Empanelment

Fundamental Step for Team Based Care

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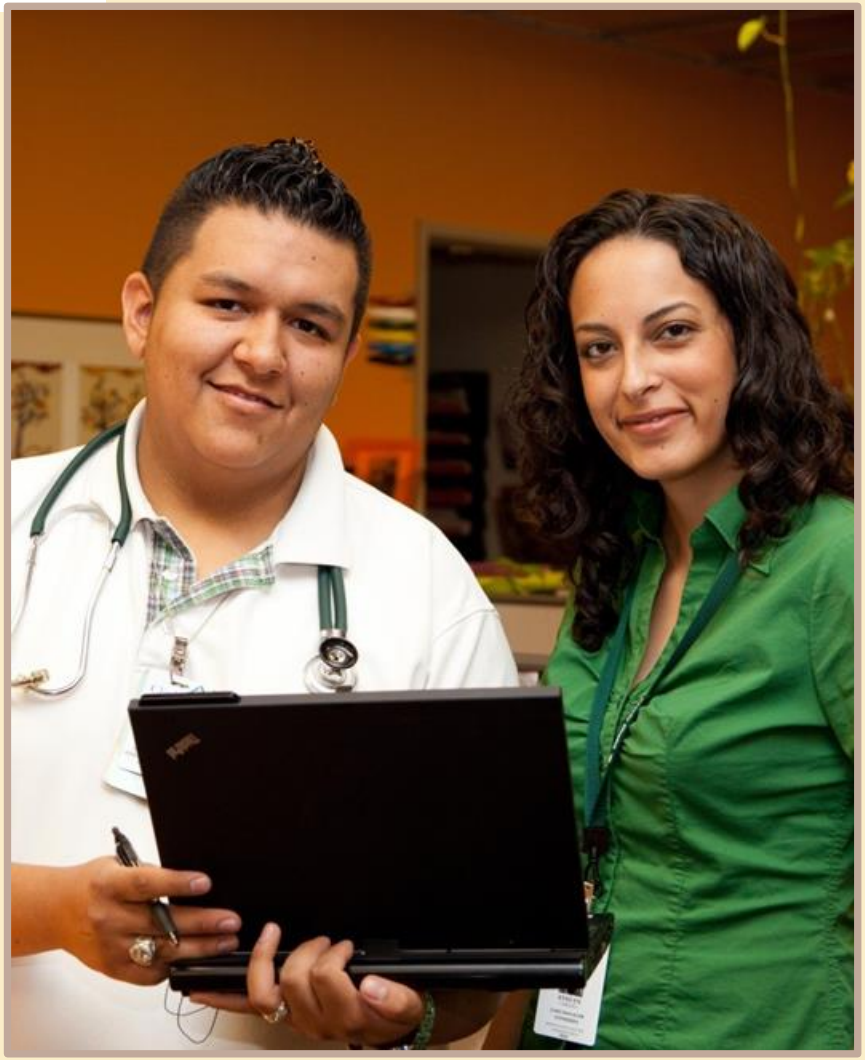
Empanelment

- Definition
- Case for empanelment
- Getting started where you are at
- Adding complexity
- Understanding variation
- Managing panels over time (help from coaches)
- Panels at High Plains

