Empanelment in an Accountable Care Environment

IMPLEMENTATION GUIDE

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# Table of Contents

**IMPLEMENTATION GUIDE**

- What is Empanelment? 2
- Empanelment: Fundamental to PCMH and Triple Aim 2
- Empanelment Guide 3

**THE EMPANELMENT PROCESS** 4

- Phase “0”: Pre-empanelment Work 4
  - Weighting Patients 5
    - Step 1: Determine the Value of a Patient Equivalent 6
    - Step 2: Develop a Base Weight 7
    - Step 3: Account for Additional Factors 8
    - Step 4: Account for Inactive Patients 9
    - Step 5: Sum Patient Weights to Calculate Total Panel Weight 9
    - Step 6: Check Weighted Panel Size Against Clinical Practice 9
- Phase 1: Developing Initial Panels 10
  - Adjusting Single Cut Logic 11
- Phase 2: Refining Panels 11
- Phase 3: Ongoing Empanelment 12
  - Managing Panels 12
    - Adding New Patients 12
    - Opening and Closing Panels 13
    - Special Consideration 14

**CONCLUSION** 17

**APPENDICES** 18

- APPENDIX A: Panel Management Policy and Procedure Domains 18
- APPENDIX B: Empanelment Scripts 20
  1. Scripts for Schedulers 20
  2. Sample Script for Provider Equity Discussion 23
IMPLEMENTATION GUIDE

What is Empanelment?
Empanelment is the process of creating and maintaining a relationship between each patient and a primary care provider (PCP). The goal of empanelment is to ensure that each Patient Centered Medical Home (PCMH) care team has a group of patients for whom they are responsible and each patient can identify to whom they can turn for their health care needs. It is a proven method for creating continuity for providers and patients.

Empanelment: Fundamental to PCMH and Triple Aim
Empanelment is a critical first step in the transformation of primary care delivery into a PCMH model of care. The PCMH model of care stems from core principles of continuity, access and coordination. Empanelment creates the foundation for actualizing these principles. A PCMH team or system of care (referred to, hereafter, as simply "PCMH") maintains continuity of care through the empanelment process (defining the patient-to-PCP relationship and the relationships with the other team members) and scheduling and communicating with patients based on those relationships. Empanelment can help a PCMH ensure access to care through managing and maximizing their capacity. A PCMH can support the coordination of care by precisely defining which PCP and care team is responsible for the care of the patient, a key feature of empanelment.

In addition to the foundational role that empanelment plays in the PCMH model of care, empanelment is a prerequisite for attaining the Triple Aim\(^1\) of accountable care. In order to attain better health outcomes in a population while improving patient experience and controlling costs, a PCMH has to clearly and prospectively identify who is responsible for caring for populations of patients. Without this clear identification patients will continue to:

- Be “lost to follow-up”
- Consume duplicate services
- Not access primary care when needed
- Receive uncoordinated care

Care will not be properly coordinated and managed because the payer, whoever that may be, will not know who to fund for the activities or be able to determine the return on the investment for the activities. Empanelment is the cornerstone in the foundation of clinical and financial accountability.

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\(^1\) The Triple Aim is a framework developed by the Institute for Healthcare Improvement to simultaneously pursue improving the patient experience of care, improving the health of populations, and reducing the per capita cost of care.
**Empanelment Guide**

This guide explains the three stages of the empanelment process and provides guidance on critical steps in the process. It also highlights special considerations for implementing panels and important steps related to information technology. The guide provides a specific vision of empanelment—one that supports an organization in delivering effective primary care and responds to today’s rapidly shifting financial environment. The appendices of this guide offer policy and procedure domains, examples and scripts to consider for use when implementing empanelment.
THE EMPANELMENT PROCESS

Empanelment occurs in three phases, with an additional “pre-phase”:

**PHASE “0”:** Pre-empanelment work

**PHASE 1:** Developing initial panels

**PHASE 2:** Refining panels

**PHASE 3:** Ongoing empanelment

**Figure 1: Empanelment Process Timeline**

![Timeline diagram]

The timeline for the process as identified in Figure 1 is dependent on many factors. For perspective, Phase 2 should be between one and six months in duration.

**Phase “0”: Pre-empanelment Work**

The purpose of this phase is to lay the foundation for the actual empanelment that occurs in subsequent phases. The leadership team creates a plan for accomplishing empanelment as well as a communication strategy. Target audiences for communication include the executive team, physicians and other providers, teams working with the providers, patients being served and other stakeholders. An important communication goal is to provide the context for empanelment within the broader effort of transforming a practice from “volume to value” or “reactive to proactive”.
Empanelment is a specific activity that has a larger strategic purpose related to an organization becoming a participant in accountable care.

Specific policy and procedure domains and suggestions are identified in Appendix A. Appendix B has suggested scripts for various procedures and responses within the communication plan.

Because the weighting process begins in Phase “0” the methodology is discussed in this phase. However, it is important to note, as shown in Figure 1, that weighting methodology is an on-going process.

