Introduction

At the heart of the Patient-Centered Medical Home (PCMH) model is the relationship between a patient and a provider and his/her practice team. All the activities of an effective PCMH should strengthen and reinforce the primacy of that relationship, and its accountability for the patient’s care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice.\(^1\)\(^2\)

But for many larger practices, especially in the fee-for-service, safety net environment, empanelment (linking patients with specific providers) has been challenging and often not an organizational priority. Empanelment must be an early change on the journey to becoming a PCMH, because other key changes such as continuous, team-based healing relationships, enhanced access, population-based care, and care coordination depend on the presence of such linkages.

This implementation guide, developed by the Safety Net Medical Home Initiative, explains the purpose and process of empanelment and provides step-by-step directions for successful implementation in the safety net.

Message to Readers: SNMHI implementation guides are living documents. Updates will be issued as additional tools, resources, and best-practices are identified.

This implementation guide provides an introduction to the following elements of empanelment:
- Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental, or additional services.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
- Understand practice supply and demand, and balance patient load accordingly.
Empanelment Implementation Guide: Change Concepts

Change Concepts

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a Patient-Centered Medical Home. Over the course of the “Transforming Safety Net Clinics into Patient-Centered Medical Homes Initiative”, we will cover each of the Change Concepts in turn. An implementation guide will be prepared and made available for each concept. This implementation guide is focused on empanelment, a foundational element of the medical home, and one we think must be addressed before the others.

**Empanelment**

**Continuous and Team-Based Healing Relationships**

**Patient-Centered Interactions**

**Engaged Leadership**

**Quality Improvement (QI) Strategy**

**Enhanced Access**

**Care Coordination**

**Organized, Evidence-Based Care**

Elements of Empanelment

- Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental, or additional services.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Understand practice supply and demand, and balance patient load accordingly.

The Patient-Centered Medical Home (PCMH) calls for a paradigm shift in the way we think about medical care. Instead of focusing on the acute needs of individual patients coming in for care, the PCMH model expects practices to take an organized, proactive approach to improving the health of a population of patients. The goal of focusing on a population of patients is to assure that EVERY patient receives optimal care, whether they regularly come in for visits or not. To care for a population of patients, a practice must first identify the group of patients for whom a physician or team is responsible and then engender meaningful relationships with those patients.

Taking a deliberate approach to identifying a panel of patients for whom a provider is responsible can be a challenge, especially in fee-for-service settings where many providers are used to thinking primarily about the care of individual patients. In these settings, caring for a defined population often means a shift in thinking. However, this shift in thinking is essential for practices interested in becoming PCMHs, as empaneling patients enables practices to:

1. Go beyond disease-specific interventions and address the preventive, chronic, and acute needs of all patients: those who regularly come into the medical practice for care and those who don’t.

2. Establish continuity of care between patients and a given provider and/or care team. Research shows that patients benefit from a long-term relationship with a provider or team of providers so long as the patient understands how the team works together.1,2

3. Manage supply and demand so that patients can reliably get in to see their provider when they need to, and ensure patients have enough time during the visit to get all of their needs met. Understanding supply and demand is the first step toward improving patient access to care.
Strong, effective leadership and ongoing operational support are essential for making empanelment work, and for realizing the improved health outcomes associated with continuous, comprehensive care and the access and quality of care benefits associated with better managed supply and demand. The first step is explicitly defining the link between the patient and the provider and care team, but that is just the beginning. Policies and procedures must be in place to ensure that patients can reliably see and build relationships with their providers. In practices where existing providers have a large or unbalanced workload, patients may need to be reassigned to other providers and encouraged to build new relationships. To maintain a specific panel size, a practice may need to hire more healthcare providers.

In addition, team roles may need to be redesigned to ensure that all the tasks associated with managing a population of patients are covered. For example, Medical Assistants may need to be trained in motivational interviewing to enable them to provide self-management support, and front desk staff may be called upon to reach out to patients for planned care visits or other necessary services. Team members may need to be reorganized to work more collaboratively with one another. Co-location and shared reporting relationships can help improve team functioning. Many teams have found that designating time at the start of each clinic session for team huddles enables them to be prepared for the day to come, and supports their ability to meet the preventive or chronic care needs of patients even when they come in for an unrelated acute need.

Finally, population-level data must be readily available for practices to understand which patients need proactive outreach and what preventive or chronic care needs can be addressed at the time of the visit. Using electronic medical records with registry functionality is one way this can be accomplished.

