

## Section 4.7 Implement

# Patient Empanelment

This tool describes the process and considerations for assigning each provider a set of patients who are cared for by that provider (and provider's care team) to ensure continuity of care while also managing supply and demand for a medical practice.

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**Time needed:** 1 hour

**Suggested other tools:** Population Risk Stratification and Patient Cohort Identification; Approaches to Patient Communications

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## How to Use

1. **Review** this tool to understand more about patient empanelment, its purpose, steps for implementing patient empanelment, and the critical need for leadership support. Also review resources and references provided within the tool.
2. **Develop** a plan for addressing patient empanelment. If your practice or community does not embrace patient empanelment yet, develop a plan for initiating discussion, encouraging adoption, and ultimately implementing the process. If a practice is becoming a patient-centered medical home (PCMH), patient empanelment is one of the expectations for such achievement.
3. **Recognize and prepare** to address issues raised by naysayers, such as providers and staff who believe patient empanelment is solely a productivity improvement technique, or providers (and patients) who may not understand how patient empanelment supports open access.

## What Patient Empanelment Is, Its Goals, Benefits, and Challenges

Simply stated, patient empanelment is a deliberate effort to identify the group of patients for whom a provider or team is responsible.<sup>1</sup> The Safety Net Medical Home Initiative further states: Empanelment is the act of assigning individual patients to individual primary care providers (PCPs) and care teams with sensitivity to patient and family preference. Empanelment is the basis for population health management and the key to continuity of 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 patient.<sup>2</sup>

### Goals and Benefits

The ultimate goals and benefits for patient empanelment are to:

- *Address preventive, chronic, and acute needs* of all patients, including those who regularly have visits as well as those who do not. This moves the practice beyond disease-specific interventions for individual patients to managing the health of a population.
- *Support patient continuity of care* by establishing a long-term relationship between patients and providers. This enables both parties to better get to know one another, anticipate care needs, understand patient preferences and challenges, and engage patients with their providers in a way that empowers them to adopt healthier lifestyles.
- *Manage supply and demand* so that patients can reliably see their provider when they need to and ensure patients have enough time during their visit to get all of their needs met. Understanding supply and demand is the first step toward improving patient access to care.

### Provider Concerns

Caring for a panel of patients whom providers come to know would seem like a natural aspect of medical practice. Most providers state they enter the caring profession of medicine to help people. Many providers also lament the fact that they do not have time to get to know their patients very well. Unfortunately, empanelment can seem counterintuitive in a fee-for-service reimbursement environment.

Providers may be concerned that:

- Getting to know their patients will require more time – even though an ongoing relationship should ultimately reduce the time required for each patient visit.
- Caring for a “limited” panel of patients because they are used to seeing as many patients as possible whether they know them or not, and whether they will ever see them again or learn of their care needs away from the visit setting.
- Caring for patients outside of a formal “visit” is not reimbursable. In fact, the more the patients can be kept healthy, the fewer the visits – which can also be a reimbursement issue (although that will open more time for more patients). In health reform, accountability for care and reimbursement based on outcomes requires a shift from

individualized care to management of population health. A critical element of this shift is to align practice changes with reimbursement changes. Patient empanelment may not be applicable for all providers or all patients seen in the practice until such reimbursement changes are universal.

### **Staff Challenges**

Staff roles present additional challenges. Staff taking on the role of care team members must work to the level of their credentials. In some practices, clinical staff members are not entrusted with tasks for which they are educated and are allowed to do per state licensure. Skills of other staff may also not be fully utilized. These issues may be due to:

- Providers not being fully aware of the responsibilities different levels of staff can perform.
- Previous staff members' mistakes or not keeping current with new procedures, which may generate lack of trust by providers who carry that lack of trust forward to all new staff.
- Clinical staff members who are not asked to perform certain functions who may lose competency in those functions without continual practice. With patient empanelment and a focus on population health it is essential that qualified clinical and other staff support be available to take on new roles. For example,
  - Advanced practice professionals may be called upon to serve as community-based care coordinators.
  - Medical assistants should be able to help provide self-management support, especially if they are included in the training for supportive communications.
  - Front desk staff may be used to reach out to patients not only to confirm appointments but to remind patients to come in for a checkup or get a prescription filled.
  - Back office staff may be called upon to prepare panel data and enter data into a registry to track patients by disease status, risk status, self-management status, and community and family needs. They may be asked to manage directories of community services and a “narrow network” of preferred specialists to whom the practice desires to refer patients because they provide the best value (quality and cost).
  - Team members, in general, may need to be reorganized to work more collaboratively with one another. This may entail physical reorganization as well as a change in reporting relationships. Daily schedules may also need to be modified to accommodate huddles that can help assure that preventive or chronic care needs of patients can be met even when visits are for unrelated acute care needs.