**Weighting Patients**

Patients need to be weighted to account for differences in the level of effort needed to care for them. This is a critical step in the empanelment process since not all patients have the same level of needs. For example, a PCP and care team will need to spend more time caring for a patient who has multiple complex chronic conditions than a patient who is in good health.

Weighting patients based on needed effort is not a one-time process since the needs of patients change. Rather, it becomes a standard and continuous process that helps ensure that panels are manageable for PCPs and care teams.

There is no single or perfect way to weight patients. The process is not intended to predict individual utilization; rather to be a useful predictor of the primary care effort needed for a population of patients. The goal is for the weighting system to be reasonably accurate down to the level of a single provider.

The outcome of the weighting process has “high stakes” for PCPs and care teams since it determines the ultimate size of their panels. Even small changes in the weighting process can produce changes in the total weighted size of the panel that are large, or at least are perceived to be large. As a practice moves away from volume-based productivity measures (visits per hour, visits per provider full time equivalent (FTE) or Relative Value Units per year), the weighted panel size should become the new core measure of productivity, which increases the stakes for PCPs and care teams.

Given the high stakes, it is important for leadership to set clear expectations and communicate the utility and limitations of the process. For example, providers should understand that weight is useful for populations of patients, not individual patients, and will not predict an individual patient’s utilization. Leadership should also ensure that the process is transparent and allows for a reasonable amount of input. Leadership can maximize support for the new system by ensuring that the outcome is fair, the selected formula or algorithm is believable and there is low risk for “gaming” the system. Although a simple weighting process may be attractive to leadership, a weighting system that lacks the necessary complexity may undermine its fairness or believability. Given that the calculations will be automated, there is little downside to selecting a more complex system.
beyond its initial programming. The suggested weighting formula is shown in Figure 2, and will be referred to throughout the weighting section.

**Figure 2: The Weighting Formula**

**Step 1: Determine the Value of a Patient Equivalent**

The weight assigned to a patient in a panel is developed using a unit called a “Patient Equivalent”. The weighting formula results in a number and the units of that number are Patient Equivalents. The first step in creating a weighting system is to determine the value of this basic unit. A standard Patient Equivalent is based on the amount of time a PCP needs to spend on a patient’s care. The standard Patient Equivalent estimates the need of patients for scheduled clinical office time with the primary care provider (generally it does not incorporate on-call time). Of note, there could be additional Patient Equivalents that are calculated based on other patient needs, e.g. a “Care Management Patient Equivalent” based on the amount of care management each patient requires.

The value of a standard Patient Equivalent is dependent on:

- The number of clinical hours expected of each provider FTE; and
- The reference number of Patient Equivalents, which is the standard number of Patient Equivalents in a “full” panel.

Any number could be used as a reference number. However, a suggested reference number for a full panel is 2000 Patient Equivalents. The primary reason for using this number is ease of communication. The end result will be that complex patients will have Patient Equivalent weights greater than one, which reflects providers’ perception of their patients.
To determine the value of each Patient Equivalent, simply divide the number of hours a full time provider is scheduled per year by 2000. This simple calculation gives the time that one Patient Equivalent should take a primary care provider per year. Although this can be translated into visits (see side bar example), it is important to think in terms of time. Changes in the practice, such as more efficient visits, phone visits and nurse visits should change the visits over time.

Step 2: Develop a Base Weight

The second step in the weighting process is to derive a base weight from each patient's age and gender. In this second step, as well as the remaining steps, it is important to note that the efficiency of providers (which is dependent on staffing, infrastructure and other factors) influences the number of Patient Equivalents attributed to each type of patient (though efficiency does not affect the Patient Equivalents themselves, which are equal to an amount of time based on provider scheduling expectations). Because efficiency affects weight, a patient with the very same characteristics can have different weights in different health care settings. Provider efficiency is, in part, dependent on the resources available to care for the patient. For example, a 45-year-old man with limited English proficiency who has diabetes, hypertension and heart failure will have a relatively high weight in any system. However, one practice may assign a Patient Equivalent weight of 2.0 to the patient because they have robust nurse care management modules for diabetes and heart failure. In a health setting without those resources, the same patient may be assigned a Patient Equivalent weight of 4.0 because the primary care provider will need to spend more time with the patient. Alternatively, both systems could have very similar resources, but one system may expect more hours from providers than the other. A Patient Equivalent may equal 45 minutes in one system and 60 minutes in another. The patient above may need 3 hours of time in both systems, but this would be assigned a weight of 4.0 in one setting (three hours divided by 45 minutes) and 3.0 in another (three hours divided by 60 minutes).

The Patient Equivalent weight for a population ought to match the time, though not necessarily the number of visits the patients will “consume”. The weight of the patient is not dependent on actual time used, rather on the average primary care provider time required for the particular type of patient. In other words, if a provider has 500 patients, all with diabetes, status-post stroke with hemiparesis, seizure disorder and family members with low educational attainment, the provider is...
likely to be very busy indeed. Another provider could have 2,500 patients who are 35-year-old men with only hypertension, and that provider would be less busy. In this exercise, the Patient Equivalents should come very close, across a population of hundreds, to matching the primary care provider effort needed.