Big 6 for Clinica Transformation-1999



1. Continuity
2. Access
3. Team Based Care
4. Alternative Visits
5. Information Technology
6. Patient Engagement

Definition-Empanelment

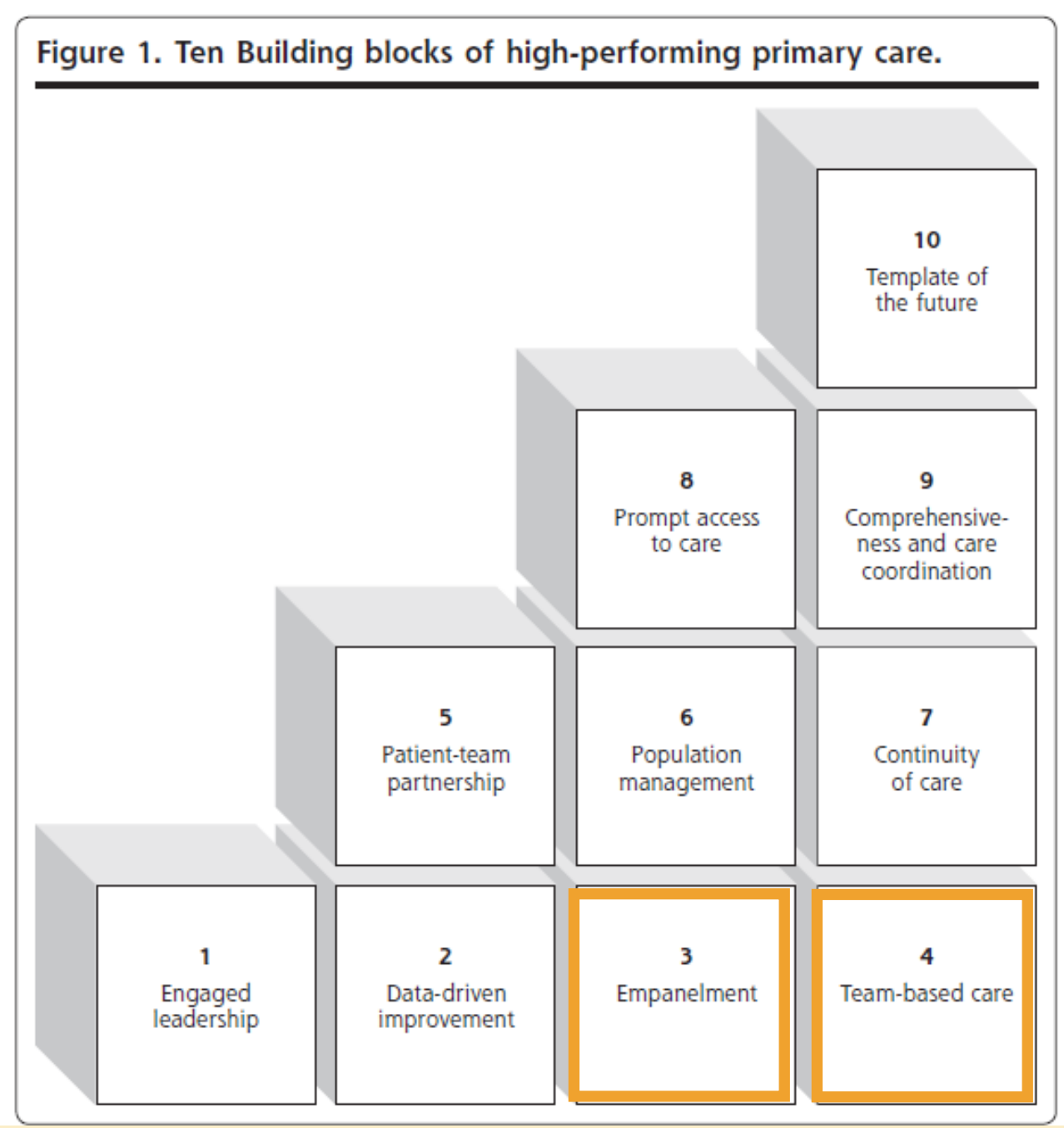
- The panel is the number of unduplicated patients assigned to each PCP and Care Team
  - The patient is a member of the team
  - Shared goals, mutual trust, defined roles, clear communication and measurable outcomes
- Empanelment is a series of processes to sort patients into populations served by the Care Team

Why Start with Empanelment?

1. Accountability to team members including patients
    - The fundamental step for Team Based Care
    - Visible fairness and equity
    - Designing support team
2. Critical tool to improve continuity and access
    - Improve clinical outcomes (hospitalizations, LOS, ER &UC visits, referrals, medications, tests, demand for appointments)
    - Patient satisfaction
    - Staff satisfaction

Why Start with Empanelment?

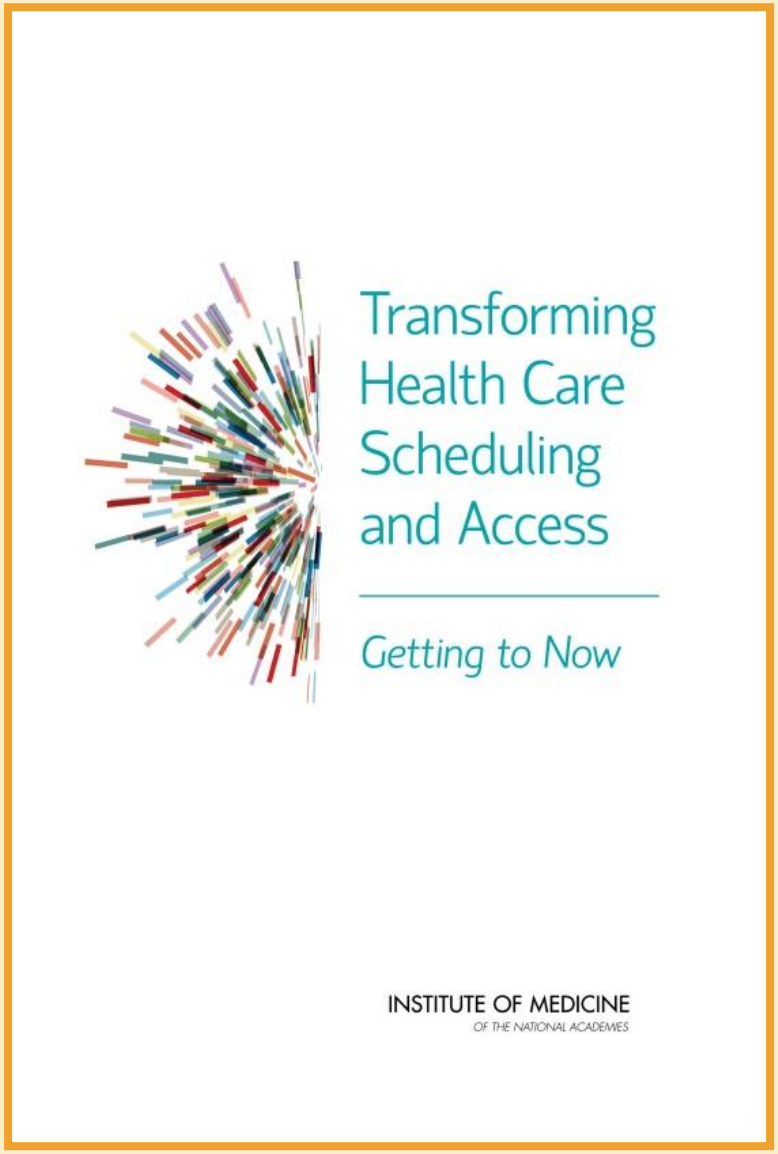
3. Operational management
    - Shouldn’t have to depend on the patient
    - Dosing of support services
    - When and how to grow
    - Open and close panels
    - Manage population with provider/team change
    - Because Ed and Katie say so