### **Patient challenges**

While the biggest challenge in implementing patient empanelment may be the difficulty in convincing providers and office staff that patient empanelment is a change for the better, patients must be convinced as well. Patient challenges include:

- Understanding of “open access.” Many practices have moved to at least some open access time wherein patients are made to believe they can call for an appointment and always get one immediately. Patient education is needed – both around what open access really means and the importance of seeing the same provider and team every time. Open access should enable all providers to have some open access time for patients in their panels, but patient expectations must also be managed so they understand it is more important to see “their” provider or to be contacted by their provider or team to discuss an issue – potentially avoiding a visit altogether, making it acceptable to delay a visit for a few days if necessary, or making it feasible to see another provider the same day as an exception.
- Patient acceptance of a primary care provider and care team. Patients need to be introduced to the care team and have explained to them the care team members’ roles and qualifications. Such introductions can be provided in the form of a small brochure, but must be reinforced by personal introduction by the patient’s primary care provider.

### **Role of Community-Based Care Coordinator in Patient Empanelment**

Considering the challenges in implementing patient empanelment, especially concerns regarding provider reimbursement, staff roles and potential reorganization, it is important to recognize that instituting patient empanelment must be a leadership-driven process. The community-based care coordinator, however, has firsthand knowledge and experience with issues of continuity of care and may be in the best position to introduce patient empanelment to key providers and members of the leadership team.

There are several ways a conversation can be initiated about patient empanelment, including some very early observations and tactics to specific recommendations:

- Identify and regularly observe how important it is for patients to have their own primary care provider. Use specific case studies to highlight benefits observed.
- Make it a point to refer to “your” patients when discussing any care coordination needs of specific patients with primary care providers.
- Periodically report on care coordination activities that would benefit from patient empanelment. For example, describe observed differences in even early milestone outcomes between patients regularly seen by one provider vs. many providers, or patients with whom practice outreach was conducted vs. not conducted.
- Recommend conducting a pilot patient empanelment project with just one or two primary care providers who are interested and willing to try out different approaches.

### **Considerations for Implementing Patient Empanelment**

As noted above, it is generally not the responsibility of the community-based care coordinator to take on the role of implementing patient empanelment. However, being familiar with resource needs and implementation steps can make the CC more confident in and lend credence to their recommendations. The following are considerations that need to be addressed for each of the steps in implementing patient empanelment:

1. **Practice leaders must recognize need for patient empanelment**, understand its benefits and challenges, and be committed to making it work. Leadership should arrange for education on patient empanelment, training on supportive communications and shared decision-making, and the ability to share experiences and learn from others. Practice leaders also must clarify and redesign roles and responsibilities as necessary through practice policy, assign empanelment roles to key persons, ensure patients are informed and can identify with their primary care provider and care team, determine capacity to serve the current population, provide access to necessary information technology, and develop policies for each patient empanelment element.
2. **Pre-empanelment planning** should include an assessment of the provider staffing structure, support staff qualifications and roles, and information technology resources. Staffing and scheduling, policies and procedures, clinical standards, and collateral material to introduce empanelment to patients and scripting for staff are also elements that need to be planned in advance. Keep in mind these other planning considerations:
  - a. Patients will not necessarily be assigned to all primary care providers in a practice. Consideration must be given to which primary care providers should be assigned patients, how part-time and mid-level providers are assigned patients, and which specialty providers may be assigned patients.
  - b. Determining which support staff will fulfill what roles should include an assessment of credentials and whether staff members are working to the level of their credentials. Identify if any further training, continuing education, or refresher skills building is needed and will be supported.
  - c. The information technology available to providers and staff – at the practice level and at the community level – should be assessed to determine reporting capability and availability of specific data fields (e.g., designation of primary care provider for each patient, each patient’s risk score) needed to track key data.
  - d. Preparation for creating panels for each provider/team includes:
    - Determining the number of active patients (usually those seen within the last 18 to 24 months).
    - Determining the average visits per patient per year by provider, provider specialty, patient age group, patient risk, and other applicable factors. Patient risk is an especially important factor to ensure balanced panels across providers/teams. For example, all diabetes patients may require an appointment with lab tests every 6 months; those with a new diagnosis of diabetes, however, may need more one-on-one follow-up contact; diabetics whose A1c is between 7% and 9% (or whatever clinical standards a practice applies) need appointments and outreach more frequently; and diabetics whose A1c is over the clinical standard will need even more support, potential referrals, and even home monitoring. (See *Population Risk Stratification and Patient Cohort Identification* for information on determining patient risk.)
    - Determining the impact of staffing and scheduling on panel size and composition, as well as changes that may be needed.