Information systems with registry functionality enable providers to examine their full panel of patients or selected sub-populations within their panels, such as diabetics or obese children, to identify sub-populations or individual patients in need of additional attention. This enables practices to schedule and organize planned visits with patients, and more effectively use their outreach capabilities such as community health workers or promotoras, to identify and respond proactively to patient needs. Empanelment and panel-data also facilitate the measurement of clinical performance and reporting of feedback at the individual provider level, which has been shown to be much more meaningful and influential to staff than practice-level metrics.

In sum, empanelment is a leadership-driven process essential for becoming a medical home. It requires a change in practice responsibilities—a shift from the care of individual patients seen in a provider’s office to the proactive and planned care of a population of patients. It also requires specific operational support including defining appropriate panel sizes; implementing policies that ensure continuity of care through scheduling practices; adjusting team roles; setting aside time for huddles; and using population-based registry information in daily practice. Ongoing leadership is needed to communicate these changes and to support their meaningful implementation.
The Mechanics of Empanelment

So how do you go about creating an empanelled practice?

The following steps were used by the Multnomah County Health Department as they began working on empanelment. More information about their efforts is available in the "Additional Empanelment Tools" section below. Grateful acknowledgement goes to Amit Shah, MD, Medical Director of the Multnomah County Health Department, for sharing his work on a webinar, from which this content was derived.

STEP 1: Assess Supply and Demand

- Collect current provider FTE and specialty.
- Determine the number of patients it is possible to take care of by plugging in your data to Mark Murray’s formula:

\[
\frac{(\text{provider visits/day}) \times (\text{days in clinic/year})}{\text{(patient visits/year)}} = \# \text{ patients}
\]

STEP 2: Assign Patients to Primary Care Physicians (PCP)

- Check to see if patients already assigned to a given PCP belong there.
- Assign patients who are unassigned using an adaptation of the Mark Murray “4 cut” method:
  1. Assign all patients who have only ever seen one provider to that provider.
  2. Develop a list of patients with their last three to five providers seen.
  3. Assign patients who have seen a provider the majority of times to the majority provider.
  4. Allow clinic teams to talk through the rest of the patients and where they belong.

STEP 3: Review Panel

- Allow all providers to review their panel for correctness. This allows for ownership of the panel.

STEP 4: Risk-Adjust

- Allow variance for specialty.
- Weight panels by age and gender average utilization.
- Weight panels by complexity or morbidity (optional).

After the mechanics of patient assignment have been mastered, substantial ongoing management is required to maintain your empanelment system. There are several areas that need to be addressed:

Integration of PCP Assignment into Existing Workflows. This includes implementing a process for assigning a PCP at or before a new patient’s first visit, and ensuring that unassigned patients are regularly identified and assigned to providers. Patients should also be engaged in the process of choosing and validating the PCP assignment. This may be accomplished through scripting for front desk staff. An example is provided on page 18.

Development of Policies and Procedures. Many details of the empanelment process need to be specifically articulated: 1.) how patients can change providers, 2.) how many new patients get assigned to a given provider, and 3.) if there a minimum staffing requirement for practitioners to ensure they can provide continuous coverage to their panel. An example is provided on page 13.

Creation of Data Definitions and Reports. Defining who is an “active” patient and is included in a panel (versus an inactive patient not included) may take some negotiation. These data definitions can have an impact on the credibility and usefulness of reports generated for providers.

A Change in Autonomy. In some cases, leadership may need to rethink their responsibilities as well. Encouraging teams to manage their own panels may require decentralizing decisions about how best to meet the needs of patients; for example,
allowing teams to develop team vacation schedules.

Implementing and maintaining patient panels requires work, but it is a fundamental step in becoming a patient-centered medical home.

Related Change Concepts

Empanelment is considered a ‘foundational’ Change Concept because it must be mastered before practices can tackle most of the others. For example, enhancing access to care relies on an ability to understand supply and demand, something that is made explicit by an understanding of patient panels. To have effective, continuous relationships, teams and patients need to recognize each other as long-term partners in care. Linking patients to regular provider teams is a core component of empanelment. Specific change concepts that rely on empanelment include:

- Continuous, Team-Based Healing Relationships
- Patient-Centered Interactions
- Enhanced Access
- Care Coordination
- Organized, Evidence-Based Care

To effectively manage the ongoing demands of empanelment, the following Change Concept capabilities are needed:

- Engaged Leadership
- Quality Improvement Strategy

Additional Resources: Workbooks and Tools

On the following pages, you will find more information and resources to help in the empanelment process, including:

- Building Better Care Provider Empanelment Guide
- Clinical Standards for Empanelment
- Provider Staffing and Scheduling Policy
- Empanelment Scripting for Appointment Scheduling

Additional Resources: Presentations and Media

Knowledge Building Session: Empanelment Webinar (October 10, 2009). Presenter: Amit Shah, MD, Medical Director, Multnomah County Health Department (Oregon). Webinar recording and slide available at: www.qhmedicalhome.org/safety-net/publications.cfm

Additional Resources: Literature

Mentor Site Examples

Multnomah County Health Department in Oregon has spent substantial time developing patient panels for their provider teams. For more information about their efforts please contact Amit Shah, MD, Medical Director at amit.r.shah@co.multnomah.or.us

Clinica Campesina in Colorado has also redesigned their teams and developed a robust approach to linking patients and providers. For more information about their efforts please contact Carolyn Shepherd, MD, Executive VP of Clinica Affairs at cshepherd@clinica.org

About the Initiative

The objective of the Safety Net Medical Home Initiative is 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 is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare 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.