Bodenheimer, Tom et al 2014
10 Building blocks of high performing primary care
Ann Fam Med 166-171

"There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs."

IOM Focus on Access 6-29-15



Assigning Patients to Panels

Unique individuals seen by practice in the last 12-18 mo.:

- Be sure to assign the patient to only one PCP
- Assign every new patient to your practice to a PCP
- 12 mo under-estimates the panel (≈15-25%)
  - Variables include % of patients with only 1 visit a year, patient turn over rates and access
- 18 mo under-estimates the panel less (≈ 10%)
- 24 mo may over-estimate panel depending on patient turnover
- The active panel creates the demand for team services
- 4 Cut method useful place to start

Assigning Patients to Panels

Unique individuals seen by practice in the last 18 mo.:

- Cut 1: Patients seen exclusively by one provider
- Cut 2: Patients seen predominantly by one provider
- Cut 3: Those patients seen same number of times by multiple providers by last preventative care visit
- Cut 4: Patients seen same number of times by multiple doctors with no well care
  - Last provider
  - Consider provider review
  - Divide this pie to create balanced equitable panels

Panel Size

Adjusting panels initially-looking for fairness to build trust

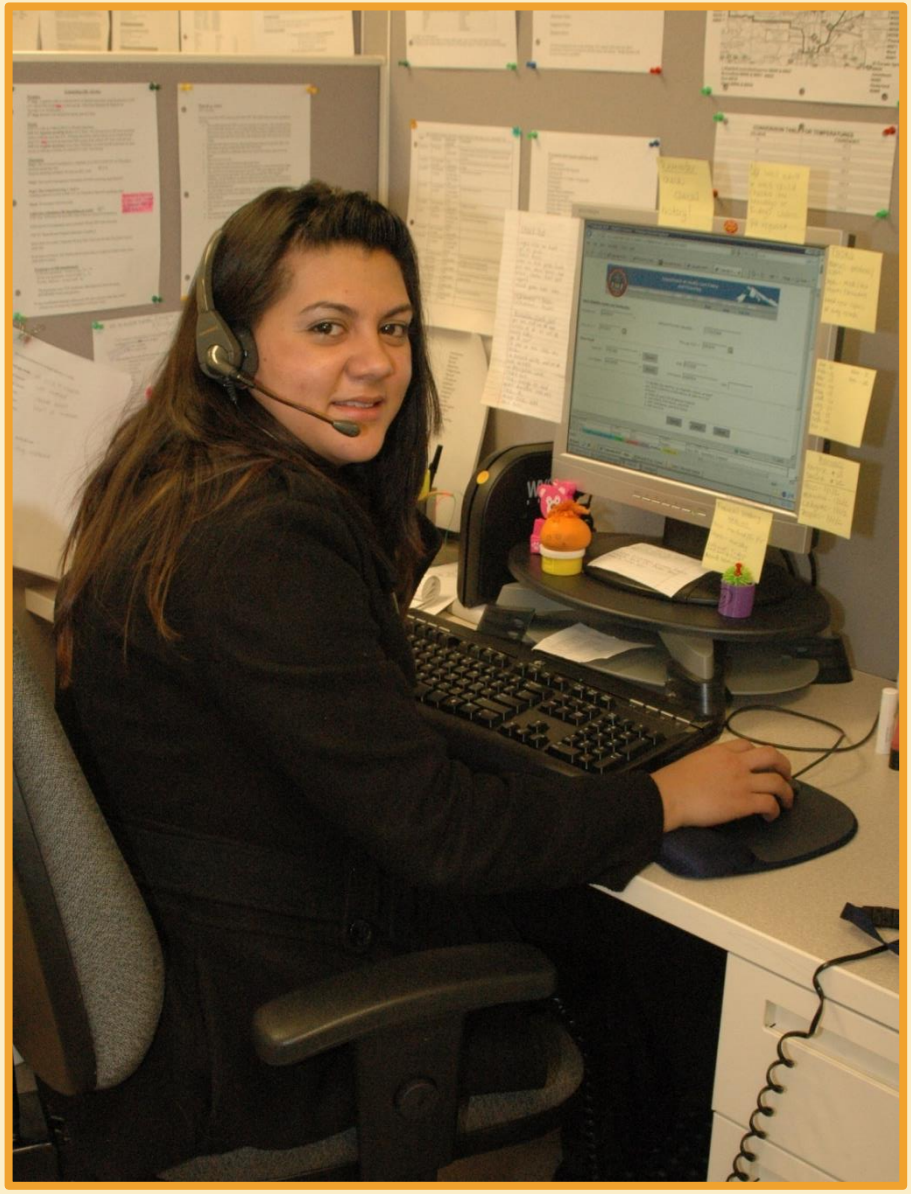
1. Move Cut 4 patients to providers with small panels
2. Run frequency of visit report for large panels-move patients seen infrequently
3. Use scripts to let patients know they can change