Figure 3 provides a useful tool for assessing relative weight (Murray et al\(^2\)), the number of visits in particular age ranges to a primary care physician (from CDC data) and a suggested starting base weight. The suggested starting base weight is based on Health Management Associates’ experience in the safety net.

**Figure 3: Reference Points and Suggested Age & Gender Weights**

<table>
<thead>
<tr>
<th>Age</th>
<th>Murray et al Relative Weight</th>
<th>CDC 2007 Ambulatory Medical Care Utilization Visits</th>
<th>Suggested weight for Patient Equivalent system Base Weight</th>
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<tr>
<td></td>
<td>Male</td>
<td>Female</td>
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<tr>
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<td>4.66</td>
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**Step 3: Account for Additional Factors**

After the base weight is developed, the next step is to apply an “Additional Factor Formula,” which accounts for the additional primary care time associated with management of chronic diseases and other related factors. The formula is shown within Figure 2. Importantly, this does not include care management staff time. In fact, as a system bolsters the care management infrastructure, it will

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make sense to decrease the weight of these additional factors since a PCP will have to expend less
effort to care for patients with these conditions.

Each additional factor is not simply added to the other factors since a provider and care team
address more than one factor when they deliver care. For example, a provider treats both
hypertension and diabetes in the same visit. Although caring for both conditions may add some
time to the visit, it is not as much as it would be if each condition were addressed in separate visits.
Therefore, only up to three factors are added to a patient’s weight and each factor is not added to
the same degree it would if it were the only factor. As factors are added, their contribution to the
weight is decreased based on how highly it is weighted relative to the other factors. The factors are
adjusted by ordering from highest to lowest and using a multiplier called the “coefficient of
extinguishment”.

If a patient has at least one additional factor, the final step to the Additional Factor Formula is to
reduce it by half the base weight. This is because the base weight already assumes some chronic
disease in the population. This subtraction reduces double counting of conditions that are
associated with age and gender.

**Step 4: Account for Inactive Patients**

After the Additional Factor Formula is applied, the next step is to determine a “Reduction Factor,”
which reduces the weight of inactive patients. Inactive patients are long past the time they ought to
have been engaged in care, e.g. come in for a visit, receive care telephonically or refill prescriptions.
For example, a patient with an overall weight of 3.0 should have an interaction about every two
months. If there is no activity in four months, the weighted contribution to the panel is reduced by
the formula over the next 12 months to zero. As depicted in Figure 2, the recommended patient
weighting formula includes the reduction factor:

**Step 5: Sum Patient Weights to Calculate Total Panel Weight**

The next step adds the individual patient weights together for all patients empaneled. This gives the
total weight of the panel, which is needed to make decisions about opening and closing panels.

**Step 6: Check Weighted Panel Size Against Clinical Practice**

The last step in the weighting process is an assessment of the outcome, which needs to be done on a
periodic basis. The experience of patients, physicians (or other provider) and their teams should be
assessed in comparison to the weighted panels. Clinical management should review the experience
of patients and care teams associated with panels of various sizes. Teams that are very close to 2000
(within 5%) should be humming along with good patient experience, well-coordinated care,
adequate access and low staff and provider burn out (or there should be plans for transformation in
the near future that will make these things true). The teams with panels of 2100 patient equivalents
or more ought to be experiencing stress. If true, the weighting system is reasonably accurate in the
current environment. It is important to note that the weights for age and gender and the weights
given for additional factors will change if and when the delivery model changes. Because the steps
in the weighting process overlap the phases of empanelment, the step by step description of weighting has taken us to into later phases. We’ll now return to Phase 1.

**Phase 1: Developing Initial Panels**

The purpose of this phase is to develop and implement a standard methodology for assigning patients to a PCP panel. The panels developed in this phase will be the initial panels and will be refined in subsequent phases. The methodology is based on the best available historic data for identifying existing patient-PCP relationships. Although there are other methodologies for identifying each patient’s current PCP, this guide proposes using the “Single Cut Method” described below.

### Identifying the Current Provider: the “Single Cut Method”

The “Single Cut Method” assigns a score to each visit that a patient has had in the prior 24 months, with the score differing by the timeframe in which the visit occurred, as noted in Figure 4. Using this method, visits that occurred in the past three months receive a score of 1.0. Visits that occurred between three and six months receive a score of 0.6 and so on, with the scores decreasing with earlier visits. A patient must have a total visit score of at least 0.6 to be empanelled. If the patient has a total visit score of 0.6 or higher, the patient is empanelled to the PCP with the highest total score.

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3 Another process of identifying the current provider is to use the “Four Cut Method.” This process is outlined in the Safety Net Medical Home Initiative empanelment materials and described by Murray et al, 2007 (Mark Murray, MD, MPA, Mike Davies, MD, Barbara Boushon, RN. Family Practice Management. 2007 Apr; 14(4):44-51). However, this method may be overly cumbersome in environments where there are thousands of patients.
patient is empanelled to the highest scoring provider. Because this method assigns a higher score to more recent visits, it improves the likelihood of identifying an actual patient-PCP relationship. Figure 5 demonstrates the application of the Single Cut Method logic. Note that in an actual practice, this should be done either by writing a report script, i.e., a short computer program, or by exporting the visit history to Excel and applying rules. Ideally the script is run through the Electronic Medical Record (EMR) or Practice Management System and the result simply inserted into the PCP field.

