EXECUTIVE SUMMARY

EMPANELMENT

Establishing Patient-Provider Relationships

May 2013

For more detailed information, see the Empanelment Implementation Guide.

What

Empanelment is the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference. The PCP is the leader of a care team that works collaboratively to optimize care. Patients are able to reliably visit their same provider and care team at every visit. Empanelment is the basis for population health management. 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 patient.

Why

The relationship between patient, provider, and care team is at the heart of the Patient-Centered Medical Home (PCMH) Model of Care. Empanelment formalizes and affirms these partnerships and sets the stage for all of the other components of effective PCMH practice. Empanelment supports continuity of care and fosters a controlled healthcare environment that allows practices to go beyond disease-specific interventions and address preventive, chronic, and acute patient needs. Patients value having one PCP as a source of first contact and coordinator of referrals. Stable patient and provider/care team relationships build trust and provide consistency in treatment approaches and follow-up, reducing intensive chart review for unfamiliar patients and controlling costs by mitigating duplicate tests, medications, and service orders. Continuity also fosters efficient patient flow processes and results in higher levels of staff satisfaction. Many providers are able to increase productivity through redesigned clinic workflows and improved team functioning.

Implementation Overview

Pre-Empanelment Work

- Designate a panel manager.
- Determine which providers to empanel. Create policies around mid-levels, part-time providers, specialty providers, and medical residents, if applicable.
- Ensure reporting capability from the practice management system.
- Identify active and inactive patients and purge inactive patients using the organization's definition (e.g., 18 months).

- Determine the practice's Average Visits per Patient per Year (AVPY).
- Determine right panel size for each practice provider.
- Determine patient demand for services.
- Determine provider supply for patient access to services (number of appointment slots available in the past year).

Steps to Empanelment

- Review patient visit history.
- Review initial panel assignments. Sort first by assigned PCP for initial panel sizes.
- For patients not already assigned to a PCP, apply the Four-Cut Method.

  1st cut. Patients who have seen only one provider in the past year: Assign to that sole provider.

  2nd cut. Patients who have seen multiple providers, but one provider the majority of the time in the past year: Assign to majority provider.

  3rd cut. Patients who have seen two or more providers equally in the past year (no majority provider can be determined): Assign to the provider who performed the last physical exam.

  4th cut. Patients who have seen multiple providers: Assign to last provider seen.
- Review preliminary panel report and amend as necessary.
- Weight panels to assure equity across providers, if desired. Weight by patient age, gender, morbidity, or acuity.
- Inform patients of their PCP assignment when they first visit the practice or immediately after empanelment occurs. Encourage patients to develop a relationship with their provider and care team.
- Alert patients that they can change their PCP/care team if desired or needed.
- Monitor and record requests by patients or providers for panel re-assignment.

Analyze, Monitor, and Adjust

- Designate a staff person as responsible for providing panel reports to providers. Continuously monitor provider and patient status changes and adjust panel size accordingly.
- Run continuity of care reports routinely (e.g., monthly, quarterly) to review the frequency of patients seen by their assigned PCP. The goal is for the patient to achieve 100% continuity by seeing only his/her provider/care team. Provide these reports to the responsible provider and care team.
- Review provider supply on an annual basis or more frequently if needed to ensure enough appointment availability to meet demands of current panel size.
- Encourage patient involvement in the process of validating PCP assignment.

Leadership Support for Empanelment

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.

Leadership must provide direction and support for empanelment to be successful:

- Clarify roles and responsibilities and update job descriptions accordingly.
- Create staffing and scheduling policies and session coverage expectations.
- Provide training and support for staff.
- Routinely monitor panel data to ensure equity across providers.
- Provide designated time prior to the patient visit for provider and care team to huddle and prepare for the day. To learn more about huddles, see the Continuous and Team-Based Healing Relationships Implementation Guide.

What Progress Looks Like: PCMH-A Level A

The PCMH-A is a self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

9. **Patients…**are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.

10. **Registry or panel-level data…**are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.

11. **Registries on individual patients…**are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.

12. **Reports on care processes or outcomes of care…**are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams, and external agencies.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

QUALIS HEALTH™

THE COMMONWEALTH FUND

GroupHealth®

MacColl Center for Health Care Innovation