The Initiative is 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 receives 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. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.


References

Introduction

The goal of Building Better Care is to shape services around the needs and preferences of patients and to continuously improve efficiency and effectiveness through a cycle of quality improvement.

The central focus is the enhancement of the patient relationship with the provider team.

The first step to achieving this is: 1. Ensuring a system in which all patients are assigned a primary care provider using consistent methodology. The second step is: 2. Establishing clearly defined roles/responsibilities for managing the PCP assignment process. Finally, the last step: 3. Establishing the provider’s panel size using a normalized weighting tool to adjust for panel complexity. This step is critical to ensuring patients have timely access to their provider.

The purpose of this instruction guide is to provide step-by-step instructions:

1. Process for PCP assignment.
2. Roles/responsibilities for PCP assignment process.
3. Establishing panel size using a normalized weighting tool to adjust for complexity.

1. Initial PCP Assignment Using The 4-Cut Method

A. Overview of the 4-Cut Method

1st Cut: Number of clients by provider who have seen only ONE provider in the past year.

2nd Cut: Number of clients by provider who have seen MAJORITY ONE provider in the past year.

3rd Cut: Number of clients by provider who have seen ONLY TWO providers in the past year—assigned to last provider seen.

4th cut: Number of clients by provider who have seen multiple providers equally in the past year—assigned to last provider seen.

2. PCP Clean-Up

Once the 4-cut report has been run, the next step of the process is to clean-up the list to ensure:

- All patients have been assigned a PCP
- All patients are assigned correctly
A. Clean-up Report

- All patients seen in the last 12 months
- PCP currently practicing at MCHD
- All deceased patients are excluded

Report consists of 5 columns:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Client has PCP Assignment in EPIC</th>
<th>4-cut method matches PCP Assigned in EPIC</th>
<th>No PCP Assigned in EPIC</th>
<th>Total Clients assigned using 4-cut method</th>
</tr>
</thead>
</table>

B. Clean-up Process:

**Step 1:** All clinic providers’ unassigned patients will be assigned to respective provider unless it is determined that an unassigned patient belongs with another provider (located in Column 4 from the 4-cut report).

**Step 2:** Each provider will be given the column 2 list of patients to review and mark as patients those that should be assigned to them (list is located in column 2 from 4-cut report). A designated clinic staff member will then manually make the PCP assignment changes in EPIC.

**Step 3:** After all providers have done above and the PCP changes have been made in EPIC, the report will be re-run and this will be the provider’s preliminary panel based on PCP assignment.

### 3. PCP Assignment Process

**A. PCP Assignment Roles/Responsibilities**

**Appointment Information Center (AIC) staff:** Confirms PCP assignment when making appointments. Reports discrepancies via appointment notes. **Does not** change PCP assignments.

**Front Desk staff**

- Confirms PCP assignment at check-in.
- Assigns new unassigned patients to provider scheduled with for first appointment.
- Resolves discrepancies between client’s stated PCP and EPIC assignment and reassigns PCP if indicated.

**Care team**

- Confirms PCP assignment with new patients.
- Resolves discrepancies with provider assignment for established patients.
- Changes PCP assignment upon request by provider or management team.

**Panel manager (or designee)**

- Reviews PCP assignments for team providers monthly.
- Addresses discrepancies in PCP assignment and unassigned patients seen by team provider.
- Tracks visits with PCP versus other providers.
- Tracks panel member changes including death, transfer to other care, etc. and makes the change in EPIC.
Management team

Follows up on patient requests to change providers.

When provider transfers or terminates, evaluates patient needs in collaboration with team and reassigns to other clinic providers, according to panel capacity, and notifies affected patients.

B. Unassigned Patients

NEW PATIENTS

- **AIC**: Schedules patient in available NPU/CRN appointment.
- **Front Desk**: Assigns PCP who client is seeing for new patient appointment.
- **Staff**: Check-in.
- **Care Team**: Confirms assignment with patient. If patient requests different provider, facilitates change of assignment.