- Calculating a “right” panel size for each provider given patient demand for services and provider supply/team availability for patient access.

**3. Elements to address** in implementing patient empanelment include:

- Constructing the actual panels – The Safety Net Medical Home Initiative has published an implementation guide for patient empanelment that provides detailed information, formulas, and analytic tools to help a practice establish panels and ensure the appropriate panel size based on the number and types of providers, the degree of “teamness” and patient attributes. Anyone responsible for constructing the actual panels should access the guide at:  
<http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf>
- Obtaining provider/team input – In addition to establishing the panels, it is very important for providers to review their individual preliminary panel assignments, amend as necessary, and adopt the final initial panel.
- Developing a provider staffing and scheduling policy – This policy should address productivity expectations for different types of providers/ teams, and schedules, including open access and time for care coordination/outreach to patients in their homes.
- Developing empanelment standards – Empanelment standards should address primary care assignment roles and responsibilities, and manages unassigned patients.

*For example,*

- Appointment staff should confirm primary care provider assignments when making appointments, report discrepancies via appointment notes, and not be permitted to change primary care provider assignments.
  - Front desk staff should confirm primary care provider assignment at check-in and resolve any discrepancies.
  - Care team should confirm the primary care provider assignment with new patients, resolve discrepancies, and make changes in assignment upon request by provider or management team.
  - Panel manager should review panel assignments monthly and make applicable adjustments.
  - Management team should follow up on patient requests to change providers, and evaluate patient needs in collaboration with the care team when a provider transfers or terminates.
- Adding patients and providers – Managing unassigned patients and adding providers to the empanelment process is another ongoing task.
  - Scripting for appointment scheduling – This may be one of the most critical implementation elements after the actual empanelment process itself. As noted as a challenge, patients can find creative ways to circumvent the empanelment process with the expectation that it will get them an appointment sooner.

Language such as “It doesn’t matter to me who I see,” or “I want an appointment today no matter what/you have a same-day policy” needs to be able to be addressed confidently, politely, but firmly with patients. How to provide alternatives and handling exceptions (usually by referral to a member of the care team) should be spelled out in advance and scripted for the appointment scheduling staff.

- g. Ongoing monitoring and adjustment of panels – Panel management must be performed regularly. Panels are not static; provider and patient status changes can and do occur. The Safety Net Medical Home Implementation Guide cited above notes that use of a “continuity of care report” that measures goals for number of visits to assigned provider vs. non-assigned provider is a useful aid in evaluating the need for change in panel composition or size. If it is feasible to link this to outcomes measures, that is even better, although more difficult to measure.

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## Resources

<sup>1</sup>The Safety Net Medical Home Initiative (Mar. 2010). Empanelment: Establishing Patient-Provider Relationships Implementation Guide, Qualis Health, The Commonwealth Fund, Improving Chronic Illness Care McColl Institute at Group Health Cooperative. Available at: <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf>

<sup>2</sup>Additional resources provided by The Safety Net Medical Home Initiative are available on its web site: <http://www.safetynetmedicalhome.org/change-concepts/empanelment>

### For support using the toolkit

Stratis Health • Health Information Technology Services

952-854-3306 • [info@stratishealth.org](mailto:info@stratishealth.org)

[www.stratishealth.org](http://www.stratishealth.org)