Adjusting panels over time

1. Remember it is TEAM BASED CARE
2. Follow access measures, utilization data, continuity
3. Use registry data to balance chronic disease load
4. Always ask these patients prior to changing PCP

Using Active Panels

- Opening and closing panels
- Assigning new patients
- Managing provider FTE and turnover
- Balancing supply & demand
- Measuring performance improvement

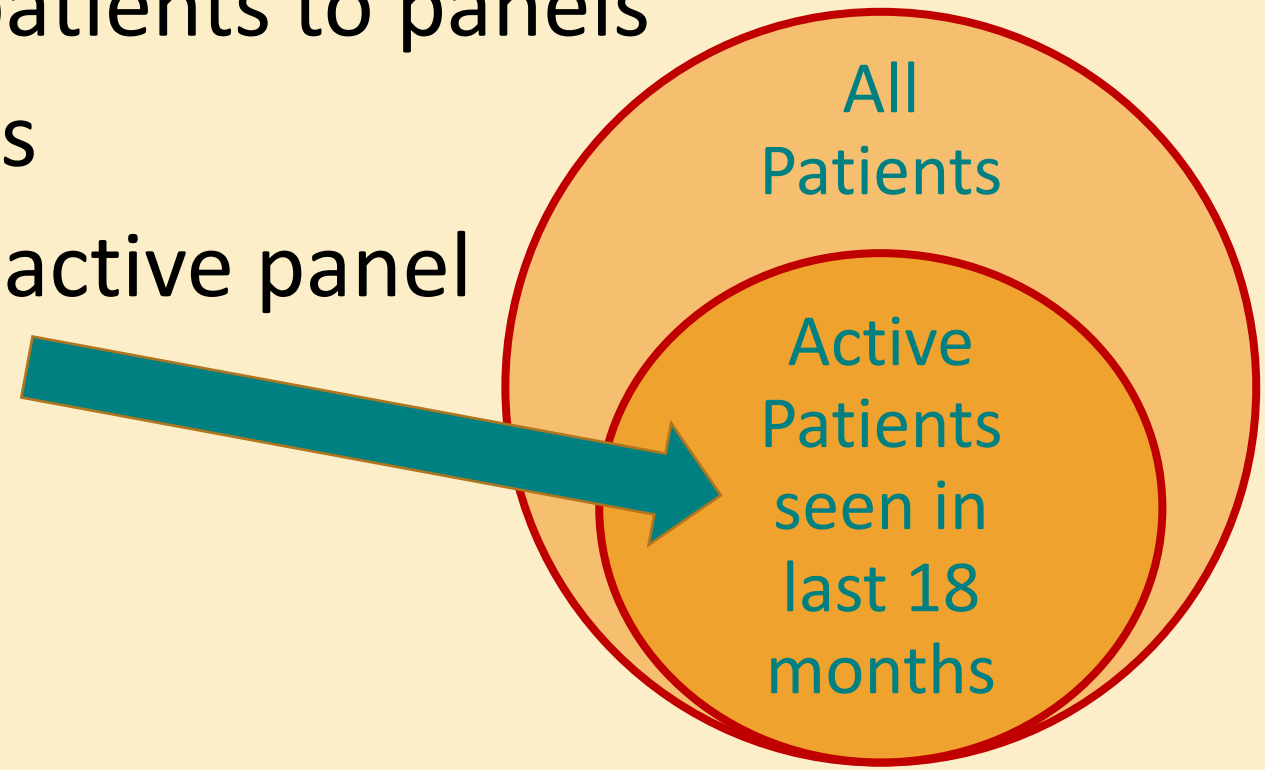


Managing Panels-All vs Active

Assigning patients to panels

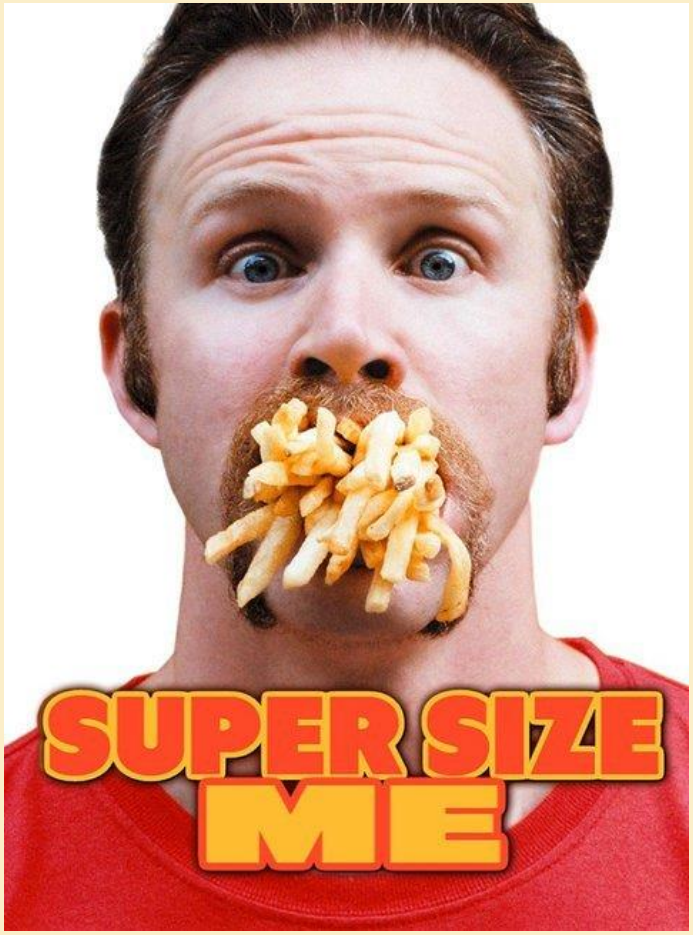
vs

Measuring active panel



Super-sized Panel

- Guarantees poor continuity (waste, high cost)
- Drives up unnecessary primary care visits, ED and UCC visits
- Decreased patient engagement
- Overflow to colleagues
- False economy-issue of fairness



Adjusting Panels

- Shared goals, mutual trust
- “My patients are sicker”-acuity formulae
- Age and Gender

Clinica Age & Sex Panel Adjustment

Panel Factor Clinica

2006 data

	F				M				Total	
	Patients	Encounters	visits per patient	factor	Patients	Encounters	visits per patient	factor	Patients	Encounters
0	1,903	11,588	6.09	1.19	1,930	12,290	6.37	1.24	3,833	23,878