UNASSIGNED PATIENT PREVIOUSLY SEEN

- **AIC**: Asks client who their PCP is-documents in appointment notes for team to confirm.
- **Front Desk**: Reviews appointment notes and EHR. Assigns to PCP previously.
- **Staff**: Seen unless patient requests different assignment.
- **Care Team**: Reviews PCP assignment and confirms with client/provider and changes assignment as indicated.

C. PCP assignment change

Client who wants to change PCP assignment within same clinic

- **AIC**: Informs the client that AIC cannot make PCP assignment change. Offers to refer to Operations Supervisor. Does not appoint to different PCP unless directed by clinic management staff.
- **Operations Supervisor**: Consults with current PCP. Reviews current provider’s history (no-shows, no-shows, number of clinic transfers).

Client requests transfer to PCP at different clinic

- **AIC**: Informs client cannot make PCP assignment change. Offers to refer client to Operations Supervisor at their current clinic. Does not appoint to different PCP unless directed by clinic management staff.
- **Operations Supervisor**: Consults with current PCP. Reviews client’s history (no of PCP changes, no-shows, number of clinic transfers).

PCP requests client reassignments within same clinic

- **Provider**: Contacts Operations Supervisor to request change. Provides accepting PCP with information re: patient and confirms new PCP will assume care.
- **Operations Supervisor**: Receives request and discusses rationale for change. Evaluates current providers who are able to accept a new patient and informs current PCP. Informs patient of new PCP and ensures PCP reassignment in EPIC.

PCP requests transfer to a different clinic

- **Provider**: Contacts Operations Supervisor to request change. Provides accepting PCP with information re: patient and confirms new PCP will assume care.
- **Operations Supervisor**: Receives request and discusses rationale for change. Informs clinic where proposed client will transfer. Confirms approval for transfer and new PCP assignment. Informs patient of new PCP. Receiving clinic changes PCP assignment.
## Step One:

### Empanelment: Panel Size

**Panel Weight (Normalized Scale)**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total Clients</th>
<th>Total Visits</th>
<th>Avg. # of Visits</th>
<th>Normalized Weight (UI/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0</td>
<td>28,782</td>
<td>107,557</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th># of Visits</th>
<th># of Clients</th>
<th>B: Avg. # of Visits</th>
<th>Normalized weight (UI/A)</th>
<th>Panel Weight (Normalized Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0</td>
<td>2,329</td>
<td>533</td>
<td>4.37</td>
<td>1.17</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,683</td>
<td>560</td>
<td>4.79</td>
<td>1.28</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3,673</td>
<td>656</td>
<td>5.66</td>
<td>1.49</td>
<td></td>
</tr>
<tr>
<td>Age 1</td>
<td>3,358</td>
<td>605</td>
<td>5.55</td>
<td>1.49</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3,936</td>
<td>656</td>
<td>6.00</td>
<td>1.61</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4,552</td>
<td>748</td>
<td>6.44</td>
<td>1.88</td>
<td></td>
</tr>
<tr>
<td>Age 2</td>
<td>1,682</td>
<td>526</td>
<td>3.20</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,914</td>
<td>570</td>
<td>3.36</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,154</td>
<td>455</td>
<td>2.54</td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td>Age 3</td>
<td>1,037</td>
<td>436</td>
<td>2.38</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,154</td>
<td>455</td>
<td>2.54</td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,045</td>
<td>468</td>
<td>2.23</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Age 4</td>
<td>1,070</td>
<td>476</td>
<td>2.25</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3,365</td>
<td>1,624</td>
<td>2.09</td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3,558</td>
<td>1,678</td>
<td>2.12</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
<td>Age 5 to 9</td>
<td>2,100</td>
<td>1,015</td>
<td>2.07</td>
<td>0.55</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,099</td>
<td>1,089</td>
<td>1.93</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,482</td>
<td>760</td>
<td>1.92</td>
<td>0.51</td>
<td></td>
</tr>
<tr>
<td>Age 10 to 14</td>
<td>3,426</td>
<td>1,143</td>
<td>3.00</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,462</td>
<td>760</td>
<td>1.92</td>
<td>0.51</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,675</td>
<td>888</td>
<td>2.07</td>
<td>0.55</td>
<td></td>
</tr>
<tr>
<td>Age 15 to 19</td>
<td>5,667</td>
<td>1,412</td>
<td>4.01</td>
<td>1.07</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>648</td>
<td>311</td>
<td>2.08</td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3,819</td>
<td>1,029</td>
<td>4.64</td>
<td>1.24</td>
<td></td>
</tr>
<tr>
<td>Age 20 to 24</td>
<td>7,197</td>
<td>1,811</td>
<td>3.97</td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>969</td>
<td>375</td>
<td>2.64</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,235</td>
<td>441</td>
<td>2.80</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Age 25 to 29</td>
<td>8,466</td>
<td>1,637</td>
<td>3.95</td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6,466</td>
<td>1,398</td>
<td>3.95</td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,000</td>
<td>239</td>
<td>2.80</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Age 30 to 34</td>
<td>1,775</td>
<td>532</td>
<td>3.34</td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,775</td>
<td>532</td>
<td>3.34</td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,775</td>
<td>532</td>
<td>3.34</td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>Age 35 to 39</td>
<td>4,775</td>
<td>1,029</td>
<td>4.64</td>
<td>1.24</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,213</td>
<td>624</td>
<td>3.56</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,407</td>
<td>769</td>
<td>4.07</td>
<td>1.36</td>
<td></td>
</tr>
<tr>
<td>Age 40 to 44</td>
<td>4,946</td>
<td>887</td>
<td>5.07</td>
<td>1.36</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3,116</td>
<td>691</td>
<td>4.51</td>
<td>1.21</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,830</td>
<td>596</td>
<td>4.51</td>
<td>1.21</td>
<td></td>
</tr>
<tr>
<td>Age 45 to 49</td>
<td>4,814</td>
<td>887</td>
<td>5.91</td>
<td>1.58</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3,005</td>
<td>633</td>
<td>4.75</td>
<td>1.27</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,811</td>
<td>254</td>
<td>5.22</td>
<td>1.53</td>
<td></td>
</tr>
<tr>
<td>Age 50 to 54</td>
<td>3,485</td>
<td>610</td>
<td>5.71</td>
<td>1.53</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,811</td>
<td>540</td>
<td>5.21</td>
<td>1.39</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,674</td>
<td>470</td>
<td>5.21</td>
<td>1.39</td>
<td></td>
</tr>
<tr>
<td>Age 55 to 59</td>
<td>2,901</td>
<td>483</td>
<td>6.01</td>
<td>1.61</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,823</td>
<td>337</td>
<td>5.41</td>
<td>1.45</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,078</td>
<td>146</td>
<td>5.41</td>
<td>1.45</td>
<td></td>
</tr>
<tr>
<td>Age 60 to 64</td>
<td>2,127</td>
<td>396</td>
<td>5.51</td>
<td>1.47</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,239</td>
<td>243</td>
<td>5.10</td>
<td>1.36</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,888</td>
<td>153</td>
<td>5.10</td>
<td>1.36</td>
<td></td>
</tr>
</tbody>
</table>
### Step Two:

#### Empanelment: Panel Size

**STEP TWO:**
Individual Provider Panel Weighting
Using Normalized Weight (from step 1)

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Client ID</th>
<th>Age</th>
<th>Gender</th>
<th>&quot;Weight&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>40.10</td>
<td>F</td>
<td>1.24</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>36.10</td>
<td>M</td>
<td>0.90</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>34.10</td>
<td>F</td>
<td>1.06</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>22.10</td>
<td>F</td>
<td>1.08</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>30.10</td>
<td>F</td>
<td>1.06</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>25.60</td>
<td>F</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>55.60</td>
<td>M</td>
<td>1.37</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>28.70</td>
<td>F</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>31.30</td>
<td>M</td>
<td>0.75</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>25.10</td>
<td>F</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>30.90</td>
<td>M</td>
<td>0.75</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>4.20</td>
<td>M</td>
<td>0.60</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>19.00</td>
<td>F</td>
<td>0.81</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>31.70</td>
<td>F</td>
<td>1.06</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>9.40</td>
<td>F</td>
<td>0.56</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>35.40</td>
<td>F</td>
<td>1.11</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>4.70</td>
<td>M</td>
<td>0.60</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>41.10</td>
<td>F</td>
<td>1.24</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>4.60</td>
<td>F</td>
<td>0.60</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>9.00</td>
<td>M</td>
<td>0.57</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>44.50</td>
<td>M</td>
<td>0.95</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>36.80</td>
<td>F</td>
<td>1.11</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>74.00</td>
<td>M</td>
<td>1.17</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>68.70</td>
<td>F</td>
<td>1.48</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>75.20</td>
<td>M</td>
<td>1.26</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>16.30</td>
<td>F</td>
<td>0.81</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>56.10</td>
<td>F</td>
<td>1.57</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>60.70</td>
<td>M</td>
<td>1.43</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>50.60</td>
<td>M</td>
<td>1.30</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>50.00</td>
<td>F</td>
<td>1.56</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>29.40</td>
<td>M</td>
<td>0.70</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>23.80</td>
<td>F</td>
<td>1.08</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>15.10</td>
<td>F</td>
<td>0.81</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>26.60</td>
<td>F</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>5.70</td>
<td>F</td>
<td>0.56</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>8.10</td>
<td>F</td>
<td>0.56</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>9.40</td>
<td>M</td>
<td>0.57</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>80.90</td>
<td>M</td>
<td>1.07</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>19.70</td>
<td>F</td>
<td>0.81</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>21.00</td>
<td>F</td>
<td>1.08</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>47.70</td>
<td>M</td>
<td>1.22</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>24.40</td>
<td>F</td>
<td>1.08</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>2.80</td>
<td>M</td>
<td>0.85</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client ID</td>
<td>5.50</td>
<td>F</td>
<td>0.56</td>
</tr>
</tbody>
</table>