**Adjusting Single Cut Logic**

While some practices may have already assigned a portion of the patients to PCPs, the assignments may not always be accurate. However, if a practice assesses that the PCP identification field already in use is reasonably accurate, this should be given precedence in the logic. In addition, if the practice has a contract with a managed care entity that assigns members to particular providers, these patient-PCP relationships must be given first priority in the algorithm.

This Single Cut methodology empanels most patients with reasonable accuracy. However, the patients that are assigned to providers that are no longer in the practice need to be moved to another provider. The Single Cut Method is also dependent on the availability of accurate visit-level data. If a practice assesses that its visit-level data is not reliable, the panels will be less accurate. Practices should continue with the development of the initial panels, making adjustments to the algorithm based on the best available data and information, knowing that significant adjustments will need to be made in the next phase.

**Phase 2: Refining Panels**

The purpose of this phase is to refine the initial panels based on “on the ground” information. This phase should occur over one to six months, depending on initial empanelment accuracy and frequency of patient interactions with the practice. During this time period many of the empanelled as well as new patients will have had some interaction with the practice, e.g. a visit or phone call. Based on data and information from the interactions, a practice can adjust the panels and assign new patients to panels.

It is important to note that this is a dynamic process. Because the historical data and information used in developing the initial panels are never completely accurate, a medical practice should anticipate that there will be many changes and adjustments.

During the first stage of phase two, e.g., within the first week or month, providers should be allowed to propose changes to their panels based on their knowledge of and experience with the patients. Frontline staff, e.g. receptionists, scheduling staff, can also verify the patient-PCP assignment by asking patients if the PCP to whom they are assigned is the correct PCP. Optimally, patients should be asked to verify this assignment during all patient interactions, e.g. when coming in for a visit, scheduling appointments, receiving test results or calling for other reasons.
A practice should have empanelment policies and procedures that are modified for this phase to account for the refinements. Because it is a time when many changes will be made to the panels and the processes, leadership should clearly communicate to staff what will happen during the refinement process and precisely when the next phase will begin.

**Phase 3: Ongoing Empanelment**

The purpose of this phase is to incorporate the calculation of the level of effort needed to care for a *population* of patients into the empanelment process (see Step 6 of the “Weighting Patients” section). It is also a time to roll out the formal and ongoing method of empanelment. This includes policies and procedures and the configuration of information technology (IT) systems, which embeds these policies and procedures into standard practice and operations.

**Managing Panels**

**Adding New Patients**

New patients generally come in through one of three mechanisms: (1) external payer assignment, (2) partner referral, or (3) patient self-referral. The process of bringing a new patient into an “open” panel is discussed in this section. The process of deciding whether or not to accept new patients into a particular panel is discussed in the following section on opening and closing panels.

Patients assigned by an external payer may come to the empaneling entity as unassigned, assigned to a particular location/address or assigned to a particular provider. It is important to note that if the external payer assigns to the level of detail of a particular provider, the external payer is also the one that needs to change the provider at a patient’s request. One complexity associated with this circumstance is that the provider system must in some way keep track of the manner in which patients were received from the external payer. Any change in patient empanelment in the provider’s system needs to also be reflected in the assignment, which is in the payer’s system. In general it is best to avoid this approach by negotiating with the payer to only allow patients a choice of practice site at the time of enrollment, rather than a particular provider. However, if the practice anticipates competing for patients who want and expect to choose an individual provider at the time of enrollment, the practice will need to facilitate the process by communicating to the payer the status of panels (open or closed). In addition, the mechanism of assignment for each patient (whether site-specific or provider-specific) will need to be tracked because patients assigned by external payers will need to be directed back to that payer to change providers in order to keep the payer assignment and the provider empanelment in sync. Separate software dedicated to tracking empanelment and assignment types could accomplish such tasks (refer to the Information Technology Environment section).

The process for accepting new patients from external partners or accepting a direct request of a patient can potentially remain the same: new patient slots are opened three months out, patients schedule appointments and patients are empanelled when their first appointment occurs. This works quite well when demand and supply for primary care service is balanced and the time to a
new appointment is very short. It does not work well when the time lag between request and an actual appointment is long. In addition to higher no-show rates and the inability to manage the scarce resource of new patient slots, this process delays accountability for new patients, which is not aligned with the PCMH model of care.

Rather than using this standard process, direct empanelment of new patients is recommended. Potential patients are screened to determine to whom they can be empanelled. The patient is then empanelled and becomes a patient of a PCP and care team as of that day. With this new process the patient immediately interacts with a care team member who determines the appropriate timing of a visit instead of waiting months for a new appointment. The first visit may be a brief encounter to address medications and/or complete a health risk assessment with a subsequent visit for a full history and physical. The paradigm shifts from individual patients requesting an appointment many months out to a process of thoughtful, strategic “onboarding” of patients.

