Manager, Panel Management Assistant and Data Analyst, with administrative support, developed, implemented and successfully integrated a diabetes panel management program into the Department of Medicine.

Using a "panel management tool" that imports relevant data, (e.g. labs, medications, immunization status, etc.) from a diabetes registry database, the tool provides a checklist of important diabetes management tasks for providers. [DATA ORGANIZED and UP-TO-DATE] A full time panel management assistant (PMA) generates 10 worksheets for review by providers during a blocked 15 minute appointment. [EFFECTIVE LEVERAGE of PROVIDER TIME] The provider reviews the worksheets, indicating any new interventions or recommendations on the worksheet using check boxes and/or writing notes on the worksheet for follow-up, including ordering lab testing, adding or adjusting medications (e.g. adding Aspirin) and referrals. [PROMOTES ACTION AND INTERVENTION] In addition, the provider indicates using check boxes when the next worksheet for a particular patient is to be generated for review again (e.g. 1 month, 3 months, 6 months or twelve months).[SUPPORTS ON-GOING CARE and CYCLICAL REVIEW]

Next the PMA contacts the patients with provider instructions including lab testing, medication prescriptions and referrals and documents information on patient use of critical medications like ASA, ACEI and statins on the tool when verified. [PROMOTES PERSONALIZATION of CARE] Information gathered is entered into the database to be re-examined at the next tool review. We estimate one PMA can support the tool management of 1200-1500 patients. We currently have 4 PMAs. [EFFICIENT USE of RESOURCES]

Currently, all 28 providers in the Department of Medicine (MDs and RNPs) are using the panel management tools regularly, up to 4 times per week per provider. In 2 years, over 13,000 tool interventions have been completed. Almost 90% of our diabetes population (5000 patients) has undergone at least one cycle of tool management so far, many have undergone several cycles.[POSITIVE IMPACT on PATIENT SATISFACTION and COMPLIANCE] Our goal is for 100% of our patients at risk for cardiovascular disease and in need of secondary prevention measures to be under tool management regularly. [COMPREHENSIVE POPULATION MANAGEMENT]

There has been very significant improvement in Richmond's quality measures for glycemic control, LDL management and use of ACEI in our target population. In recent monitoring, KP Richmond was 11% above the regional average in the Northern California composite measure of patients with all appropriate medications for secondary risk reduction, including 70% of Richmond's members with diabetes. [IMPROVED QUALITY OUTCOMES]