1	538	1,914	3.56	0.69	586	2,177	3.72	0.73	1,124	4,091
2	520	1,457	2.80	0.55	458	1,290	2.82	0.55	978	2,747
3	441	1,143	2.59	0.51	520	1,341	2.58	0.50	961	2,484
4	440	1,001	2.28	0.44	453	1,011	2.23	0.44	893	2,012
5-9	1,276	2,647	2.07	0.40	1,213	2,589	2.13	0.42	2,489	5,236
10-14	972	2,342	2.41	0.47	935	2,010	2.15	0.42	1,907	4,352
15-19	1,465	10,988	7.50	1.46	433	839	1.94	0.38	1,898	11,827
20-24	2,324	20,338	8.75	1.71	231	520	2.25	0.44	2,555	20,858
25-29	2,207	17,889	8.11	1.58	397	912	2.30	0.45	2,604	18,801
30-34	1,730	12,124	7.01	1.37	379	956	2.52	0.49	2,109	13,080
35-39	1,109	6,451	5.82	1.14	366	1,080	2.95	0.58	1,475	7,531
40-44	703	3,526	5.02	0.98	293	1,005	3.43	0.67	996	4,531
45-49	549	2,691	4.90	0.96	241	961	3.99	0.78	790	3,652
50-54	411	2,193	5.34	1.04	214	996	4.65	0.91	625	3,189
55-59	348	1,973	5.67	1.11	164	910	5.55	1.08	512	2,883
60-64	309	1,898	6.14	1.20	160	856	5.35	1.04	469	2,754
65-69	200	1,104	5.52	1.08	124	662	5.34	1.04	324	1,766
70-74	107	627	5.86	1.14	78	378	4.85	0.95	185	1,005
75-79	59	403	6.83	1.33	47	298	6.34	1.24	106	701
80-84	42	349	8.31	1.62	30	159	5.30	1.03	72	508
85+	28	118	4.21	0.82	11	39	3.55	0.69	39	157
Total	17,681	104,764			9,263	33,279			26,944	138,043
										5.12333