Opening and Closing Panels

It is critical to continuously review panel data to determine when a provider’s panel should be closed to additional patients. A particular system may decide to partially close panels at an earlier stage, keeping them open only for particular types of patients. An example would be keeping panels open longer for patients who are discharged from a hospital.

This multistage panel restriction is provided in Figure 6. The goal in this example is to have 2,000 Patient Equivalents in each panel. At 1,700 Patient Equivalents the system is restricting empanelment to only certain types of patients (or has decided to decrease the number of new patient slots). When 95% goal is reached, the system has further restricted empanelment and the rate of increase again falls off. The vertical line represents the addition of managed care lives, which may be assigned to panels by managed care organizations in blocks. After

4 A practice may decide to not empanel some patients due, for example, to a lack of capacity to provide a PCMH model of care to all patients. However, empaneling all patients is optimal, enabling practices to better manage their patient population and balance supply and demand for care.

Figure 6: Example of One Provider’s Panel Over Time
a panel has reached “full” empanelment there should still be an allowance for strategic additions that are needed by the organization. These are depicted as lives added under managed care contracts (vertical lines).

After these additions, the number of Patient Equivalents begins to fall in each case in the figure. This occurs because there is always a turnover rate in patients. The turnover rate should be monitored and kept to the lowest level possible. One reason for keeping it low is to support continuity in care, a core principle in the PCMH model which is proven, particularly in lower socioeconomic patients, to result in the delivery of higher quality care. Turnover rate depends on the population; however, a turnover rate of less than 10% per year is desirable. A turnover rate above 20% represents lost opportunities in being accountable for a population and will also result in lower provider satisfaction.

The red line in this example is set at 110% or 2200 Patient Equivalents. If a provider reaches this point, there should be no patient additions until attrition has created space for additional patients. The provider and the care team should consistently work on retaining current patients, reducing turnover and delivering the Triple Aims for the population.

Another factor to consider is individual provider capabilities. Some providers may deliver high quality care but are unable to do so at the normal expectation level. The empanelment system and the data become a way of discussing compensation and work-life balance. This can be handled by keeping the Patient Equivalent and the expectations per FTE all the same, but allowing for reductions in clinical FTEs for some providers. Other providers may find that they no longer struggle to achieve volume-based productivity targets because there is now a system that recognizes patient complexity (see Appendix B containing script for discussing with PCPs).

**Special Consideration**

Providers of primary care to whom patients can be empanelled come in a variety of “types.” Licensed and credentialed physicians (MD or DO) are one type of primary care provider. Another is Advanced Practice Nurses (APNs) who are often Nurse Practitioners (NPs) in the primary care setting. In most states NPs can practice independently to diagnose and treat patients. If this is the case and the NP is practicing independently, he or she is treated precisely the same as a physician in the empanelment process. In other practices the NP or Physician Assistant (PA) may have his or her own panel and but be paired with a physician for direct supervision of care. In other cases, each patient in the panel is assigned to a unit made up of an NP or PA and a physician. Patients will see both the physician and the other member of the dyad (the unit made up of two members). The dyad principal is used in empanelling patients to residents and their faculty supervising physician. The Electronic Medical Record (EMR) and the entire empanelment environment need to reflect the dyads for purposes of scheduling, quality oversight and care management.
The Information Technology Environment

Organizations and practices have a wide variety of information technology (IT) solutions to support the delivery of care in their environment. Software solutions (or applications) come in a wide variety of forms, including EMRs, practice management systems, referral software, patient registries and others. The confusing array of software solutions can be considered by functionality such as documentation, e-prescribing, referral management, billing, quality reporting and others. Empanelment is an important function within this list and can be performed by various applications. However, certain specific requirements should be included in the suite of applications in order to attain functional empanelment including:

- The PCP should be prominently and unambiguously displayed
  - In the scheduling application within the EMR or Practice Management System
  - In the documentation application, which is generally part of an EMR or patient registry
  - In the care management application; and
  - In the patient registry or population management application.

- The PCP-patient associations should have a standard place in which they reside and feed other applications. This is especially critical if IT systems do not interact. It can be in the EMR, Practice Management System or elsewhere—as long as everyone knows where it is.

- The PCP-patient associations should be easy to change for specific patients or for blocks of patients. However, a practice may need to have an enrollment application to attain this flexibility.

- The PCP-team associations should be an input variable (i.e., that data can be entered and managed) in order to route care management tasks to the correct person. Unfortunately, no current off-the-shelf application does this well.

- Standard file formats of member assignments from outside sources, e.g. from Managed Care Organizations, should automatically populate a practice’s IT system (Practice Management System, enrollment application) to avoid manual data entry.

Figure 7: A Sample Information Technology Environment for Empanelment
• NP and PA relationships to a collaborating or supervising physician should be an input variable. However, no current off-the-shelf application does this well.

• Resident relationships to their supervising physician should be an input variable. Again, no current off-the-shelf application does this well.