Total PCP Clients: 949

Weighted Panel using MCHD Age/Gender: 964

TOTAL: 949

TOTAL: 964
Step Three:

<table>
<thead>
<tr>
<th></th>
<th>Total Clients</th>
<th>Total Visits</th>
<th>Avg # of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peds</strong></td>
<td>7,284</td>
<td>17,188</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Family Practice</strong></td>
<td>18,507</td>
<td>55,832</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Women's Health</strong></td>
<td>3,157</td>
<td>8,287</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Internal Medicine</strong></td>
<td>8,452</td>
<td>28,388</td>
<td>3.4</td>
</tr>
</tbody>
</table>
### 4. Determining Panel Size

#### A. Definitions

**Panel Size:** Number of individual patients under the care of a specific provider.

**Determining Panel Size:** Demand for appointments must equal supply.

- **Panel size x visits per patient per year (demand)** = Provider visits/day x provider days per year (supply)

#### B. Process Steps

**Step 1 (pg 10):** MCHD average visits per age range in last year.

**Step 2 (pg 11):** Individual provider panel weighting using normalized weight.

**Step 3 (pg 12):** Weighting by provider specialty.

**Step 4 (pg 13):** Determine ideal panel size adjusted for FTE.

#### Panel Weighting:
Weighting a panel to adjust for complexity is complicated, and there isn't strong evidence-based literature supporting one methodology over another. For this purpose, we will use an age/gender distribution marking the groups with the highest utilization (based on number of visits). MCHD took IHI sample age/gender weighting and applied its own utilization data to arrive at the following Age/Gender Specific Panel Adjustments.

---

**Step Four:**

**MCHD Empanelment Example**

*01/24/2008*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Provider</th>
<th>FTE</th>
<th>Visits/day (18) x days worked (210)</th>
<th>Average Visits (3780/3)</th>
<th>Weighted Panel (by MCHD age/gender)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>Provider A</td>
<td>0.8</td>
<td>3780</td>
<td>949</td>
<td>964</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ideal Panel Size Based on Specialty Avg. Visits</th>
<th>Ideal Panel Size Adj. for FTE (1260 x 0.8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>3.0</td>
<td>1008</td>
</tr>
</tbody>
</table>
Clinical Standards for Empanelment

Suggested Citation: Shah A, Stadtlander M. Building Better Care “Empanelment”. 1st ed. Portland, OR; Multnomah County Health Dept, December 2009.

Purpose
To link each primary care client with a Primary Care Provider (PCP).

Goal
To increase client and provider satisfaction, improve continuity of care, and improve delivery of care.

Procedural Steps

1. PCP Assignment Roles/Responsibilities

AIC Staff:

- Confirms PCP assignment when making appointments. Reports discrepancies via appointment notes. Does not change PCP assignments.

Front Desk Staff:

- Confirms PCP assignment at check-in.
- Assigns new unassigned patients to provider scheduled with for first appointment.
- Resolves discrepancies between client’s stated PCP and EPIC assignment and reassigns PCP if indicated.

Care Team:

- Confirms PCP assignment with new patients.
- Resolves discrepancies with provider assignment for established patients.
- Changes PCP assignment upon request by provider or management team.

Panel Manager (or designee):

- Reviews PCP assignments for team providers monthly.
- Addresses discrepancies in PCP assignment and unassigned patients seen by team provider.
- Tracks visits with PCP versus other providers.

Management Team

- Follows up on patient requests to change providers.
- When provider transfers or terminates, evaluates patient needs in collaboration with team and reassigns to other clinic providers according to panel capacity and notifies affected patients.

2. Unassigned Patients

NEW PATIENTS

AIC: Schedules patient in available NPU/CRN appointment.

Front Desk: Assigns PCP who client is seeing for new patient appointment at check-in.

Care Team: Confirms assignment with patient. If patient requests different provider, facilitates change of assignment.

UNASSIGNED PATIENTS PREVIOUSLY SEEN

AIC: Asks client who their PCP is, and documents in appointment notes for team to confirm.