Managing Panels at Clinica

Panel Size Report

Provider	Pod	FTE	Current Number of Patients	Goal (w/factor)	2013-1 Panel (adjusted)	2013-2 Panel (adjusted)	Over (Under)
Lafayette							
Archuleta, Charlene	Purple	0.50	6	600		5	(595)
Hinman, Julie	Purple	0.56	842	672	887	860	188
Keenan, Chris	Purple	0.50	593	600	575	584	(16)
Mitchell, Susan	Purple	0.75	989	900	1,008	1,028	128
Obrien, Daniel	Purple	0.80	917	960	892	914	(46)
Shepherd, John C	Purple-Gon	0	5	0	4	4	4
Blair, Jennifer	Red	0.60	642	720	628	645	(75)
Funk, Karen	Red	0.70	843	840	876	886	46
Kanner, Mary	Red	0.65	977	780	962	995	215
Monyok, Eileen	Red	0.68	864	816	839	865	49
Boysen, Eric	Red-Gone	0	577	0	535	527	527
Johnson, Jennifer	Red-Gone	0	6	0	5	3	3
Unassigned	No PCP		27		60	26	N/A
Total - Lafayette		5.79	7306	6948	7,289	7,361	387

Unassigned plus wrongly assigned: (27+5+6)/7306 =0.5% defects

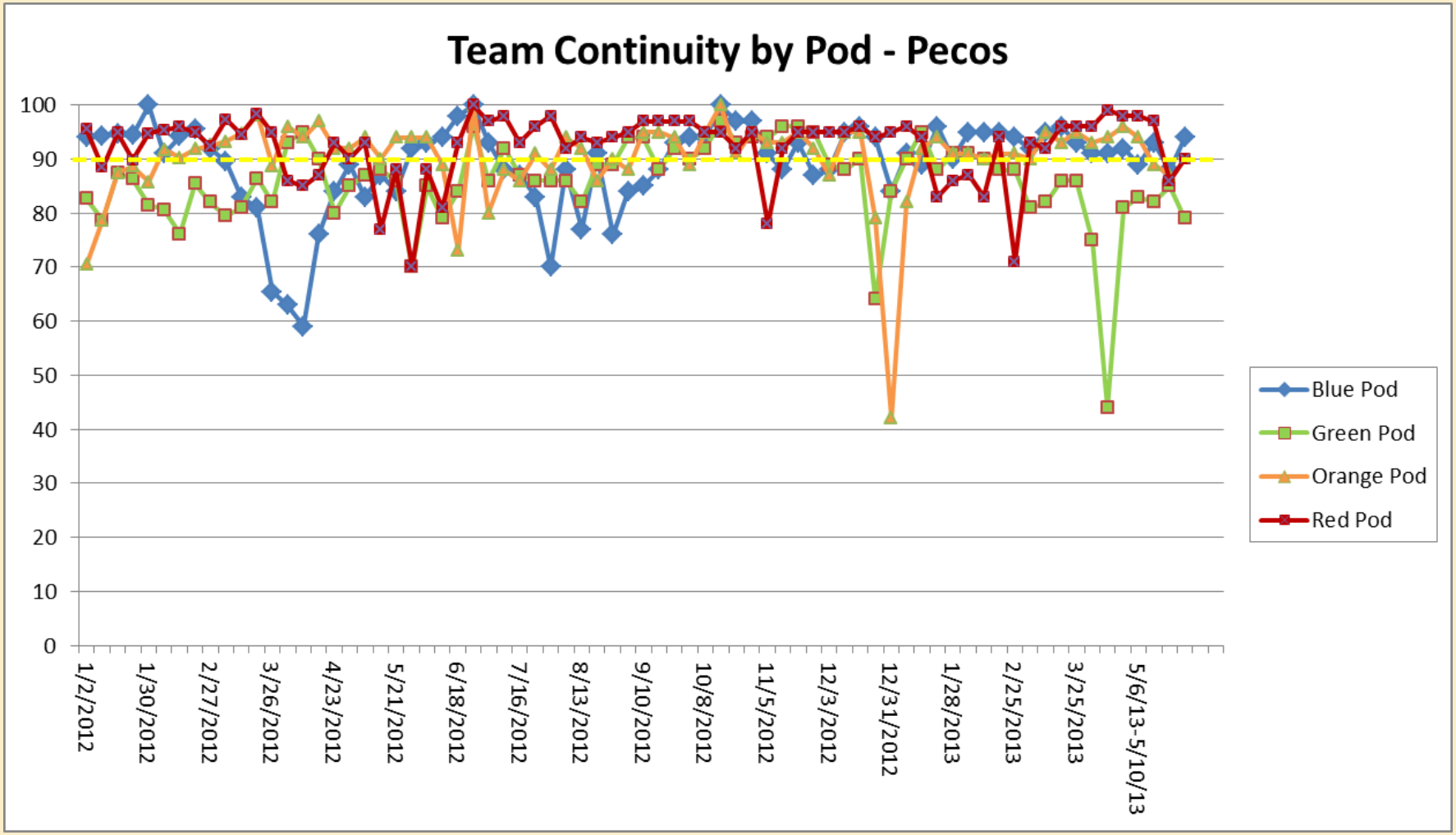
Lessons Learned-Empanelment

- Direct new patients to PCP teams with unfilled panels.
- Help new pts select a PCP and team and encourage them to do so.
  - Opportunity to educate patients on being part of the team
  - Develop a script, bios w photos, business and appointment cards, picture sheet & board to help pts select and learn PCP. Confirm at every contact.
- Develop procedure for patient driven PCP changes
- Display PCP/Team in every field in the EHR-especially scheduling modules