Each organization will have strengths and weakness in terms of the IT environment and the ability to support empanelment. The size of an organization will also impact the IT requirements for sustaining empanelment. A small organization (e.g. with less than 10,000 unique patients) may be able to support empanelment with little or no automation. A larger or growing organization, or one looking to begin practicing population management, will need a robust empanelment process.
CONCLUSION

Empanelment is a foundational step for both the Patient Centered Medical Home model of care and the Accountable Care model of health care delivery and financing. A continuous healing relationship between a primary care provider (and team) and a patient sets the stage for a better patient experience, lower costs and improved outcomes. The formal tying together of patient and primary care provider (and team) allows for team-based care, planned care and, perhaps most importantly, a finance mechanism for supporting the work that produces these outcomes.

This document describes a general path to empanelment, though unanticipated barriers are often encountered. For this reason, organizations may want to seek further expertise and assistance in addition to using this document, especially during early phases. The ultimate goal is for organizations to learn how to empanel and manage panels as a standard and continuous process, creating a foundation for effectively managing their patient populations.
## APPENDIX A: Panel Management Policy and Procedure Domains

Although not exhaustive, the following is a list of priority areas to consider when developing empanelment policies and procedures.

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Principle(s)</th>
<th>Policy Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria for Empanelment</td>
<td>PCMH teams can only deliver the right care for a finite number of people. The scope of each team's accountability (the people for whom the team is responsible) must be clearly defined.</td>
<td>The policy may include some or all of the following criteria: insurance status and managed care contract requirements, which patients may be in need of episodic care and which would benefit from a medical home, patient interest in establishing an ongoing relationship with the clinic, patient complexity and fit with expertise of providers in the health center.</td>
</tr>
<tr>
<td>PCP Assignment and Changing Providers</td>
<td>Patient choice is central; only patients can choose and only patients can change their provider.</td>
<td>Policy requires panel manager to assess patient according to empanelment criteria; determine eligibility for empanelment; and with input from patients, assign patients to PCPs with open panels.</td>
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<tr>
<td></td>
<td></td>
<td>Policy requires panel manager to receive patient request to change PCP assignment; discuss reason for change request separately with patient and PCP; with input from patient, reassign patient to new PCP; and track and report visits with PCP versus other providers.</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Particularly for persons with lower socio-economic status, a continuous healing relationship with a provider results in better health outcomes at lower cost. This continuity will extend to a team of licensed and unlicensed support staff and care management staff.</td>
<td>Policy requires PMH team members to confirm PCP assignment when scheduling patients, introduce and reinforce the purpose of empanelment as needed and report and resolve discrepancies in assignment.</td>
</tr>
<tr>
<td>Call Routing</td>
<td>To the extent possible, extend continuity with PCMH team to phone encounters.</td>
<td>Policy requires steps for technology set up for automatic call routing to patients’ assigned PCMH team, or steps for manual routing to appropriate team member.</td>
</tr>
<tr>
<td>Proxy Tasks when Team</td>
<td>A proxy system must be in place when providers or</td>
<td>Policy requires assignment of back-up team members for phone encounters and other tasks, procedures to</td>
</tr>
<tr>
<td>Area</td>
<td>Key Principle(s)</td>
<td>Policy Recommendations</td>
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<tr>
<td>Members are Absent</td>
<td>team members are absent.</td>
<td>ensure that phone calls and electronic task alerts are directed appropriately, and steps to set up security access to ensure receipt of electronic tasks alerts.</td>
</tr>
<tr>
<td>Provider Transfer or Termination</td>
<td>The health center will notify patients in the event of a PCP transfer or termination and ensure a smooth transition in care.</td>
<td>Policy requires standard, personalized letters from the PCP to notify clients of the transfer or termination; letters will indicate that the health center will inform the patient when a new PCP has been hired and to whom they are reassigned. Until reassignment occurs, the panel manager will facilitate determination of the PCP the patients will see in the interim.</td>
</tr>
</tbody>
</table>
APPENDIX B: Empanelment Scripts

1. Scripts for Schedulers

Scripts Covered:

1. **Outbound call to an assigned new patient**

2. **Inbound call from a person wanting to be a new patient**

3. **Inbound call from an established patient whose PCP is not available**

4. **Inbound call from established patient who wants to change providers**

5. **Inbound call from established patient who wants a follow up appointment in 3 months**

Key Concepts:

- Continuity with a doctor and team results in better health outcomes. To help ensure continuity, schedule the patient with the assigned provider to the extent possible. Make sure the focus is on the convenience of the patient even if that means they might see a different provider for a particular visit.

- The patient has a choice of providers. The patient can choose and change providers upon request.

- Schedule patients out no further than 2 weeks if possible since the no-show rate rises after that time. Make sure the focus is on the comfort of the patient. If this scheduling approach really doesn’t work for the patient, schedule further out but be sure to do a reminder call.

Sample Scripts:

1. **Outbound call to an assigned new patient**

*Introducing the concept of “empanelment” to patients*

Scheduler: “Hello, this is [name and title] and I’m calling from [name of health center] I was informed that you have been assigned to [health center] for your health care. Is that your understanding?”
Patient: “Yes, I signed up with [name of health center] because it’s close to where I live.”

Scheduler: “Great. We look forward to working with you. It looks like you were assigned to [Dr. X], were you informed of that?”