Front Desk Staff: Reviews appointment notes and EHR. Assigns to PCP previously seen unless patient requests different assignment.

Care Team: Reviews PCP assignment and confirms with client and provider, and changes assignment as indicated.
3. PCP Assignment Change

CLIENT WHO WANTS TO CHANGE PCP ASSIGNMENT WITHIN SAME CLINIC

**AIC:** Informs client cannot make PCP assignment change. Offers to refer to operations supervisor. Does not appoint to different PCP unless directed by clinic management staff.

**Operations Supervisor:** Consults with current PCP. If transfer is approved, confirms acceptance by new PCP (should include PCP-PCP communication).

CLIENT REQUESTS TRANSFER TO PCP AT DIFFERENT CLINIC

**AIC:** Informs client cannot make PCP assignment change. Offers to refer client to operations supervisor. Does not appoint to different PCP unless directed by clinic management staff.

**Operations Supervisor:** Consults with current PCP. Reviews client’s history (# of PCP changes, no-shows, number of clinic transfers).

PCP REQUESTS CLIENT REASSIGNMENT WITHIN SAME CLINIC

**Provider:** Contacts Operations Supervisor to request change. Provides accepting PCP with information re: patient and confirms new PCP will assume care.

**Operations Supervisor:** Receives request and discusses rationale for change. Evaluates current providers who are able to accept new patient and informs current PCP. Informs patient of new PCP and ensures PCP reassignment in EPIC.

PCP REQUESTS TRANSFER TO A DIFFERENT CLINIC

**Provider:** Contacts Operations Supervisor to request change. Provides accepting PCP with information re: patient and confirms new PCP will assume care.

**Operations Supervisor:** Receives request and discusses rationale for change. Informs clinic where proposed client will transfer. Confirms approval for transfer and new PCP assignment. Informs patient of new PCP. Receiving clinic changes PCP assignment.

4. Client notification of provider transfer or termination

In the event of a provider transfer or termination, each clinic site will take responsibility for notifying clients.

**Clinic Manager or designee:**

- Notify Application Support Services of the provider change within two weeks of receiving notice.
- Notify Application Support Services of the termination/transfer date so the EPIC provider profiles can be updated and needed client extracts, letters and labels can be provided.

**EPIC Staff:**

- Provide the clinic a list of clients assigned to the provider, client letters and optional mailing labels, if needed.

**PCP/Clinic Manager or Designee:**

- The manager will assure that the computer is updated with the revised PCP information. Standard personalized letters will be sent from the provider to notify clients of the transfer or termination. Clients should be told that the clinic will notify them when their PCP has been replaced. Until reassignment occurs, clients will be seen by the appropriate provider as determined by the clinic manager in coordination with the other providers at the site.

**Clinic Manager or Designee:**

- Notify EPIC when a new PCP is hired or when caseload needs to be reassigned to new provider. Clinics will be responsible for reassigning the client to a new PCP within the clinic site.
Provider Staffing and Scheduling Policy

Suggested Citation: Shah A, Stadtlander M. Building Better Care “Empanelment”. 1st ed. Portland, OR; Multnomah County Health Dept, December 2009.

Policy Statement

Provider staffing and scheduling practices are designed to ensure timely access and promote continuity of care. Providers are expected to achieve annual productivity targets. Provider teams are responsible for ensuring adequate coverage during all hours of clinic operation.

1. Provider Productivity Expectations

A. Established Providers

<table>
<thead>
<tr>
<th>Primary Care Medical</th>
<th>18 patients/8hr day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23 patients/10hr day</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>10 patients/day</td>
</tr>
<tr>
<td>HIV</td>
<td>12 patients/day</td>
</tr>
<tr>
<td>School Based</td>
<td></td>
</tr>
<tr>
<td>Elementary/Middle</td>
<td>12 patients/day</td>
</tr>
<tr>
<td>High School</td>
<td>14 patients/day</td>
</tr>
</tbody>
</table>

B. New Providers (with experience)

- First 80 hours of clinical practice 50%
- 80-160hrs 75%
- 160-320hrs 90%

C. New Providers (without experience)

Individualized productivity advancement plans are developed and 100% productivity is expected at 6 months.

D. Provider Transfers within Primary Care

- First 2 weeks 50%
- 2-4 weeks 75%
- 4-8 weeks 90%
- 8 weeks > 100%

2. Provider Scheduling

A. Limitations to scheduling are based on scope of practice and must be pre-approved by clinic management team.

B. All primary care (except HIV) providers are given one 20-minute appointment slot at the beginning of each day for team planning and 40 minutes at the end of the day (60 minutes for providers who work 10 hour shifts).