Lessons Learned-Empanelment

- Added risk adjustment for age & sex about 3 years in
- Regular measurement of patient centered continuity
- Regular measurement to assure access to PCP
- Quarterly process to clean up panels
- Share panel/access/continuity data to all staff
- Understand the variation in panels/access/continuity

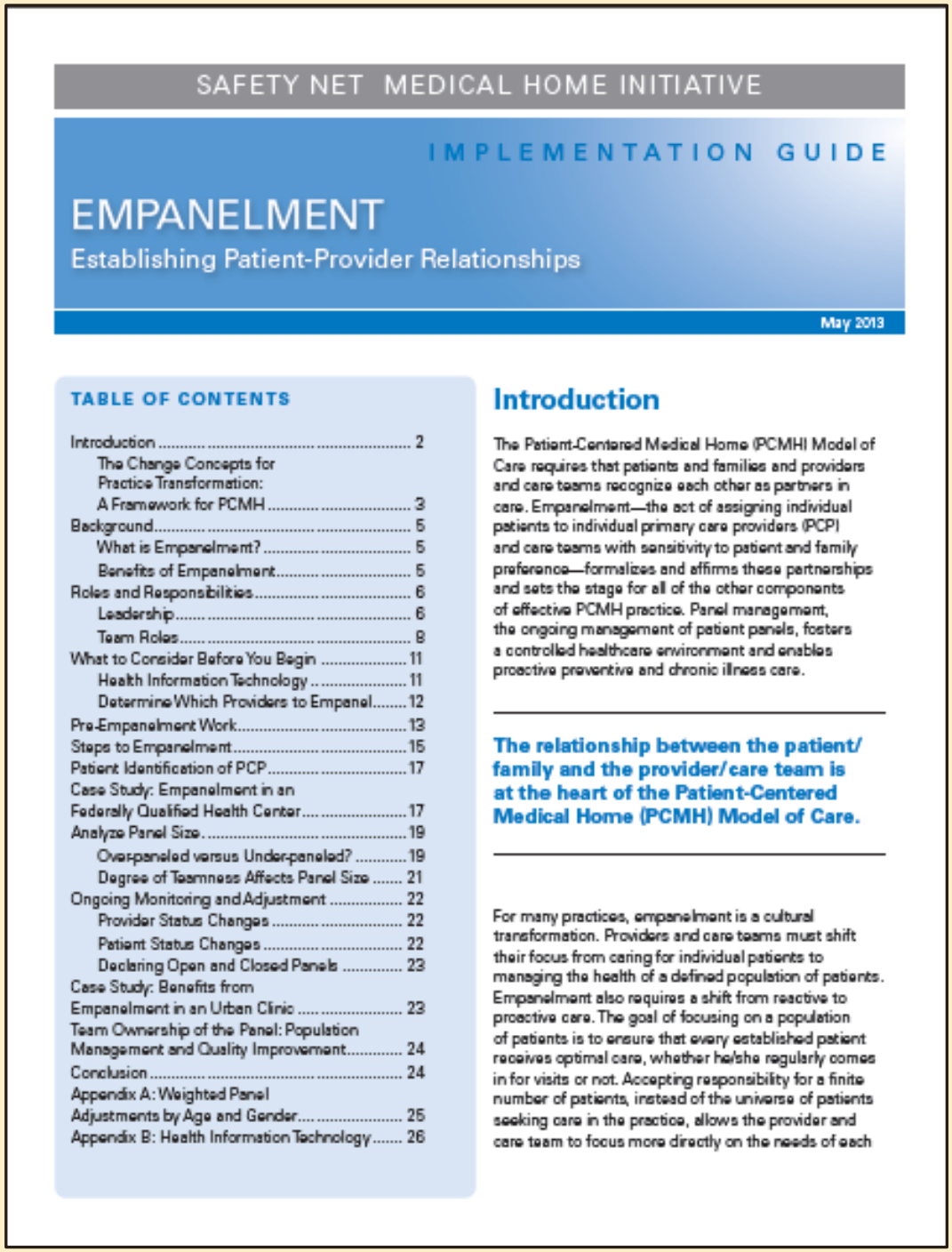
Measure and Drive Continuity



TBC
Team Based Care

References: Safety Net Medical Home Initiative

http://www.safetynetmedicalhome.org/change-concepts/empanelment



SAFETY NET MEDICAL HOME INITIATIVE

IMPLEMENTATION GUIDE

EMPANELMENT

Establishing Patient-Provider Relationships

May 2013

TABLE OF CONTENTS

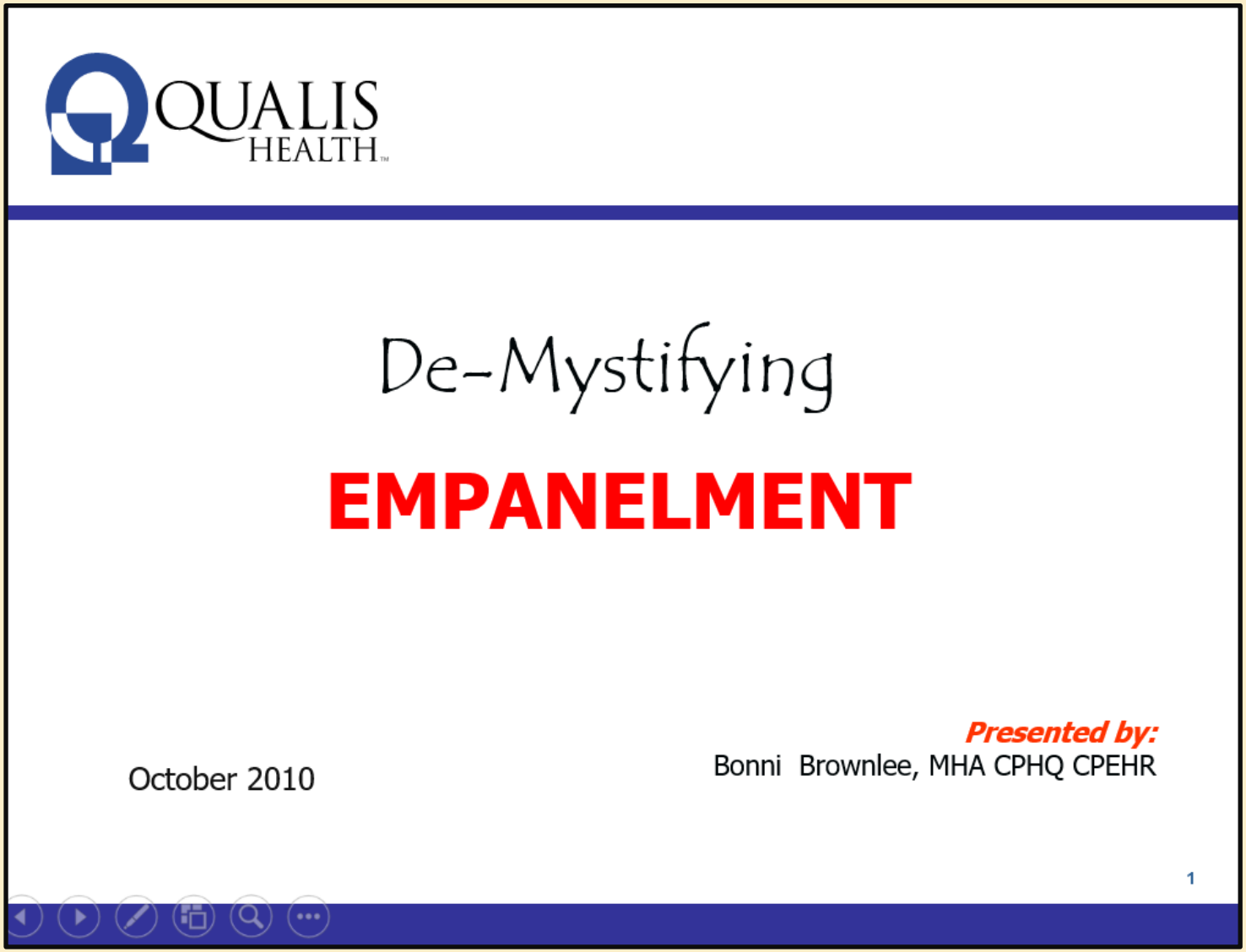
Introduction

The Patient-Centered Medical Home (PCMH) Model of Care requires that patients and families and providers and care teams recognize each other as partners in care. Empanelment—the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference—formalizes and affirms these partnerships and sets the stage for all of the other components of effective PCMH practice. Panel management, the ongoing management of patient panels, fosters a controlled healthcare environment and enables proactive preventive and chronic illness care.

The relationship between the patient/family and the provider/care team is at the heart of the Patient-Centered Medical Home (PCMH) Model of Care.

For many practices, empanelment is a cultural transformation. Providers and care teams must shift their focus from caring for individual patients to managing the health of a defined population of patients. Empanelment also requires a shift from reactive to proactive care. The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether he/she regularly comes in for visits or not. Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each

References: Bonni Brownlee



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