Patient: “No, but if he’s a good doctor, that’s fine with me.”

Scheduler: “Ok. [Dr. X] is a [primary care specialty and anything else that might be of interest.] I think you’ll be pleased but you always have the option to change doctors. I want to tell you a little bit about how we organize care here at [health center.] [Dr. X] typically works with the same nurse, the same medical assistant and the same clerk (me!) most of the time. We call this team your ‘medical home team.’ Seeing the same medical home team at each visit will allow you and the team to get to know each other better. Health care teams that really know their patients can take better care of them. Does that sound good to you?”

Patient: “Yes. I have a diabetes and COPD and I hate having to tell my story over and over again to different people, so this will be a relief!”

Scheduler: “That’s exactly the point. I’d like to schedule a time for you to come in for a history and physical, and for you to meet your medical home team...”

2. **Inbound call from a person wanting to be a new patient**

*Facility with Central Scheduling:*

Patient: “Hi. My name is Eula Young and I have some health problems that I need to get taken care of. I haven’t been there before, but would like to schedule an appointment sometime soon.”

Scheduler: “Ok, Ms. Young, I will need to transfer you to our manager who will ask you a few questions and get you set up.”

Panel Manager: “Hello Ms. Young, I understand that you would like an appointment. I’d just like to ask you a few questions. [Refer to empanelment criteria; patient meets criteria.] Did you have a particular doctor you would like to see here?

Patient: “My sister sees Dr. X; can I go with him too?”

Panel Manager: “Yes, actually that would be fine. He will be your regular doctor and we will try our best to schedule you with him every visit. Since it’s Friday and he doesn’t have any more open appointments today, the soonest I can get you in is early next week; how’s Monday at 10a.m.?”

Patient: “Ok.”
Panel Manager: “Great, we will see you then. You mentioned that you had some health problems. Since the visit is not for a few days, would you like to speak with the nurse now?”

Patient: “Yes I would.”

[If the health center has a clinical intake unit, Panel Manager would make the first appointment with the clinical intake unit and then empanel the patient.]

3. **Inbound call from an established patient whose PCP is not available**

*Patient needs to be seen as soon as possible but empaneled provider is unavailable*

Patient: “I would like to make an appointment with Dr. Green for tomorrow.”

Scheduler: “I’m sorry, Dr. Green is not in tomorrow. He can see you today at 4p.m. or Friday at 10a.m. “

Patient: “I can’t come in this afternoon and Friday is too late, I really need to be seen tomorrow morning.”

Scheduler: “That’s fine. I can schedule you with Dr. Green’s partner, Dr. Purple. The next time we will try to get you in with Dr. Green.”

4. **Inbound call from established patient who wants to change providers**

*Patient wants to change providers*

Patient: “Hi. This is Christie Kosten. I need to come in for a repeat pap smear.”

Scheduler: “I have an appointment available for tomorrow with your doctor, Dr. Male.”

Patient: “Hmm. You know, I’d much prefer a woman doctor especially with some of my new health problems. I think I’d just feel more comfortable talking about them with a woman doctor. Can I switch doctors?”

Scheduler: “Of course. Let me transfer you to our manager. She will help you make the switch.”

Panel Manager: “Hello Ms. Kosten. I understand that you would like to switch doctors and that you would prefer a woman doctor. Dr. Female is an internal medicine doctor who has been practicing here for about 5 years and patients really like her.”

Patient: “Oh yes, I’ve heard of her, can I be switched to her?”

Scheduler: “Yes, consider it done. I understand you need to come if for a repeat pap smear. She has an available appointment for Friday at 11a.m., does that work for you?”

Patient: “Yes, thank you.”
5. **Inbound call from established patient who wants a follow up appointment in 3 months**

*Patient wants to schedule a three-month follow up appointment*

Patient: “This is Mrs. Brown. I just had a visit with my doctor over there yesterday and I just realized I left without a follow up appointment. I need to come back in for my diabetes in 3 months like I always do.”

Scheduler: “Actually, we have a new approach to patient scheduling. We purposely did not give you a follow up appointment. We try not to schedule out so far because plans change. It can be hard to keep an appointment that is scheduled so far in advance. We will plan to call you around the time you should be seen. We keep several appointment visits open each day for follow up visits. Is that ok with you?”

Patient: “I don’t really like that. What if you forget to call me and my diabetes gets bad?”

Scheduler: “We have a reliable reminder system to make sure we call you when you are due for your next visit. You can also write it down on your calendar and plan to call us if you prefer. Also you should feel free to call us any time you’re not feeling well so a nurse can talk with you and have you come in earlier if needed.”

Patient: “I just want to make sure I see my regular doctor and I’m afraid if I wait so long to make the appointment, his schedule will be all filled up. I just don’t like this!!”

Scheduler: “It sounds like this new way of scheduling follow up visits is causing you some stress. I can go ahead and schedule you now. We will call you the day before to make sure you are still able to come for that appointment…”

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2. **Sample Script for Provider Equity Discussion**

Provider: “I really don’t think this whole concept of empanelment is going to turn out fair. You know I see most of the complex patients here and if you do this I’m going to be buried.”