1. Behavioral Health providers have 30 minute appointments and have a total of 90 minutes of team planning for every 8 hours worked.

2. HIV providers have 25 minute appointments and have a total of 50 minutes of team planning for every 8 hours worked.

C. Additional appointment slots are added based on provider no-show rate. The provider and clinic management can choose where on the schedule the additional slots occur.

- 0-10% = 2 additional appointments/8 hour shift (3 for 10 hour shifts)
- 10-15% = 3 additional appointments/8 hour shift (4 for 10 hour shifts)
- >15% = 4 additional appointments/8 hour shift

D. Number of new patients scheduled is determined by panel capacity. Clinic management team chooses where on the schedule these occur.

E. Lunch/breaks are determined by the provider in collaboration with clinic management.
3. Provider Team Staffing

A. All providers are in clinic a minimum of 4 days/week with the exception of administrative providers.

B. Practice partners’ regular schedule covers all clinic sessions 5 days/week.

C. If half days are used to achieve above, then they must be equally distributed between AM and PM sessions.

D. Practice partners cannot have the same planned time off (e.g. vacation, CME).

E. Provider teams must have two of the following members scheduled every day (provider and team CHN or 2 providers).
Empanelment Scripting for Appointment Scheduling

Suggested Citation: Shah A, Stadtlander M. Building Better Care “Empanelment”. 1st ed. Portland, OR; Multnomah County Health Dept, December 2009.

Receptionist: “Which provider do you regularly see?”
Patient: “Dr. Moore, but it really doesn’t matter to me.”
Receptionist: “It really is better for you to see the same one as frequently as possible, so that he gets to know you better and can take better care of you. Dr. Moore is not in today, but I can schedule you tomorrow with him when he returns.”
Patient: “I would rather come in today.”
Receptionist: “That’s fine, you can see one of his partners today, and next time we will try to get you in with Dr. Moore.”

or

Patient: “I would like to make an appointment with Dr. Moore.”
Receptionist: “When would you like to come in?”
Patient: “Tomorrow sometime”
Receptionist: “Dr. Moore is not in tomorrow. He could see you at 3:00 today, or he will be back in on Thursday and I could schedule you then.”

(Patient gets to choose)

or

Patient: “I would like to make an appointment for next month with Dr. Moore for my physical.”
Receptionist: “We really try not to schedule out so far, since plans change, and it can be hard to keep an appointment that is scheduled so far in advance. Would you like to come in sooner, or would you like to call back within a few days of when you would like to be seen? We will have appointments available then.”

(If patient is insistent and the schedule is open, go ahead and schedule, but make a note for someone to confirm appointment the day before)

or

Receptionist: “Dr. Moore’s schedule is full today, and we have already worked in a few emergencies. Since you are requesting a routine physical, I will need to schedule you for another day with Dr. Moore. What day is best?”

Patient: “@#$%^&*+()%$! You people first tell me something about a same day appointment and have asked me to call on the same day, and now that I do, you tell me that I can’t come in today! When are you going to get your @#$%^$& act together??”
Receptionist: (Pleasant and smiling) “We are doing the best that we can. We have gotten so busy that we have had to schedule out a few days, but we are working hard to get back to the same day appointments. Remember when you used to call and it took a month to get in? If you really can’t wait, one of Dr. Moore’s partners can get you in today, but I know that Dr. Moore would really like to see you himself, since he knows all about you. He can see you at 8:00 am tomorrow, and you will be his first patient of the day.”

or

Receptionist: “Dr. Moore’s schedule is full today, but you can see him tomorrow morning or one of his partners today.”
Patient: I want to see Dr. Moore, but I don’t know what I am doing tomorrow. I want to call back tomorrow.
Receptionist: “If that works better for you, that is fine. Try to call as early in the day as you can, since the schedules fill up fast, and I can’t guarantee that you will get the time that you want.”

Remember…

- It’s the patient’s choice – accommodate them whenever possible.
- Always confirm PCP and schedule with that provider whenever possible.
- Try not to schedule out any further than 2 weeks, if possible, since the no-show rate rises after that length of time.
- Anything that you are scheduling for another day, try to encourage the early morning appointments. If the patient insists on a later time, go ahead and schedule (it’s the patient’s choice!).
- If the conversation is getting tense, get the point across to the patient that we want his appointment time to work for him so that he will be sure to make it.
Below is a link to a slide deck developed by the Primary Care Renewal Collaborative in Oregon. This presentation provides an overview of empanelment, practical examples, and requirements for successful implementation.

To view this slide deck, click here.

For more information about the Primary Care Renewal Collaborative, visit: [http://www.careoregon.org/pcr/index.html](http://www.careoregon.org/pcr/index.html)