Administrator: “We know that you see many of our complex patients which is one of the reasons you are such an incredibly valued member of our practice. I’m sure you know we’re empaneling patients to ensure continuity of the patient-provider relationship, but we may not have fully described the patient weighting system we’re planning to use. The weighting system will help ensure equitable provider effort across panels. Instead of assigning a certain number of patients to each panel, we’re assigning a certain number of patient equivalents. The weighting formula accounts for gender, age and chronic conditions. We know you see many of our more complex geriatric patients. These patients will be weighted much more heavily than a younger, healthier
population. So, while [Dr. X] might have 1600 individual patients, you might have half that many. The formula has been used successfully in many similar practices; it will guide us as we begin this process and we can make adjustments as we go. I’d like to share the weighting formula with you. [Share.]"
Dr. Greg Vachon is a Principal with HMA, providing consulting assistance in system approaches to prevention and chronic disease management including the patient centered medical home (PCMH) model of care, payment structures to promote the triple aims of quality, access and efficiency, and design and implementation of clinical care innovations.

Dr. Vachon’s work in system approaches include development, evaluation and implementation of patient registries for large health systems, assessment of information technology capacity and requirements for ACO and ACO-like entities, and the creation and use of patient empanelment systems. Dr. Vachon’s work has spanned developing strategic plans, to writing business rules for coding, to training staff to use technology effectively within the patient centered medical home. Payment structure consultation has included work with ACO and ACO-like organizations in several states as well as with State leadership. Dr. Vachon has assisted many organizations with clinical care innovations and is founder and CEO of a company offering a groundbreaking wellness incentive model.

Prior to joining HMA Dr. Vachon served over ten years as Medical Director of Austin Health Center of Cook County in Chicago. There he developed a novel group-care model for diabetics incorporating components of the chronic care model including registry use to monitor quality improvements. As a Chair of the Diagnostic Services Committee for the Ambulatory and Community Health Network (ACHN) of the Cook County Bureau of Health Services (CCBHS), he provided lab contract oversight, improving quality while lowering costs. He served as the Chair of the Information Technology Committee for the Care Improvement Collaborative, a quality improvement project that developed capacity in health centers throughout the network to enhance chronic disease management. Dr. Vachon was the 2007 Peterson Scholar at the University of Illinois at Chicago’s School of Public Health where he focused on health care economics and policy analysis. His current clinical practice is at an FQHC on the south side of Chicago.
As a senior consultant with Health Management Associates, Lori Weiselberg provides consulting assistance in the areas of health system development, approaches to disease management, and the development of public health initiatives.

Ms. Weiselberg has over 20 years of employment experience related to the improvement of the health and health care of medically underserved populations in both rural communities and urban centers. She worked for the State of Wisconsin’s Department of Education promoting a comprehensive school health program with emphasis on HIV/AIDS prevention. She also directed a federally–funded Area Health Education Center (AHEC) to improve the capacity and quality of primary health care services through health professions training in New York City. Ms. Weiselberg worked with a city health department to develop a primary care outreach campaign for the NYC Childhood Asthma Initiative.

Ms. Weiselberg has also assisted healthcare providers, academic institutions and public/private entities to implement disease management programs for chronic conditions in underserved neighborhoods in Chicago/Cook County. The projects she managed involved community engagement, patient empowerment, health center reorganization and provider practice change. Prior to joining HMA, she managed a National Center of Excellence for the Reduction of Asthma Disparities. Ms. Weiselberg holds a bachelor’s degree from Cornell University and a Master of Public Health from the University of Michigan.

Ms. Weiselberg works out of HMA’s Chicago office.
Health Management Associates (HMA) has amassed a wealth of on-the-ground experience that is important to share more widely as the nation undergoes the dramatic changes anticipated over the next several years. To that end, it is forming the Accountable Care Institute (ACI). The ACI will:

- provide a venue in which to share experiences and best practices from across the country related to the development of community-specific integrated delivery systems, new financial strategies to incentivize value, and innovative partnerships between providers and payers to ensure effective care for the unique populations they are both trying to serve;

- develop and offer resources to others to help spread lessons learned in the development of these new approaches to the delivery of accountable care;

- facilitate the training of new leaders in health system change; and

- translate delivery system lessons learned on the ground into policy and policy into change at the delivery system level, whether financial, legal, clinical or organizational.

Over the past decade, HMA has been assembling a growing practice of senior health care clinicians and administrators, finance experts, behavioral health professionals, managed care leaders, long term care innovators and others committed to developing new approaches to delivering health care services, particularly to populations and communities that have traditionally been under-served. HMA has worked for large health systems, consortia of providers, individual hospitals and ambulatory providers, states and counties, foundations and managed care plans to assess current delivery of care, plan new approaches and assist in implementation. This work has been growing in volume as the country has started to seriously grapple with how to assure access and quality—and the improvement of health status—while rolling back the cost trajectory which is universally agreed to be unsustainable. Expertise in integrated and accountable care as it applies to the delivery of care to those funded by public dollars is in demand; it is anticipated that the ACI will provide a vehicle for meeting that demand.